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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1976

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

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

DANIEL J. FLOOD, Pennsylvania, *Chairman*

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PART 6

TESTIMONY OF MEMBERS OF CONGRESS AND OTHER INTERESTED INDIVIDUALS AND ORGANIZATIONS

Printed for the use of the Committee on Appropriations

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR FISCAL YEAR 1976

TUESDAY, MAY 13, 1975.

TESTIMONY OF MEMBERS OF CONGRESS AND OTHER INTERESTED INDIVIDUALS AND ORGANIZATIONS

THE NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

WITNESS

DR. RICHARD P. SCHMIDT, CHAIRMAN, NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL DISORDERS AND STROKE

Mr. FLOOD. Now we will begin the hearings for what we call the public witnesses. Ever since the hearings began early in the year, there have been various Government witnesses for various departments and agencies. But now, as is the custom and the practice, we begin the testimony from the public witnesses.

The first witness will be Dr. Richard Schmidt, chairman of the National Committee for Research in Neurological Disorders and Stroke.

Dr. Schmidt?

Dr. SCHMIDT. Thank you, Mr. Chairman.

Mr. Chairman, I have several written statements, one for myself, one from Dr. Bucy, one from Dr. Langfitt at the University of Pennsylvania, and the other is from Dr. Snow, also from the University of Pennsylvania, who are all associated with our committee.

GENERAL STATEMENTS

To save your time, Mr. Chairman, I would request permission to introduce these into the record rather than having them appear personally.

Mr. FLOOD. Without objection, that will be done.

[The statements follow:]

STATEMENT BY DR. PAUL C. BUCY, CHAIRMAN EMERITUS, NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL DISORDERS

I am Dr. Paul C. Bucy, chairman emeritus of the National Committee for Research in Neurological Disorders. This committee represents some 50 voluntary health agencies and professional organizations concerned with the prevention, diagnosis, and care of patients with neurological, and communicative disorders. I am also professor emeritus of Neurological Survey of Northwest-

ern University Medical School, Chicago, Ill., and clinical professor of Neurology and Neurosurgery, Bowman Gray School of Medicine, Winston-Salem, N.C. I am also the editor of a neurosurgical journal known as "Surgical Neurology." I appear before you on behalf of the National Committee for Research in Neurological Disorders regarding the budget for 1976 of the National Institute of Neurological and Communicative Disorders and Stroke.

NINCDS is the Institute in NIH which is concerned with research in the neurological and communicative disorders and in the basic sciences related to those disorders. It is concerned with a wide variety of diseases which not only affect approximately 20 percent of our citizens but which are the third (stroke) and fourth (injury to the brain and spinal cord), most common causes of death. In addition and, in fact, much more importantly, these diseases are those which cripple and disable chronically more of our citizens than any others. These diseases are also among the most obscure and difficult to investigate and understand. This is true not only because the nervous system is enclosed within bony walls where it cannot be readliy seen or examined but because of its intricacy. Even more important, the central nervous system in man is that part of the body which differs most from the comparable organs in animals. As a result, although animal research is important, much of the investigation of human disease must be conducted on man himself, and all research findings made on animals in the laboratory must be confirmed in man before we can be confident that the observations are true for man.

During the brief 25 years that the Neurological Institute has been in existence it has made great contributions to the understanding and treatment of neurological and communicative disorders. In 1950 the specialty of neurology was literally dying on its feet. It was an erudite diagnostic specialty which had little in the way of prevention and treatment to offer its patients. As a result there were very few neurologists in this country and there were many medical schools with no one specially trained in neurology on their faculties to teach their medical students. In the past 25 years that has changed remarkably, and largely as the result of the activities of this Institute. All medical schools have neurologists on their faculties. Many of them have independent departments of neurology. The laboratories in basic neurosciences have increased in numbers and expanded fantastically. Practically all of these teachers and investigators have received their training in programs supported by NINCDS and the laboratories have been created and in large measure operated through funds awarded by NINCDS.

Until 2 years ago NINCDS had operated with decreasing allotment of funds ever since 1968, and with a decreasing staff. In the past 2 years the funds available to NINCDS have increased and the Institute has been able to expand its activities into necessary areas which had been neglected because of the lack of funds in prior years. The President's budget for fiscal year 1976 calls again for a decrease in funds for this Institute of approximately 20 percent. If such a decrease were to occur the Institute would be forced to cut back on the important programs which it has recently instituted and to discontinue its expansion into new areas. What are the most outstanding needs of the Institute and in the areas of neurological and communicative disorders?

First, NINCDS must have a larger staff. The reducton of staff from 649 to 515, a reduction of 20 percent, is completely unrealistic. The Institute cannot develop and operate the new programs so badly needed if it is not permitted to have a staff large enough to deal with its problems. Instead, the Institute should be permitted to increase its staff by a very modest 10 percent or by 52 positions. Even such an increase would not allow the Institute to return to the level which formerly existed, namely a staff of 649. Numbers alone are not enough. The grade level of the members of the staff must also be permitted to rise to that required to meet the need of the Institute.

For the past several years the policy of destroying the training programs of the Institute has been disastrous. The teachers and investigators in neurology, neurosurgery, otolaryngology, and basic neurosciences which the Institute helped to create over the past 25 years are for the moment carrying the burden. But it takes years to train teachers and investigators. The number now being trained will not be sufficient to supply the needs of the existing and newly formed medical schools, of the enlarged body of medical students, and to replace those teachers and investigators who will retire or die in the next 5 years. First, the policy of the administration destroyed the training programs and substituted for them an inadequate program of individual scholarships. This policy has many

disadvantages and inadequacies, the greatest of which is the fact that no one can train men without a well-developed on-going program. Second, the administration abolished support for the training of clinical teachers and investigators. The one field of medicine in which clinical investigators is of the greatest importance is that of the nervous system because the nervous system of man is so vastly different from that of all animals. This policy of the administration was developed, so it was said, because the Government should not contribute to the training of men who were going to go into the practice of medicine and make hundreds of thousands of dollars a year. This excuse was false on two grounds. The training was for teachers and investigators and not for private practitioners of medicine. And teachers and investigators working in our medical schools and laboratories do not make the incomes suggested by those who destroyed these training programs. Third, now the administration is seeking to destroy all training programs. Conduct of research and the dissemination of knowledge about neurological and communicative disorders will not be possible if the training programs for teachers and investigators are not reestablished. Because improvement in the understanding, diagnosis, and treatment of neurological and communicative disorders is of importance to all individuals in all parts of the United States, the expense for both research and training should be borne by all of the people. This can only be done through the Federal Government. It is not only unjust to expect research and training to be supported by a few individuals, or a few municipalities or States, but it is unrealistic. If it is not done by the Federal Government, it will not be done.

This past year the level of support for research grants increased. The percentage of applications which were approved was essentially the same in fiscal year 1975 as in fiscal year 1974 and fiscal year 1973, but the percentage funded increased in fiscal year 1975 to 46 percent as compared with 31 percent in fiscal year 1974 and 34 percent in fiscal year 1973. However, if the appropriation for NINCDS is not increased in fiscal year 1976 over what it was in fiscal year 1975 and greatly over what the President has recommended, the number of funded research grants will again decline. In the opinion of NCRND even to have 46 percent of all applications funded is inadequate. Of all applications for research support which were submitted the review committees and the Advisory Council of NINCDS found 70 percent worthy of approval. All of these should have been financially supported, but 35 percent of them were not. The Director of NINCDS, Dr. Donald Tower, has told this committee that if the Institute is supported at the level of the President's budget, only 19 percent of new research applications will be funded. And in addition, the support for other research activities will be decreased. This is not the way to abolish crippling, disabling neurological and communicative disorders.

The National Committee for Research in Neurological Disorders has carefully surveyed the needs of the National Institute of Neurological and Communicative Disorders and Stroke. It strongly recommends that the necessary steps be taken to increase the staff of NINCDS by 60 positions and to survey the grade level of all appointments and increase the grade wherever necessary. NCRND also strongly recommends an appropriation of $193 million for NINCDS for fiscal year 1976. The categories to be supported in that appropriation are indicated below. In addition NCRND has heard that the appropriation at this time may be for 15 months rather than the usual 12 months. If the appropriation is for 15 months it should be $241,250,000.

Recommendation for fiscal year 1976 for 12-month period

Grants:	
Research grants	$123,000,000
Fellowships	23,700,000
Training grants	3,800,000
Subtotal	150,500,000
Direct operations:	
Laboratory and clinical research	15,000,000
Research and development contracts	14,000,000
Other	13,500,000
Subtotal	42,500,000
Total	193,000,000

STATEMENT BY JAMES B. SNOW, JR., M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF OTORHINOLARYNGOLOGY AND HUMAN COMMUNICATION, SCHOOL, OF MEDICINE, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA.

Unprecedented progress has been made in the prevention and amelioration of disorders of human communication and in the rehabilitation of our people with communicative disorders. This progress has been achieved i nlarge measure through the support of research and training in the communicative sciences by the National Institute of Neurological and Communicative Disorders and Stroke.

This progress has occurred in many areas. Not only have new developments led to new and effective treatment, but our fundamental understanding of the structure and function of the body in the communicative processes has been enhanced and provides the basis for the practical application of new knowledge to those with communicative handicaps. The combination of new information from the fields of biology, electronics, electrical engineering, computer science and radiation has improved diagnosis, therapy and rehabilitation.

In recent years significant progress has resulted from research in the surgical treatment of common causes of hearing loss such as otosclerosis, serious otitis media and chronic otitis media. Major progress has occurred in the prevention of sensorineural hearing loss due to the ototoxicity of drugs, rubella, measles, mumps, syphilis and noise induced hearing loss.

The survival of patients with malignant tumors of the voice box and throat has been improved by imaginative combinations of radiation therapy and surgery. Likewise new developments in the early detection of tumors of the vocal tract have led to higher cure rates with less disability secondary to the treatment.

Much of he information upon which the levels of control of environmental noise to prevent noise induced hearing loss incorporated in the Occupational Safety and Health Act was developed in research supported by the National Institute of Neurological and Communicative Disorders and Stroke.

The number of people in the United States who are afflicted with disorders of human communication is quite great. Indeed, there are over 20 million Americans who are disadvantaged by hearing loss and speech, language and voice disorders.

New information has reached a sufficient stage of development so that new breakthroughs can result from further research in many of the problem areas afflicting these 20 million Americans. These areas include serous otitis media (a common cause of childhood hearing loss), hearing loss from head injury, vestibular disorders which result in recurrent and persistent vertigo and imbalance, laryngeal cancer, laryngeal papillomatosis (a devastating disease of the upper airway in young children), stuttering, aphasia (the loss of speech, one of the most profound and persistent disabilities resulting from stroke), language development (critical for early childhood) and voice disorders (a prominent cause of economic disadvantage for those so afflicted). For example, experts in the problem of serous otitis media who are meeting at Ohio State University, Columbus, Ohio, later this month believe that we are on the threshold of discovering the secret to the prevention of this common childhood problem. Although a satisfactory means of surgical treatment of this form of hearing loss has been developed through research, the importance of discovering the means of prevention cannot be overemphasized because of the anguish it causes and the economic impact of it. It has been estimated that more medicaid funds are spent on the treatment of this condition than any other single disease process. Serous otitis media is another area requiring additional research which is likely at this time to have a large payoff.

Likewise, recent progress in the implantation of auditory devices has reached a state of art in which additional research may make the difference between isolation and communication for the large segment of our population (60,000 persons) who are profoundly deaf. The scientific community concerned with auditory prostheses has made a cogent statement supporting a major research effort in implantable devices to restore hearing at this time. The rewards of this endeavor for the profoundly deaf defy quantification in economic or human terms.

An area of great importance to the hard of hearing (2 million persons) is the development of the miniaturized master hearing aid which allows alteration of acoustic characteristics to fit the individual's needs. It provides hope through research of making hearing aids useful to persons who previously had not obtained satisfactory improvement.

Another example of an impending breakthrough is the immunotherapy of laryngeal papillomatosis. Preliminary data suggest that this form of therapy offers the most rational approach to this tragic childhood disease. In the area of communi-

cative disorders, it is possible to cite many leads like this one which are well worth pursuing with urgency and determination.

At the operative level of the fiscal year 1975 National Institute of Neurological and Communicative Disorders and Stroke budget ($142 million), only 42 percent of the research projects dealing with the medical problems of human communication (hearing, speech, and language) were awarded. At the level of the President's 1976 budget ($114.5 million), only 19 percent of the new proposals addressed to the exploitation of this new research knowledge can be funded. The magnitude of this tragedy becomes apparent when one recognizes the high scientific merit and social significance of the projects that cannot be awarded at this level. The National Committee for Research in Neurological Disorders urges the appropriation of $193 million for the National Institute of Neurological and Communicative Disorders and Stroke so that the work so vital to the communicatively impaired may continue with renewed vigor.

Not only are additional funds needed to support currently proposed research by outstanding investigators, but funds are needed to support research training in the communicative sciences to provide a steady infusion of young creative investigators to pursue the problems evolving along the road of our progress. There is currently a manpower shortage in the research areas of the communicative disorders. These professional fields include the medical specialties of otorhinolaryngology (ear, nose, and throat) and neurology, the allied medical disciplines of audiology and speech pathology and the basic sciences of biochemistry, developmental neurobiology, immunology, electrophysiology, biophysics, and virology. Support for training programs and individual fellowships are of the highest priority in the opinion of experts in the fields of the communicative sciences. The termination of the "old" training grant program was particularly detrimental to the development of research manpower in the communicative sciences. These training programs provided support for the academic environment and training and for the individual trainees. The new program supports the trainees in selected research areas including the communicative sciences and will help meet the national need. However, the level of support must be significantly increased over the operating level for fiscal year 1975 in order to make the necessary impact on the national manpower shortage in the communicative sciences.

Now is a propitious time to increase support for the National Institute of Neurological and Communicative Disorders and Stroke in research in view of the research leverage provided by impending scientific breakthroughs and in training in view of the national manpower shortage in the communicative sciences.

Statement of Doctor Thomas W. Langfitt

My name is Thomas W. Langfitt, M.D. I am chairman of the division of neurosurgery and vice-president for health affairs at the University of Pennsylvania. In my testimony last year before your subcommittee, I provided some background for the current research efforts of NINCDS in the areas of head injury and stroke. In this report I will address some concepts and purposes of the NINCDS Clinical Research Centers, how these concepts have been put into practice and the purposes served, then discuss some problems that have to do with the application of information and clinical expertise that have been developed in these centers to patient diagnosis and management throughout the country.

CONCEPTS AND PURPOSES OF THE NINCDS CLINICAL RESEARCH CENTERS

The principle goal of neuroscience research in general and of the neuroscience Clinical Research Center in particular is to generate new information potentially applicable to the diagnosis and treatment of neurological diseases and at the same time application of existing knowledge to the management of those diseases. The establishment of clinical research centers was stimulated by recognition of a gap between the generation of knowledge and its application to patient care. The gap has been bridged by combining the basic neurosciences, clinical neurosciences, and direct patient care within the centers. Hypotheses are developed and tested in animal experiments; those hypotheses that offer promise in patient management are then tested in the clinical setting with meticulous attention to the safety and the rights of the individual patient. Conversely, hypotheses are also developed from patient management and tested in the laboratory. Oftentimes in the past the personnel and facilities to test the new hypoth-

eses were not available to the research team. Colleagues in other parts of the university had the expertise to do so, but they were busy with their own work. They did not have the time to understand this new application of their own research area. The research center has ameliorated this age old problem, because it is multidisciplinary; most importantly it contains both basic and clinical research scientists who can relate well to their colleagues in other fields. A neurochemist can communicate with a physical chemist who has something to offer the research center as the neurologist or neurosurgeon ordinarily cannot do.

The neuroscience trauma center is but one example of the effectiveness of this approach. In the early part of this century both experimental and clinical head injury research was concentrated in neuropathology. Neuropathology had emerged as an exciting and productive scientific discipline due to the development of tissue staining techniques that permitted a detailed description of the morphology of the brain, and at the same time neuroanatomists were continuing to define the tracts and anatomical connections within the central nervous system. The study of neurophysiology followed as techniques for recording the electrical activity of the brain became more accurate and sophisticated. Thus, until the mid 1950's most research on trauma was directed toward defining the neuropathology and the electrical events produced by a traumatic injury to the brain or spinal cord, and much of the research was conducted by neurosurgeons and neurologists who had special training in these disciplines.

Wide application of the strain gage transducer to measure pressures in blood vessels and the intracranial cavity, and the introduction of isotopes to study brain and cerebrospinal fluid chemistry came in the late 1950's. The metabolism of oxygen and glucose by the normal brain was defined. The stage was now set for the investigation of central nervous system trauma with a degree of sophistication and understanding that was at the same time exciting, challenging, and mind boggling. Again neurologists and neurosurgeons took special training in these fields, but for the most part they could not aspire to the competence of basic scientists who had spent their professional lives in these areas of research. Furthermore, the equipment was expensive and required large amounts of new research space.

The neuroscience Clinical Research Center emerged from this background of need. The challenge was not so much to develop new technology; rather the challenge was to develop specific hypotheses regarding the effects of trauma on the brain and spinal cord, then gather together the scientists to apply this technology to specific issues. The principle investigators found themselves wallowing in a sea of plenty; the challenge was to select imaginative and realistic hypotheses to be pursued to a logical conclusion, often over many years, using whatever scientific resources that were required. The goal of all of this effort was clear, reduction in the morbidity and mortality of head and spinal cord injury; therefore, the clinicians and particularly the principle investigators in the Clinical Research Centers had to avoid being so mesmerized by the inevitable excitement of the pure research going on in their laboratories that they lost sight of the primary goal of the Center. The Head Injury Centers have fulfilled these requirements well. The Spinal Cord Centers are younger but are progressing well. Each head injury center has developed a program based on the strengths of the principle investigator and his immediate colleagues in neurosurgery and the basic neurosciences as well as strengths of the institution in basic and clinical sciences that had not been applied to head injury research in that university or, frequently, anywhere else. Some head injury centers concentrate on the pathophysiology of brain injury, others on the effects of trauma on brain metabolism, and still others on the electrical properties of the brain. All head injury centers incorporate a neurosurgery intensive care unit where acute head injuries are managed and where ultimately hypotheses are both developed and tested.

There are problems. As the field of head injury research has expanded geometrically since the establishment of Head Injury Centers was approved less than a decade ago, it has been more and more difficult for even the most sophisticated research team to grasp the significance of all of the information that has been generated in recent years. Attractive new hypthoses and technologies tend to divert the team from their primary purpose and create a diffusion of effort. Sometimes there are organizational problems, because the clinician and the basic scientist do in fact speak a different language, and communications between them can be difficult.

Nevertheless, in my opinion, the NINCDS Clinical Research Center offers the greatest single opportunity to apply the vast quantity of information that has

been acquired in recent years to the needs of our patients; and that is what our research is all about.

CONCEPTS OF THE ORGANIZATION OF HEALTH SERVICES

The public and governments are proud of the accomplishments of the biomedical research community. They are distressed, however, by failures in the health care system that center on access to the system, geographic and specialty maldistribution, and the increasing number of foreign medical graduates training and practicing in the United States. The emphasis is on primary care. It is ironic, I believe, that one of the major purposes of the Regional Medical Programs instituted by President Johnson in 1966 was to reorganize tertiary care. That effort failed; rather than examining why it failed, then develop alternative approaches, the emphasis has shifted to newly perceived needs in primary care, and the reorganization of tertiary care largely has been forgotten.

In Europe, neurosurgery services, which I know best, are organized into university units responsible for patient care, teaching, and research. Probably no more than 5 percent of all operative neurosurgery is performed outside of the university setting. In cooperation with regional and national governments, each country has been divided into referral areas for the neurosurgery centers such that no center serves less than 1 million nor more than 2.5 million inhabitants. Lines of communication and ambulance service have been established between peripheral hospitals and the centers. The volume of neurosurgery performed by most of these centers exceeds the volume of neurosurgery performed in any university in the United States with only a few exceptions. The number of head and spinal cord injuries on European neurosurgical services is 50 to 80 percent of all neurosurgical patients hospitalized on the unit at any given time. A few years ago, when I visited the largest social service hospital in Madrid, there were 75 patients with severe or moderately severe head injuries on the service. The patients were managed well, but investigation of head injury was impossible because the service was understaffed. The physicians and nurses had difficulties enough keeping up with the patient load. In contrast, it is unusual for a single hospital in the United States to admit more than 100 severe head injuries in 1 year despite the fact that there are a total of 3 million head injuries and upwards of 50 thousand deaths per year from head injuries in the United States. The reason is that most head injured patients are taken to the nearest hospital and remain there irrespective of the quality of the facilities available to treat them. Some cities have made progress in recent years in identifying hospital centers for trauma, but much work remains to be done. In Philadelphia and the Delaware Valley, for example, a severely head injured patient is transported to the nearest hospital.

The results of these practices is that European neurosurgical units have the patients but neither the time nor the resources to investigate them, whereas many American neurosurgical units have the research team, the physical resources, and are brimming over with ideas but do not have enough patients. At the heart of the problem in the United States is the plethora of neurosurgeons practicing in nearly every hospital in the city and in the countryside. They refuse to give up their patients because of personal pride, sometimes well justified, and because of the pride of the local hospital and the necessity to fill its beds. These are also the major reasons why reorganization of tertiary care under the Regional Medical programs fail. We need to, and will, reduce the number of neurosurgeons trained in the United States, but the effects of the program will not be felt for a long time. Meanwhile the enormous potential of the NINCDS Clinical Research Centers cannot be realized, and probably never will be realized irrespective of improvements in manpower numbers and distribution, until our system for health care delivery is reorganized in directions that have served so many European countries so well.

Dr. SCHMIDT. Furthermore, I have my own written statement.

Mr. FLOOD. Very well.

STATEMENT OF DR. RICHARD P. SCHMIDT

Dr. SCHMIDT. Mr. Chairman and members of the committee, I am honored by the opportunity to appear before this distinguished committee of the Congress to testify on behalf of an adequate budget for the National Institute of Neurological and Communicative Disorders

and Strokes. In so doing, I speak as the chairman of the National Committee for Research in Neurological Disorders, which represents more than 50 voluntary and professional organizations interested in the neurological, neuromuscular, and communicative disorders. To go one step further, I represent the millions of Americans who suffer from the yet unsolved or incompletely solved diseases of the brain, spinal cord, neuromuscular system and the communicative functions of speech and hearing.

By way of personal introduction, I am a physician who has specialized in neurology. I am a native of Ohio, a graduate of the University of Louisville School of Medicine in Kentucky. I have served on the faculties of several universities, including my alma mater; the University of Washington in Seattle, the University of Florida, and the State University of New York, Upstate Medical Center in Syracuse of which I am currently president. I have served on a variety of advisory committees of voluntary organizations and government, including a recently completed term as a member of the Council of the NINCDS and the National Multiple Sclerosis Commission. I am past president of the American Academy of Neurology and of the American Epilepsy Society.

Mr. Chairman, you and the other Members of the Congress are faced with the awesome responsibility of deciding the budget priorities of our country and I fully realize that you are unable to give all that may wisely be used for each project or function which may come before you. The budget proposed for the NINCDS is, however, a drastic reduction from fiscal 1975, and is only slightly above the rescission level which you have rejected. The sum of $114,955,000 will be a serious setback in the vital research areas which are the responsibility of this Institute. This is an absolute reduction of $27,545,000 from the 1975 budget of $142,500,000. This will mean that many high-quality and important research projects will not be funded or will be seriously limited in their capabilities of performance.

In December, the committee on budget of our national committee recommended a total of $193 million for the 1976 budget of the Institute. It recognized that there were significant staff shortages which curtailed administrative functions and intramural research. There should be a minimum of 68 new positions for the Institute to meet its responsibilities. The committee emphasized that there should be at least an amount equivalent to 20 percent of the NINCDS budget for training of scientists for fundamental and clinical research.

The total recommendations are as follows:

Grants:	
Research grants	$123,000,000
Fellowships	23,700,000
Training grants	3,800,000
Subtotal	150,500,000
Director operations:	
Laboratory and clinical research	15,000,000
Research and development contracts	14,000,000
Other	13,500,000
Subtotal	42,500,000
Total	193,000,000

The group of diseases represented by this Institute are among the major killers and causes of chronic disability. The Director of the Institute, Dr. Donald Tower, in his testimony has presented an excellent outline of these and of the progress being made. I will not repeat his testimony in this regard since it has already been before you and you have asked very good questions of him. I do, however, most respectfully ask that you give very serious consideration to a more adequate support for these vital programs than has been put before you in the President's budget for 1976.

We feel that the budget as presented in the executive budget of $114.955 million is a gross shortage of that which needs to be done in the research and other programs of this Institute.

It represents an absolute reduction of over $27 million over the fiscal 1975 and is only slightly above the rescission level which the Congress has already turned down.

Our Budget Committee, which I support, would submit that the wise spending in the variety of research programs in multiple sclerosis, in stroke, injuries of the head and spinal cord, cerebral palsy, epilepsy, all of these things, including deafness, all would be best supported by a budget of $193 million. We, the NCRND membership, feel this is a wise budget, researched and substantiated by the accompanying statements, and this is what I testify on behalf of, Mr. Chairman. If the appropriation is for 15 months it should be $241,250,000.

It would permit the trust to go forward in such things as the Commission recommendations for the Multiple Sclerosis Commission, the funders of the plan for comprehensive epilepsy centers in several areas of the country, and eventually abolishment of crippling, disabling neurological and communicative disorders. It would also prevent good research from being neglected.

At the $114 million—I believe Dr. Tower, the Director of the Institute, himself testified, only 20 percent of the research that would be applied for of the applicants could be supported at that level of funding, which we feel is grossly inadequate, Mr. Chairman.

Mr. FLOOD. Thank you very much.

ARTHRITIS RESEARCH

WITNESSES

JUDGE THOMAS A. MASTERSON, PHILADELPHIA
DR. JOHN L. SBARBARO, JR.

Mr. FLOOD. Next is Judge Thomas A. Masterson on arthritis research.

Mr. MASTERSON. Good afternoon, Mr. Chairman.

I, too, have prepared a written statement with an attachment, which is a statement of Dr. John Sbarbaro, who is accompanying me here today.

I also would like permission to have them made part of the written record of these proceedings.

Mr. FLOOD. Without objection, that may be done.

[The statements follows:]

Mr. Chairman and committee members, my name is Thomas A. Masterson. I am an attorney and a partner in the law firm of Morgan, Lewis & Bockius in Philadelphia.

I have been ased by the eastern Pennsylvania chapter of The Arthritis Foundation, as a member of its governing board, to represent the views of some of the scores of arthritis volunteers who assist the foundation's 73 chapters across the Nation in trying to explain arthritis to the American public, especially what is being done to improve treatment for the 20 million Americans who suffer from our No. 1 crippling disease. My acquaintance with this terrible disabler of young and old is personal, not professional, and the views which I express here today are my own, and do not necessarily represent the official position of The Arthritis Foundation. However, since I have seen first hand what this disease can do in every generation of my own family, I think that I can speak from some direct knowledge of the immediate need for a massive attack upon this disease.

Dr. Evans Calkins will appear before the committee later with an eloquent plea concerning the importance of funding further basic research and the establishment of arthritis centers throughout the country with which I am in entire agreement.

I would like to spend just a few minutes, however, to emphasize to the committee the importance of insuring that a significant amount of the money is made available for the purpose of a broad based professional educational program designed to give the practitioners in the field the benefit of the latest technique of diagnosis and treatment of this dread disease.

I brought with me a simplified map of the area included in the Eastern Pennsylvania Chapter of the Arthritis Foundation, and I think it tells a story which is typical throughout the country with respect to the epidemiology of the disease and the medical resources available to treat it. Look at the exhibit; you'll see that the disease is, of course, significant in every single county covered by the Eastern Pennsylvania Chapter. The numbers in black show the estimated numbers in bracets show the number of physicians who are members of the Amershow the number of qualified rheumatologists in that county, and the red numbers in brackets show the number of physicians who are members of the American Rheumatism Association and who have had some exposure to the updated methods of diagnosis and treatment of this disease. The numbers in blue which are bracketed represent the total number of physicians in each county.

The first thing that strikes one in looking at this exhibit is that in this 22-county area of Pennsylvania, there are approximately 572,000 sufferers of arthritis with 44 fully qualified rheumatologists, 91 physeicians who are members of the American Rheumatism Association, and some 11,000 general practitioners. These figures and the way they are scattered on the map make it obvious that the average suffer from arthritis, if he is going to get any relief at all, must look to the family physician for help. The simple mathematics of the situation in this area alone demonstrate that there is 1 qualified rheumatologist for every 13,000 sufferers, and 1 member of the ARA for approximately every 6,000 sufferers, but there is approximately one family physician for every 52 sufferers. It is obvious then that if any meaningful relief is going to be given to the overwhelming bulk of people suffering from arthritis, a massive effort has to be made to bring to the general practitioner the tools that have already been developed to diagnose and treat this disease.

Another significant and probably typical phenomenon about the disease and the resources to meet it which is demonstrated by the exhibit is the clustering of both the qualified rheumatologists and the members of the ARA in the areas immediately adjacent to the six medical schools which operate in Philadelphia. Of the 44 qualified rheumatologists in a 22-county area, 41 of them are located in Philadelphia, Montgomery, and Delaware Counties. Of the 22 counties covered by this exhibit, there are 13 in which there are not only no rheumatologists, but there isn't even a single physician who is a member of the American Rheumatism Association to whom the Arthritis Foundation would normally refer patients as a qualified specialist in arthritic diseases.

The seriousness of this situation can be grasped when it is realized that recent revolutionary advances in the early diagnosis and treatment of many of the most

crippling forms of arithritis are comparable with the revolutionary success which has accompanied the early detection and treatment of breast cancer in women. The busy general practitioner whose every 10th patient complains of a vague back pain or a vague pain in the joint, tends naturally to treat these complaints symptomatically. As a result, there is an inevitable tendency for the arthritic process to advance in an insidious manner until the pain becomes excruciating or disabling. At this point, too often, the process has advanced too far for complete rehabilitative measures to be taken. The same patient treated by a physician who had been adequately trained to recognize and treat the disease with the armamentarium of knowledge presently available would be able to arrest the disease before it became crippling in an estimated 80 to 85 percent of the cases.

The Eastern Pennsylvania Chapter of the Arthritis Foundation has been fortunate in the past 15 years of having an extremely dedicated group of physicians and laymen who have been willing to give of themselves in an attempt to broaden the base of medical knowledge of the disease throughout the chapter area. They have recognized that as important as basic research and the establishment of centers is the disemmination to the frontline general practitioners of the knowledge of the most recent techniques of diagnosis and treatment. This effort has been carried on by the physicians on a limited basis for the past 15 years. Currently, through the regional medical program, some $200,000 is being spent in a pilot program designed to reach the general practitioner. In order to take the current knowledge of the disease to the practitioners in the field, qualified rheumatologists are conducting training seminars, demonstration clinics, and public awareness programs at the local level.

Dr. John L. Sbarbaro, a distinguished orthopaedic physician, who is also president of the Eastern Pennsylvania Chapter of the Arthritis Foundation, has prepared a brief statement describing in detail what has been done in this chapter by way of educating primary care physicians who must deal with these patients on a day-to-day basis. A copy of his statement is included with my written statement, and I would appreciate it being added to the record of these hearings. He has estimated that in order to mount a program which would begin to make the knowledge which exists in the laboratories and medical schools available to the physicians for use in their practice every day would require a program involving two symposia of 2 to 3 days duration per year at a convenient location, and 12 half-day demonstration clinics followed by half-day seminars at key areas throughout the region. To staff these seminars and demonstration clinics would require a group of physicians and associated personnel experienced in the whole range in diagnosis and management of these arthritic patients. These teams and the need for them in the management of the disease will be described in greater detail in Dr. Calkin's testimony. Such a program in this 22-county area would require an annual budget of something in the order of $250,000. Project this need nationwide, and it would suggest a national annual budget for this educational purpose alone of approximately $10 million.

This represents an approximate doubling of the amount currently being expended by 29 regional medical programs on the first year of a similarly designed program.

These programs should be regarded as an essential part of the implementation of the National Arthritis Act.

I thank you, Mr. Chairman, for allowing me the time to appear before you today on behalf of one of our most serious national health problems, arthritis.

THE ARTHRITIS FOUNDATION, EASTERN PENNSYLVANIA CHAPTER
INCIDENCE OF ARTHRITIS AND MEDICAL RESOURCES (BY COUNTIES)

County	Estimated number of arthritis sufferers [1]	Number of rheumatologists	Number of ARA members	Number of physicians
Berks	29,638	1	5	386
Bradford	5,796	0	0	90
Bucks	41,506	0	1	432
Carbon	4,432	0	0	49
Chester	27,831	0	0	382
Columbia	5,511	0	0	47
Delaware	60,001	4	10	1,335
Lackawanna	23,411	0	2	283
Lehigh	25,530	2	4	418
Luzerne	34,230	0	4	411
Monroe	4,542	0	0	63
Montgomery	62,380	9	15	1,930
Northampton	21,437	0	1	267
Philadelphia	194,860	28	50	4,713
Pike	1,182	0	0	7
Potter	1,640	0	0	11
Schuylkill	16,009	0	0	154
Sullivan	596	0	0	2
Susquehanna	3,434	0	0	21
Tioga	3,969	0	0	24
Wayne	2,958	0	0	34
Wyoming	1,908	0	0	15
Total	572,801	44	91	11,074

[1] With arthritis severe enough to need a physician's care.

PHILADELPHIA, PA., *May 7, 1975.*

Judge THOMAS MASTERSON,
Strafford, Pa.

DEAR TOM: The intent of an arthritic professional educational program is to increase the awareness of all practitioners in the multiple problems of rheumatic disease. This can be accomplished in two ways: (A) with arthritis demonstration clinics and (B) regional arthritis seminars. Furthermore, a system for continued education of practicing physicians can be introduced so that professional education can be continued.

A demonstrative clinic is an out reach program by a team of experts that go into a community and conduct an arthritis clinic with local patients for local doctors. The patients receive expert consultations while the physicians see first hand how the rheumatologist conducts the examination, employs diagnostic techniques and executes therapy. Physicists and orthopedic surgeons are part of the team and are also used where indicated.

The seminars are didactic presentations at a professional level for formal educational purposes.

OBJECTIVES

(1) To increase the awareness of practicing physicians, including family practitioners, peditricians, internists and orthopedists of the multiple diagnostic, emotional, social, and therapeutic problems of patients with rheumatic diseases.

(2) To provide a basic pathogenetic mechanism of the various rheumatic diseases so that intelligent diagnosis and management may result.

(3) To augment the clinical diagnostic acumen of practicing physicians regarding both the common and more esoteric rheumatic diseases.

(4) To inform the practicing physicians of the nature and availability of the several laboratory and roentgenographic tests of rheumatic diseases.

(5) To broaden the differential diagnosis of rheumatic disease presentations and provide skills for precise diagnosis.

(6) To familiarize the physician with the multiple management disciplines utilized in the care of rheumatic disease patients. These will include drug therapy, physical modalities, occupational therapies, surgery, psychosocial support and sexual and marital counseling.

(7) To increase the practicing physician's ability to appropriately manage a number of incomplicated arthritic problems.

(8) To provide guidelines for the referral of a rheumatic disease patient to a rheumatologist and to make substantial improvements in patterns of referrals

to the arthritis demonstration clinics especially of complicated rheumatic disease problems.

(9) To provide guidelines and indications for hospitalization of patients.

(10) To increase the practicing physician's awareness and utilization of rehabilitation mechanisms for arthritis treatment.

(11) To facilitate a positive attitude on the part of physicians toward an intense contact experience with and the higher utilization of the allied health professionals who are necessary in the complete care of arthritic patients.

(12) To provide background information so that the practicing physician may serve as a coordinator in the basic care and rehabilitation of the arthritic patient.

(13) To promote effective collaborative relationships between the primary care practitioners and those in the specialties concerned with the treatment of arthritis.

(14) To provide strong links between the clinical arthritis centers and the outlying areas of the Greater Delaware Valley region.

(15) To evaluate the effectiveness of arthritis seminars which will be held periodically throughout the year and in conjunction with the arthritis demonstration clinics.

(16) To provide a stimulus for continuation of the educational activity after the expiration of this grant program by forming a strong bond between the physicians throughout the region and the specialists involved in this programmatic effort.

These symposia should consist of lectures by outstanding rheumatologists and orthopedics on both the diagnosis and management of a variety of rheumatic disorders. A symposium should last approximately 8 hours and will be conducted at a convenient location. The material presented should be collated into a manual presented to each course participant. Slides and film should augment the lectures. Audio tape cassettes can be available for those who prefer them. At each of the arthritis symposia, small group discussions can be provided in order to solve specific educational problems of some of the physicians. These sessions will be geared to problems in both diagnosis and management of rheumatologic disorders. Lectures and demonstrations will be standardized from clinic to clinic.

Cognitive material to be presented should include but not be limited to the following:

1. Rheumatoid arthritis in adults and treatment—its diagnosis and treatment.
2. Rheumatoid arthritis, the "problem patient" and the team approach to a solution.
3. Diagnosis and management of ankylosing spondylitis and similar diseases including Reiter's syndrome and arthritis of ulcerative colitis, regional enteritis or psoriasis.
4. "When to diagnose a connective tissue disease?", specifically systemic tupus erythematosis, systemic sclerosis and polymocytis.
5. Infectious arthritis—early diagnosis and treatment.
6. Osteoarthritis—basic approaches to the common case and recognition that all cases can be effectively treated.
7. Nonarticular rheumatism in office practice—fibromyositis tendonitis.
8. Gout and pseudo-gout—methods of early diagnosis and managements.
9. Psychosocial aspects of patients with arthritis.
10. Sexual problems of the patient with arthritis.
11. Techniques of intraarticular aspirations and injections.
12. Management of the patient with chronic low-back pain.
13. Early and reconstructive surgery for arthritis.
14. The place of physical medicine and physical rehabilitation in the treatment of rheumatic disease.

This project represents a major effort to increase the knowledge and ability of primary care physicians and specialists concerned with arthritis, notably the diagnosis, management and rehabilitation of rheumatic disease patients. The conduct of the educational program for practicing physicians can provide an experience yielding continued benefits.

In the Delaware Valley alone, it is estimated that a minimum of 1,500 physicians per year could be retrained in this disease complex. The resources of the Arthritis Foundation are a natural mechanism for implementation.

Very sincerely,

JOHN L. SBARBAOR, Jr., M.D.

Mr. MASTERSON. The designation of the subject of my testimony before this committee this afternoon is a little misleading.

I am here on behalf of the eastern Pennsylvania chapter of the Arthritis Foundation as a member of its governing board to give the committee the benefit of the views of one of the countless thousands of volunteers who assist the foundation's 73 chapters across the Nation, attempting to bring public knowledge of, and support for, the early detection and treatment of this most crippling disease.

Later on in this committee's proceedings, Dr. Evan Calkins will appear before the committee with an eloquent plea concerning the overriding need to fund basic research and to establish regional treatment centers for this disease.

I am here to make a somewhat narrower point, basically, to ask that the committee do what it can to assure that of the funds eventually appropriated for the massive attack on arthritis that Congress has already indicated it is determined to mount on the Nation's No. 1 crippler sufficient funds be made available through appropriate agencies so that an ongoing systematic, professional education program can be carried on to bring to the physicians in the field the benefits of what we already know about how to detect, treat, and manage this disease.

We prepared, if the Chair please, a simple exhibit which I am going to refer to, because I think it graphically describes the problem.

This is a simple map of the 22-county area with which the eastern Pennsylvania chapter of the Arthritis Foundation deals.

The numbers tell a story, once you relate them to the key. The numbers in black are the numbers of sufferers of arthritis in the respective counties.

The numbers appearing in blue in brackets are the number of physicians in those counties.

The numbers appearing in red in brackets are the numbers of physicians who have been members of the American Rheumatism Association and, therefore, who have had advanced training in the modern technique of early diagnosis and treatment of the disease and the numbers in red, without brackets, are the numbers and location—I should say represent the numbers and locations of qualified rheumatologists.

Now, just looking at the gross figures, this little chart tells a story.

In the 22-county area, there are approximately half a million sufferers of arthritis in one of its many forms.

In that same area there are 44 trained rheumatologists. That makes a sufferer-patient ratio of about 1 to 13,000. In the same general area there are about 90 physicians who are members of the American Rheumatism Association and who have made it their business to maintain currency with respect to the techniques of diagnosis and management or arthritis.

That gives a ratio of approximately 1 trained man for every 6,000 patients.

If you will look at Luzerne County, Mr. Chairman, the map would indicate there are approximately 34,230 sufferers of arthritis; there are 411 physicians throughout the county, and there are 4 physicians who are members of the American Rheumatism Association.

Mr. FLOOD. Of all the counties in the United States, why would you pick Luzerne County?

Mr. MASTERSON. I thought the Chair might have some familiarity with it.

Another interesting thing that this map demonstrates, which I would suspect would be fairly typical—is that of the approximately 42 trained rheumatologists in the whole 22-county area, there are 13 counties which not only do not have a trained rheumatologist but they do not even have a physician who is a member of the ARA.

Mr. FLOOD. Is Philadelphia included?

Mr. MASTERSON. Yes, sir. Philadelphia is down here, it is the smallest county in terms of geographic area.

Mr. FLOOD. It is in that batch?

Mr. MASTERSON. Right down at the very bottom of the chart.

Mr. FLOOD. I know where it is.

Mr. MASTERSON. And that tells another story.

Of the 42 trained rheumatologists in the whole surrounding 22 counties, 41 of them are in Philadelphia, Delaware, or Montgomery Counties, and that is because they work closely with the six medical teaching hospitals in Philadelphia. But the net result is the whole northern part of this territory is virtually virgin territory so far as persons trained to deal with this particular disease.

Now, the significance of that is this: If you just look at these numbers, it is graphically clear that the ordinary sufferer of arthritis is not going to get to an ARA member, let alone a fully qualified rheumatogolist. He has to depend upon his family physician, the general practitioner, to help him with the disease.

There rises the problem because, as a result of the research that has been done, much of it funded by the Federal Government in the last 20 years, there has been an explosion of knowledge about the nature and treatment for this disease, such that no busy physician can possibly cope with what we now know concerning detection and treatment of this disease.

The net result is that there is a tendency for sufferers from this disease to appear before a physician complaining of a vague pain in the back or a pain in the joint and the normal thing for the physician to do is to treat it symptomatically, give them some aspirin, and so forth.

What happens very frequently is that that person has a form of progressively crippling rheumatoid arthritic disease which, if properly diagnosed early enough, can be fully arrested; but, unfortunately, very often it is not diagnosed properly soon enough, with the net result that that patient ultimately becomes crippled, and by the time the symptoms reach the point where the local physician recognizes that specialized treatment is in order, it is too often too late.

Now, referring back to this chart again, it is really a simple logistic problem.

Down here where you see all the red, where you see the trained rheumatologists and the clustering of the members of the ARA, in those hospitals and in those laboratories there presently exists today knowledge which, if translated out here, could help countless numbers of these patients who, for want of that knowledge, will become cripples and add to those enormous statistics that are in the recitals of the 1974 Arthritis Act.

I have attached to the written testimony a two-page statement by Dr. Sbarbaro of what has been done on a pilot basis in this area.

It has been accomplished in the last year on an appropriation of a little under $200,000. Basically, it is an attempt to translate the laboratory and hospital knowledge that exists down here in the south-

eastern corner out into the field. The way that is done is by having seminars lasting 2- and 3-days at which doctors or physicians are brought in to be exposed to lectures and demonstration clinics by these specialists whose life is this disease.

They bring with them the train of experts which have now been developed in the highly organized medical centers to treat this disease.

Dr. Calkins will have more to say about those teams.

Mr. FLOOD. I am sure he will.

Mr. MASTERSON. But what we ask, sir, is that in considering this entire problem, that you remember simply this: That we all want to see money to fund research, to find the cause and cure of this disease, but at the same time, it is equally vitally important to the millions of people who suffer from the disease, that the knowledge we already have concentrated in medical centers be disseminated to the practicing physicians who are the people on the firing line who are going to be treating the disease.

Mr. FLOOD. Thank you very much.

Mr. MASTERSON. Thank you, sir.

SIDNEY FARBER CANCER CENTER

WITNESS

DR. NORMAN JAFFEE, SIDNEY FARBER CANCER CENTER, HARVARD MEDICAL SCHOOL

Mr. FLOOD. Dr. Norman Jaffee of the Sidney Farber Cancer Center, Harvard Medical School.

Dr. JAFFEE. Thank you, Mr. Chairman.

Mr. FLOOD. We have these two charts that you have shown us.

Dr. JAFFEE. Yes, sir, I will refer to them. I have no statistical tables with me, but I do have those two charts and I shall refer to them shortly.

Instead, I would like to tell you how some of the appropriations from this committee are spent on a day-to-day basis in the treatment of bone cancer.

I will say about 700 words and submit a written statement for the record. Bone cancer afflicts children and youth mostly.

Ordinarily, it arises in the thigh, upper part of the leg, or upper part of the arm near the shoulder, though any part of the skeleton might be affected.

Mr. FLOOD. Why does it start there?

Dr. JAFFEE. The reasons are undetermined.

Mr. FLOOD. All right.

Dr. JAFFEE. The standard treatment has been to amputate wherever possible. The kind of research I and others are doing proves that some burn amputations can be avoided and life can be extended. But even if amputation is, so to speak, successful, the majority of patients have microscopic tumors in their lungs, so-called metastases, at the time the so-called bone cancer is diagnosed. This is what they die of.

The survival rate in the most favorable circumstances varies from 15 to 20 percent. This is illustrated in chart No. 1 if you would kindly refer to it. The patient on the left-hand side has a tumor in the leg.

Mr. FLOOD. How long has that condition been in the lung?

Dr. JAFFEE. It is probably there at the time of presentation, which is about 2 to 3 months, but it is microscopic and it is not detectable at the presentation.

Mr. FLOOD. Is that condition peculiar alone to this disease?

Dr. JAFFEE. It is present in some cancer, peculiar to this disease.

Mr. FLOOD. Why can you not determine it exists by examining the lung?

Dr. JAFFEE. Unfortunately, the tumor has to grow to a particular size before it can be diagnosed.

Mr. FLOOD. How long does that take?

Dr. JAFFEE. That probably takes 4 or 5 months.

Mr. FLOOD. Even so, should you not find it then?

Dr. JAFFEE. By the time the patient presents himself, the patient deserves immediate treatment.

There is no sense in delaying it because approximately 20 percent of patients do not have the submicroscopic evidence of disease in the lungs and they require immediate amputation for cure.

I will try to illustrate that as I proceed.

Mr. FLOOD. Of course, general checkups do not include that kind of examination.

Dr. JAFFEE. That is correct, sir.

Now, as I indicated, the patient on the left-hand side of the chart that I have submitted has a tumor in the leg. Since the metastases are not visible under radiological examination, an immediate amputation is performed.

Death, however, occurs within 18 months because these metastases eventually appear. This is noted in the upper section of the chart. Only approximately 15 or possibly 20 percent of patients will be cured because at the time of the presentation——

Mr. FLOOD. Off the record.

[Discussion off the record.]

Mr. FLOOD. Back on the record.

In some cases I understand the lung condition does not exist indentically with the carcinoma, is that so? It does not always exist?

Dr. JAFFEE. That is correct in 20 percent of patients; in the optimum circumstances it may not be there.

I tried to illustrate in the lower section of the chart, indicating that approximately 15 percent of patients will be cured because at the time of presentation the metastases, the tumor has not developed in the lungs.

Under those circumstances an immediate amputation will result in a cure, nothwithstanding 80 percent of the patients still die because submicroscopic disease has spread to the lungs at the time of the presentation.

Mr. FLOOD. But the condition that exists in the lung is so well-known that the minute there is any suggestion of carcinoma of this kind, the lung is always examined?

Dr. JAFFEE. That is correct, sir, that is correct.

Now, research in a group of 20 patients treated in a new way by means of chemotherapy since 1972 indicates that this group will experience a 70-percent survival instead of a 20-percent survival as in the past.

On patient who was treated prior to the initiation of this formal study in the 20 patients has remained free of tumor for 4 years and seems to have many more years ahead of her.

This is illustrated in the second chart that I have submitted.

The chart shows that in the left radiograph there are two lung metastases which developed after amputation. Two months later, following chemotherapy, eradication of these metastases has been achieved.

The patient is presently alive and well, free of disease and has demonstrated no adverse effects whatsoever to the chemotherapy administered.

Now, this is not a fluke. I do not speak just for myself and for my work. We are putting data together from five major centers in the country, comprehensive centers with all the personnel and resources to standardize procedures rigidly.

I see no scientific or mathematical reason why the improved survival rate will not be the survival rate in bone cancer cases in the near future.

Mr. FLOOD. Would you say it would apply to the male and female equally?

Dr. JAFFEE. There is a slight preponderance in the male.

Mr. FLOOD. Any age bracket?

Dr. JAFFEE. From 10 years to 25 years, approximately.

Under the circumstances of the condition of the treatment that we have administered, sir, I would submit that in the near future the 20-percent survival rate will be history.

Now my work involves the use of drugs to counteract the growth of these small tumors in the lung which most often accompany the bone cancer at the time of presentation. The drugs comprise methotrexate in high doses with citrovorum factor to counteract the effects of the methothrexate and adriamycin.

Your investment of the taxpayers' money is characterized in one of my recent articles which appeared in the February issue of this current year in Pediatric Annals designed specifically for dissemination to the general practitioner and to the pediatrician. I quote:

> Many of the protocols are of an investigational nature and can be administered only in specialized cancer centers where adequate supportive measures are available. However, the resources and cooperation of the referring physician are usually enlisted to help in observing the patient in the intervals between treatments or to assist in the administration of the chemotherapeutic agents on an ambulatory basis.

You see, sir, we cannot get along without the comprehensive cancer centers, but in similar fashion we must keep the family doctor actively involved.

I chose my words carefully, then, and I choose them carefully now when I quote again from this article:

> The preliminary results obtained with chemotherapy are highly encouraging and suggest that the natural history of the bone tumor osteogenic sarcoma has been altered.

This will not change the face of this so-called dread disease. This new treatment will be required by only some 700 of the 365,000 cancer cases per year in the United States. But for those 700, their families, their friends, their employers, this advance is truly meaningful. It provides hope for all and life extension for many.

The hope is important because it convinces both the patient and the doctor to eke out every chance of support for a cure.

While fewer than two cancer patients per thousand have bone cancer, this same sort of advance is being made by concentrated drug research on breast cancer, prostate, bladder, colon, lung and others.

These are the solid tumors, the big ones, the difficult ones. The small bits of progress definitely add up.

The national cancer plan is not 5 years old yet. If we had found a 100-percent sure cure, the instant that you enacted the conquest of cancer law, we would still not have a single 5-year survivor for the statisticians.

I am convinced that we shall have significant increases in five-year survival rates as a result of intense studies of known drugs and other therapies as we pull more and more science out of the fundamental research laboratories and the academic journals to be used for the work of the patient.

We cannot do this without adequate funding. Please give cancer patients the $898.5 million in the citizens budget. It is less than the panel of consultants recommended.

Anything below this total reneges on the country's decision to make the conquest of cancer a national priority.

Mr. FLOOD. I notice some drugs coming from Great Britain, and I also note your accent. I think particularly of the drug on gallstones. Where was the drug you are talking about discovered?

Dr. JAFFEE. I am talking about drugs which are specifically active in cancer.

Mr. FLOOD. I know.

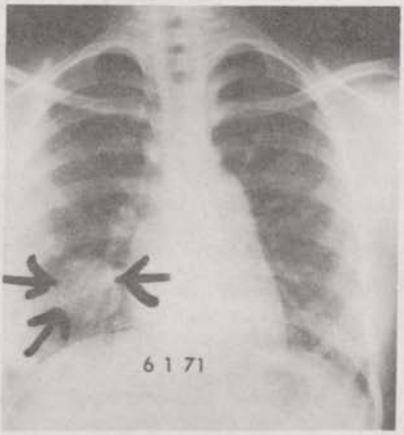
Where was it discovered, the first one you talked about?

Dr. JAFFEE. This was discovered in our own country, sir, the United States.

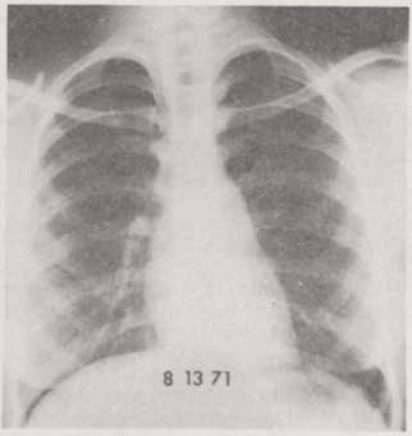
Mr. FLOOD. Thank you very much.

Dr. JAFFEE. Thank you.

[The witness' full statement and exhibit follow:]



Before treatment:
Metastases present



After treatment:
Metastases disappeared

Advances in the Treatment of Osteogenic Sarcoma

Mr. Chairman and members of the subcommittee, I am Dr. Norman Jaffe, a physician at the Sidney Farber Cancer Center, located in Boston, Mass. The institution was previously known as the Children's Cancer Research Foundation and was established over 25 years ago by Dr. Sidney Farber for the treatment of cancer in children. The center subsequently broadened its activities and assumed major responsibilities for the treatment of cancer in adults. It is affiliated with Harvard Medical School.

I have been engaged in full time cancer research for the past 10 years, most of which I spent under the direction of Dr. Sidney Farber and, more recently, under the current director and physician-in-chief of the center, Dr. Emil Frei III. I appreciate the opportunity to report to you on our investigations in the treatment of one of the more common bone tumors, previously considered unresponsive to chemotherapy.

OSTEOGENIC SARCOMA

This is a bone tumor which occurs primarily in preteenage and teenage children. The underlying mechanisms responsible for its occurrence and development are unknown, although occasional cases are probably related to the prior administration of radiation therapy to the affected area. In older patients, the condition is usually found in association with Paget's disease of the bone.

The tumor may arise in various parts of the skeleton. However, the predominant areas affected are the thigh, upper part of the leg and upper part of the arm near the shoulder.

NATURAL COURSE OF THE DISEASE

In the majority of patients, the tumor presents initially as a vague dull ache in the limb. This may be accompanied by a minor swelling. In over 80 percent of such patients, microscopic deposits of tumor have spread to the lungs at the time of diagnosis. This is referred to as pulmonary metastases. These metastases are not visible by routine radiographic examination. However, they account for the poor survival rate which has been obtained with conventional treatment involving immediate amputation. The metastases enlarge and can be detected within 6 to 9 months by radiologic examination of the lungs. Accelerated growth generally occurs at this stage and most patients die within 12 months after the chest radiograph becomes positive. The survival rate in optimum circumstances is approximately 20 percent.

CHEMOTHERAPEUTIC ADVANCES

During the past 4 years, several chemotherapeutic agents have been shown to be effective in the management of osteogenic sarcoma. These principally comprise high-dose methotrexate followed by citrovorum factor and adriamycin.

(1) High-dose methotrexate and citrovorum factor

In 1971, the Sidney Farber Cancer Center demonstrated that high-dose methotrexate followed by citrovorum factor (so-called citrovorum factor rescue) was effective in producing destruction of tumor in a number of patients with osteogenic sarcoma which had spread to the lungs. The procedure involves the administration of massive potentially toxic doses of methotrexate over several hours followed by citrovorum factor which counteracts the toxic effects of the drug. In the early investigations, this chemotherapeutic regimen produced a 40 percent response rate. One of the patients who responded has remained free of tumor for the past 4 years and has not demonstrated any adverse effects from the chemotherapeutic program.

Investigations at the clinical and experimental level demonstrate that chemotherapy is far more effective against microscopic disease than it is against gross or bulk tumor. This observation provided the impetus to administer high-dose methotrexate-citrovorum factor treatment to newly diagnosed patients without evidence of clinical spread to the lungs. It was considered that the potential for achieving tumor destruction would be far greater if the effective chemotherapeutic regimen were employed early when possibly only microscopic spread of the disease had occurred. Consequently, 20 consecutive patients, most of whom underwent immediate amputation, were subjected to treatment over the succeeding 2 years.

Results.—The survival of these patients has been markedly improved. With followup periods ranging from 1½ to 3½ years, 70 percent remain free of disease

in comparison to past experience where the survival rate was approximately only 20 percent. Projections based on data pooled from five major centers in the United States employing similar programs would suggest that this survival rate will not change and, under these circumstances, a permanent increase in the cure rate is anticipated.

(2) *Adriamycin*

In addition to high-dose methotrexate with citrovorum factor rescue, adriamycin has also been shown to be effective in osteogenic sarcoma. Consequently, a new treatment program combining both effective regimens was initiated at the Sidney Farber Cancer Center in April 1974. Although the results of this program are still preliminary, projections based on data to date would indicate that an even greater disease-free survival may be anticipated.

CAN AMPUTATION BE AVOIDED?

The encouraging results obtained with the combination of high-dose methotrexate and citrovorum factor and adriamycin prompted investigations at the Sidney Farber Cancer Center and elsewhere to determine the feasibility of performing local resection in selected cases rather than classical amputation for removal of the primary tumor. Preliminary results indicate that preservation of the limb with useful function together with cure under these circumstances may, indeed, be possible. Additional major studies in this direction are in progress.

PROJECTIONS FOR THE FUTURE

Experiences in osteogenic sarcoma have firmly demonstrated that chemotherapy is far more effective against microscopic disease. The results are supported by recent reports that adjuvant chemotherapy employed in patients with stage II breast cancer immediately following surgery significantly decreased the recurrence rate with followup periods of up to 2 years. These exciting results strengthen the need for the early administration of chemotherapy. Projections based on these experiences herald an increase in the number who may be cured. They call for intensified support on a nationwide basis for programs designed to improve the clinical management ultimately leading to major advances in the conquest of this disease.

DIABETES

WITNESSES

HON. H. JOHN HEINZ III, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA
CARL STENZLER, ACTING CHAIRMAN, PENNSYLVANIA DIABETES INSTITUTE
DR. ARNALL PATZ, PROFESSOR OF OPHTHALMOLOGY, DIRECTOR OF THE DIABETIC RETINOPATHY CENTER AT JOHNS HOPKINS
DR. RICHARD SCHWARTZ, PROFESSOR OF GYNECOLOGY AND OBSTETRICS AT PENNSYLVANIA UNIVERSITY AND DIRECTOR, JERROLD R. GOLDING DIVISION OF FETAL RESEARCH
DR. RICHARD A. FIELD, PHYSICIAN IN CHIEF, NEW ENGLAND SINAI HOSPITAL
DR. ROBERT KUGEL, VICE PRESIDENT FOR HEALTH SCIENCES, UNIVERSITY OF NEW MEXICO
DR. WILLIAM HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. FLOOD. I see our distinguished colleague from the great Commonwealth of Pennsylvania, Congressman Heinz.

Mr. HEINZ. Mr. Chairman, thank you very much.

Mr. Chairman, I have no prepared statement; my remarks will be brief.

I am Congressman John Heinz, a member of the Health and Environment Subcommittee of the House Interstate and Foreign Commerce Committee.

With me today are these gentlemen whom I will introduce formally at the conclusion of my statement.

First of all, I want to thank you, Mr. Chairman, for the opportunity to introduce a distinguished panel of expert witnesses from my own State, and yours, of Pennsylvania.

The individuals are members of the Commonwealth of Pennsylvania Committee on Diabetes and Blindness, who represent the various disciplines: heart, eyes, kidneys, vascular and nervous degeneration, perinatal diseases, genetics, aging, oral diseases, skin uclers, brain damage, juvenile and mature diabetes, because, Mr. Chairman, diabetes includes all these conditions in its duration-related forms.

The individuals I introduce today are all individuals with considerable collective authority. I am very pleased that our Governor, Milton Shapp of Pennsylvania, took the leadership in appointing a committee with the expertise and concern to help develop a landmark law for my Public Health and Environment Subcommittee, originally Public Law 93–354, which has permitted us to expand our Federal and State emphasis in the fight against diabetes.

Most particularly, Mr. Chairman, Public Law 93–354 created a National Commission of Diabetes to develop long-range plans to encompass coordinated research in all Institutes and to recommend budgets for each of the seven NIH Institutes.

It is the funding of these budgets that most concerns me and, I believe, the panel members. Estimates for all Institutes must be prepared by the fiscal year ending June 30, 1976.

As of Friday, May 9, I am informed that the Commission had not filed such a budget request with your Committee. Such funds are essential to begin or to implement diabetes research in all Institutes.

Indeed, Mr. Chairman, the interested community and I appreciate your initiative in notifying Dr. Cooper of HEW that requests for diabetes funding support by the respective Institutes must be received before you go into markup.

With Institute budgets reduced by executive direction, and with the knowledge that Institutes commit their resources to established programs, it is doubtful that the Institute directors will give more than lip service to diabetes research unless specifically earmarked funds are so provided.

To break the logjam, new and unusual measures are necessary.

Mr. Chairman, I respectfully urge you and the members of your most distinguished Subcommittee to increase the established Institute budgets by 3 percent for new or additional diabetes research.

The sums involved are relatively small in each Institute.

For instance, the National Heart and Lung Institute is on record as requesting $300 million. Three percent of that will equal an additional $9 million.

I believe Dr. Cooper said that 75 percent of the diabetic population is expected to die prematurely from cardiovascular causes. Translated into human terms, that means as many as a quarter of a million diabetics die each year from coronary or vascular malfunction, or as

many as one-quarter of all our heart deaths can be attributed to diabetes.

Mr. Chairman, an additional $9 million is little money in terms of the problem at hand. The same reasoning, I think, applies to all Institutes.

I again respectfully urge your Committee to give important consideration to the 3 percent increment for diabetes research in all Institutes. And I thank you, Mr. Chairman, for giving your attention to me and to the arguments of the expert panel which I am about to introduce.

Mr. Chairman, the first member I would like to introduce is Carl Stenzler.

Mr. Stenzler is in many ways a unique man. As Chairman of the Pennsylvania Commonwealth Committee on Diabetes and Blindness and himself a diabetic for nearly 50 years, Carl Stenzler has been in a good position to attest to the need for a national research effort to eradicate this disease, and from this position Mr. Stenzler has generated a first-class citizen lobby for a national diabetes research act.

So while I am proud of the role of our subcommittee and my own role in the establishment of the legislation I referred to earlier, Carl Stenzler deserves tremendous credit for his initiative and aggressive pursuit of the objectives of this legislation, which was ultimately approved by our subcommittee.

With Mr. Stenzler, Mr. Chairman, are three very learned physicians: Richard A. Field, physician-in-chief at New England Sinai Hospital, where he also serves as an Associate Clinical Professor of Medicine at the Harvard Medical School.

Additionally, Dr. Arnall Patz, Professor of Ophthalmology and the Seeing Eye Research, Professor of Ophthalmology at Johns Hopkins University, and Director of the Diabetic Retinopathy Center at Johns Hopkins.

Finally, accompanying Mr. Stenzler is Dr. Richard Schwartz, Director of the Jerrold R. Golding Division of Fetal Research of the Department of Obstetrics and Gynecology at the University of Pennsylvania School of Medicine.

I am informed that Dr. Christian Klimt had expected to be here today, but unfortunately is ill. He is Professor and Director of the Division of Clinical Investigation, the Department of Social and Preventive Medicine at Johns Hopkins University.

I am informed that his wife is either here or will be bringing his testimony for inclusion in the hearing record.

[Dr. Klimt's statement follows:]

STATEMENT BY DR. C. R. KLIMT, UNIVERSITY OF MARYLAND

I would like to address myself to the area of the therapeutic plight of the adult onset diabetic. This type of diabetes, constituting roughly 95 percent of all diabetics known to have the disease in this country, is different from the juvenile form, inasmuch as this disease shows and insidious beginning. It only rarely proceeds to be insulin dependent, and is predominantly defined as a disease by the excess risk of large and small vessel disease. The predominant vascular complications are in excess over normal expectancy of 2½ times in the frequency of myocardial infarctions, of visual impairment and blindness specific for diabetes, of kidney impairment with fatal outcome, and of occlusion of peripheral vessels leading to an excess frequency of amputations of the lower limbs.

My knowledge of these problems comes from a widely known Study financed by the National Institutes of Health, known as the university group diabetes program. This study, which is about to terminate after 14 years of gathering data on over 1,000 patients in 12 different renowned clinics of this country, has led to the following principal conclusions.

Prototypes of each of the two chemical entities used for the treatment of adult onset diabetics (by mouth); i.e. tolbutamide for the sulfonylurea group and phenformin for the biguanide group, have both shown not only not to provide any benefits in reducing the vascular complications of diabetes, but may also lead to an excess mortality from cardiovascular causes. Their value is, therefore, reduced to simple symptomatic control of diabetes, and that only for a limited period of time until drug resistance develops.

The UGDP has also evaluated insulin treatment of the adult onset diabetic in patients of the type who are not dependent on insulin treatment for their acute survival; i.e. the prevention of keto-acidosis. Insulin treatment did not help in prolonging life and preliminary analysis indicates no effect of insulin in preventing vascular complications. It shows no signs of adverse effects of any kind, and is, therefore, ideal for relieving diabetic symptoms. Insulin, of course, has the drawback that it must be injected, that the dosage is critical, and that its global supply is absolutely limited by the amount of pancreas that is available from major slaughtering facilities for cattle and for pigs.

Diet of any composition is the one remaining recourse for treatment of the adult onset diabetic, and it has never been subjected to a rigorous controlled trial. There is, in fact, uncertainly as to what constitutes an antidiabetic diet. Limiting of calories, particularly reducing of fat calories, is commonly recommended, since the adult onset diabetic is usually obese. The value of this is questionable and ought to be subjected to a massive controlled trial. Other dietary interventions would be antiatherosclerotic, reducing not only the amount of fat calories but changing the source of fat to vegetable origin with high polyunsaturated fatty acid content. In addition, the intake of cholesterol-containing food, such as egg yolk, milk products, and certain seafood such as shrimp and lobster would be reduced.

In conclusion, we are in a desperate situation as far as the majority of diabetics are concerned. We have no proven therapy of value for the majority of adult onset diabetics; i.e. those who do not need insulin for short term survival. A variety of forms of diet need controlled evaluation on large numbers of patients. New types of oral drugs need to be tested for their therapeutic value and absence of toxicity when taken over long period of time. Without such massive efforts, we have at present nothing to offer which would reduce the frequency of vascular complications and restore normal life expectancy for the adult onset diabetic, constituting the overwhelming majority of all diabetics.

Mr. HEINZ. Mr. Chairman, if I may at this time, I would like the members of the panel to come forward.

Mr. FLOOD. Yes.

Mr. HEINZ. Mr. Chairman, I ask the consent of the committee, if the chairman so wills, to include the curricula vitae of the members in the hearing record at the appropriate point.

Mr. FLOOD. Yes; that may be done.

CURRICULUM VITAE

Name: Christian Robert Klimt.
Address: 916 Army Road, Baltimore, Md. 21204.
Date of birth: December 25, 1918.
Place of birth: Vienna, Austria (U.S. Citizen).
Marital status: Married, four children.
Social Security: 219-40-3320.

EDUCATION

Primary and high schools in Vienna, 1924–38.
M.D.: University of Vienna, 1944.
Rotating Internship—Wilhelminen Hospital, Vienna, 1945–48.
M.P.H.: The Johns Hopkins University, Baltimore, 1952.
Dr. P.H.: The Johns Hopkins University, Baltimore, 1959.

PROFESSIONAL EXPERIENCE

1972– : Professor and Director—University of Maryland, Department of Social and Preventive Medicine, Division of Clinical Investigation.
1970–71: Director—Office of Scientific Coordination, Bureau of Drugs, Food and Drug Administration.
1966–67: Director—Institute of International Medicine, University of Maryland.
1965–72: Professor and Director—University of Maryland, Institute of International Medicine, Division of Epidemiology and Biostatistics.
1962–65: Associate Professor and Director—University of Maryland, Institute of International Medicine, Division of Epidemiology and Biostatistics.
1960–62: Associate Professor—University of Minnesota, School of Public Health.
1959–60: Assistant Professor—The Johns Hopkins University, School of Hygiene and Public Health.
1949–59: Medical Officer—World Health Organization, Geneva/Cairo/Baghdad.
1948–49: Assistant—Pasteur Institute, Vienna.
1945–48: Rotating Internship—Wilhelminen Hospital, Vienna.

FELLOWSHIPS

1948–49: World Health Organization—University of Maryland; National Institutes of Health, Bethesda; Johns Hopkins Department of Pathology; Rockefeller Institute, Princeton, New Jersey.
1951–52: Rockefeller Fellowship—Johns Hopkins University School of Hygiene and Public Health.
1958–59: United States Public Health Service Fellowship—Postdoctoral fellowship.

PROFESSIONAL SOCIETIES

American Diabetes Association.
American Epidemiological Society.
American Heart Association Council on Epidemiology.
American Public Health Association (Fellow).
Association of Teachers of Preventive Medicine.
Maryland Public Health Association; President-elect for term 1971–73.
New York Academy of Science.
Society for Epidemiologic Research.

COMMITTEES

Member, American Diabetes Association Committee on Statistics (1965–73) (Chairman, Committee on Statistics—1965–71).
Member, American Diabetes Association Editorial Review Board (1965–).
Member, Commonwealth of Pennsylvania Committee on Diabetes and Blindness (1973–).
Member, National Institutes of Health Study Section on Cancer Chemotherapy (1966–70).
Member, National Heart Institute Study Section on Special Projects in Cerebrovascular Disease (1966).
Member, Policy Board, U.S. Public Health Service Cooperative Study on Pyelonephritis and Hypertension (1966–70).
Member, World Health Organization Expert Committee on Diabetes (1969–).
Consultant, Food and Drug Administration (1974–).

PUBLICATIONS AND PRESENTATIONS

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2. Klimt, C. R.: Tierexperimenteller vergleich der immunisierungsfähigkeit von phenolisierter mit UV-Licht inaktivierter lyssavakzine (Comparison of immunizing ability of phenolized and of ultraviolet inactivated rabies vaccine in laboratory animals). *Wiener Medizinische Wochenschrift* 99:39–40, 1949.
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Mr. FLOOD. Mr. Stenzler?

STATEMENT OF CARL STENZLER

Mr. STENZLER. Mr. Chairman, I am Carl Stenzler and I do apologize for the fact that I have only one copy of my statement.

Unfortunately, this diabetes was a problem that I had trouble coping with during the past week and very little work was consummated. So this was started at 5:30 this morning and I regret that I do not have copies with me, but I hope that I can make additional copies if you want them.

I am not unprepared in a knowledgeable sense. I am unprepared in a formal sense. I hope you will bear with me on that score.

I will read my statement.

I wish to thank the members of this distinguished committee for inviting me to speak as chairman of the Diabetes Institute.

Within the last several weeks the Governor encouraged and, through the Department of Health, we created a new nonprofit corporation to replace the temporary committee, Commonwealth of Pennsylvania Committee on Diabetes and Blindness. So I am using what is now in a state of transition, now the Pennsylvania Diabetes Institute, it has a legal structure and hopefully a prepetuity to its stay.

We are of course assuming that Governor Shapp will not remain Governor forever and this is a mechanism to make it as permanent as we can.

As chairman of the Pennsylvania Diabetes Institute, I represent 25 members selected from the medical profession, the Pennsylvania State Legislature, and concerned laymen from all States. The institute is a permanent, nonprofit corporation that works in cooperation with the Pennsylvania Department of Health.

I am here today to plead the cause of millions of diagnosed, undiagnosed, and potential diabetics in this country today. Indeed, the disease which affects them is so devastating and so little understood that, unless we now fully commit ourselves to dealing with its horrible impact, millions of our citizens will die unnecessary deaths.

There is neither prevention nor cure for the disease. The cause is unknown. Its progressive, ultimately lethal impact on all body functions might be retarded with therapy, but not stopped. In 1969, diabetees mellitus was the eighth cause of death in the United States. Now, it is rated by Dr. George Tokuhata, professor of epidemiol-

ogy and biostatistics at the University of Pittsburgh Graduate School of Public Health, as the third cause of death.

Experts disagree as to the direction of even stopgap or palliative therapy, treatment, and control. Early detection and control through insulin therapy neither prevents nor significantly retards the development of such sequential complications as blindness and heart disease.

Unquestionably, diabetes represents in the main a genetic defect, but its nature is unknown. The mechanism of the genetic defect can only be speculated.

Let me sketch the problem a little more fully. Diabetes is a systemic disease that can and does erode virtually every part of the body. In terms of our national health and well-being, it is a clear and present danger which must be heeded. Failure to do so will be at our peril, and at a financial cost to our Nation which cannot, and must not be sustained.

Every diabetic is a candidate for one or several complications: 50 percent of those who live with the disease for 10 to 15 years and 95 percent of those who survive for 25 years will suffer dreadful consequences for their genetic defect.

Ten million diabetics are in jeopardy of blindness, heart disease, kidney failure, stroke, vascular degeneration, hypertension, nervous system breakdown, sexual incompetence, or amputation.

The U.S. Health Service has identified diabetes as a major cause of new blindness. Most ophthalmologists look at diabetes as the first cause of all blindness in the United States.

Almost half of the patients with onset of diabetes under the age of 15 die of kidney disease.

Incidentally, diagnosis of nephropathy is literally a mark of it being fatal. Death is usually anticipated in 5 or 6 years and there is nothing that can be done about it.

Fifty percent of all diabetics blinded by retinopathy will be dead from heart, kidney, or brain disease within 5 to 10 years from onset.

Dr. Theodore Cooper, Assistant Secretary for Health at the U.S. Department of Health, Education, and Welfare, recently testified before this committee that 75 percent of all diabetics suffer from terminal heart disease. The National Heart and Lung Institute has identified diabetes as a serious cause of heart disease; and that 65 percent of all heart patients have abnormal carbohydrate tolerance, which frequently leads to manifestation of the diabetes syndrome and can shorten a normal lifespan by as much as 50 percent.

Diabetes is the first cause of male impotence, and a serious cause of female sexual incompetence.

Diabetes is the first cause of pregnancy loss.

Diabetic mothers bear 15 to 20 percent more fetal waste, and three times as many malformed children as their nondiabetic counterparts. Brain damage is not uncommon among children of diabetics.

The life expectance of a diabetic is only two-thirds that of the general population. A diabetic child of 10 years can expect to live only 44 more years as compared with 62 years for a nondiabetic child. At age 30, the diabetic's remaining life may be only 30 years while a nondiabetic can look forward to another 42 years.

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Mortality among diabetics is higher at every age. Death rates are from 5 to 10 times greater in the general population among children and young adults and at least double in later life.

In 1935, there were 500,000 diabetics in the United States. In 1959, there were 2,930,000 diagnosed and undiagnosed diabetics.

In 1975, the American Diabetic Association stated that 10 million Americans, or 1 out of every 20 persons, is diabetic, diagnosed, undiagnosed, and potential. The association also reported that 1 out of every 4 persons is a carrier of the recessive gene that transmits the disease to children or grandchildren. It projects an increase of 1 million persons in the diabetic population every 3 years. Thus, by the year 2000, an additional 10 million persons may become diabetic.

The testimony which follows mine, given by my distinguished colleagues and comembers of the Pennsylvania Diabetes Institute, will clearly demonstrate the specific, devastating effects of diabetes mellitus on those parts of the body which are their specialty. Unfortunately, in the interests of time, experts dealing with all the systemic complications of the disease cannot testify. Therefore, I should like to refer the committee to the statistics detailing these problems attached at the conclusion of my statement.

As a layman, I wish to conclude my description of its devastation by entering into the record a copy of a letter I received from a 40-year-old woman with juvenile diabetes. A copy of the letter is attached for your reference. (Read the letter.)

I am here today, on behalf of the institute, to request Federal funds for research into the causes of, and establishment of methods of prevention of, the primary and secondary effects of diabetes.

The Directors of the National Institutes of Health have testified before this committee, indicating not only how much Federal money is allocated to the study or prevention of diabetes, but how little money is allocated. To illustrate, the Director of the National Heart and Lung Institute testified that, for fiscal 1976, $5 million, or one-sixtieth of a budget of $300,000 for his institute was set aside for diabetes. As diabetes is attributed to approximately 25 percent of all heart patient deaths, and 75 percent of all diabetics die from heart disease, this figure is appallingly low.

I recognize that reduction in Federal health funds as proposed in the fiscal 1976 budget may be a necessary response to inflationary pressures. But it renders impossible adequate response to ongoing health programs, and prohibits the stimulation of new and much needed research and prevention of a previously untouched health problem such as diabetes. In fiscal 1964, the cost of health research was 4 percent of the total health cost of $35.9 billion. In fiscal 1974, this cost was still 4 percent of the now-increased $105.8 billion. Although obviously more real dollars were involved in 1974, general inflation rendered this an inadequate response to a growing problem.

I wish to commend this and past administrations for their efforts in health research, and especially, in regards to diabetes. However, I recognize that such attempts were severely limited because of the great lack of information on the subject, the general ignorance as to the nature and extent of medical complications, and the appalling inadequacy of Federal funds allocated for research and prevention.

Given the rapid geometric progression in the size of the diabetic population in this country, we can no longer tolerate this situation and sit idly by.

The Pennsylvania Diabetes Institute proposes that the budget of each National Institute of Health be increased by 3 percent, the funds to be earmarked for diabetes.

I acknowledge, of course, that everyone today is clamouring for more funds, and that inflationary concerns prevent existing moneys from being used with maximum effectiveness. But I must urge this committee to consider the loss of potential incoming revenues from income-producing citizens and the high out-going expenditures to and from the national treasury if funds for preventive research and ongoing complications are not made available.

Federal attention must not only be devoted to people who have already suffered, but to research to prevent others from suffering in the future. I hope that financial incentive can be provided to each of the Institutes so that they can coordinate their efforts. Their competing and conflicting goals and objectives for a small pot of money designed to deal with so vast a problem as our Nation's health must be rationalized and harmonized.

We must now commit ourselves to new, broadened attempts to dealing with a major killer and maimer of our Nation's people. We must reassess our national priorities and give proper, and long overdue consideration to whether or not people live or die.

Statement of Dr. Arnall Patz

Mr. Flood. Our next witness is Dr. Patz, professor of ophthalmology at Johns Hopkins University School of Medicine.

Dr. Patz. I am Arnall Patz, M.D., professor of ophthalmology, the Johns Hopkins University School of Medicine, and director of the Diabetic Retinopathy Center of the Johns Hopkins Hospital, Baltimore, Md. I appear before this committee representing the National Society for the Prevention of Blindness as a member of its board of directors and as a member of its public relations and public information committee. I am also here as a member of the Pennsylvania Diabetes Institute.

The diabetic patient, the public at large, and even some members of the medical profession have been lulled into a sense of false security on the assumption that adherence to a special diet and the use of prescribed doses of insulin will permit the individual with diabetes to lead a normal and productive life. Although these measures may control the blood sugar level, damage to small blood vessels throughout the body continues insidiously throughout the lifetime of most diabetic patients. For example, in the eye, damage to blood vessels in the retina affects 80 percent of diabetic patients after 20 years' duration of diabetes and 95 percent of patients having diabetes for 25 years show blood vessel damage in the retina. Fortunately, all of these individuals do not develop severe changes, but enough sustain severe retinal damage that diabetic retinopathy has become the largest cause of blindness in this country in individuals under 60 years of age.

With your permission, I would like to make one additional comment that is not in my written report. On our way up here today Mr.

Stenzler asked me if I had any explanation for the increased severity and frequency of diabetic ophthalmology in black females. For reasons which we do not understand, there is a much greater incidence of the severe diabetic retinopathy in black female patients. Since these are his most productive years, the burden of blindness causes significant financial and emotional hardship for the patient and his family.

It is generally recognized that at least 60,000 diabetic patients in the United States are legally blind. A much larger number of additional diabetic patients has partial loss of vision in both eyes, or blindness in only one eye, and are, therefore, not "legally blind." Considering only the legally blind, with an average cost of $2,000 in public and private aid to each of these 60,000 individuals, we have the staggering amount of $120 million per year for support of the diabetic blind. In addition, the estimated loss of income of $3,000 per blind diabetic individual adds up to a total for both aid and loss of income for the diabetic blind to approximately $400 million annually in this country. Contrast this $400 million average figure with the $4,500,000 available to the National Eye Institute of NIH for its entire research program concerning diabetic eye disease this year—a ratio of almost $100 to support the diabetic blind for each dollar spent on research.

The National Eye Institute is to be commended on recognizing the high priority of diabetic blindness. Indeed, the modest figure of $4,500,000 actually represents a three-fold increase over the funds allocated for diabetic eye research just 4 years ago. But $4,500,000 for all research on diabetic blindness is grossly inadequate since the basic cause of diabetic retinopathy is unknown and there is no effective method of prevention. Furthermore, treatment of retinopathy, once it has developed, is very limited.

Approximately one-third of the total funds this year for diabetic research support the 15-hospital cooperative study to test photocoagulation treatment. Photocoagulation is that technique of coagulating or welding abnormal blood vessels in the retina by focusing a light, or laser beam, on the vessels. Even if this treatment proves definitely beneficial, we already know that many stages of retinopathy cannot be treated by this method. As a member of this cooperative study and of the executive committee that supervises the program, I recognize its importance as it represents the principal therapy now available. But, in actuality, this approach is a stop-gap one, comparable to putting a finger in the dyke. And even when this form of treatment is effective, it may be only temporary and a recurrence of the retinopathy may develop later after an initial success. What is required, and should be given the highest priority, is a major increase in basic research support to determine the fundamental cause of retinopathy and to develop methods of prevention of this dread complication of diabetes.

In addition to supporting the priority need for multidisciplined basic research efforts in all systems affected by diabetes, the National Society for the Prevention of Blindness calls attention to the need for better education of the diabetic population and their families, as well as their physicians and other paraprofessional personnel, dealing with the complex problems of the diabetic patient.

I strongly recommend an increase in appropriations to support multidisciplined and coordinated research, training of research scien-

tists, and the improvement of facilities for patient care. I make this request on behalf of my patients as director of the largest diabetic retinopathy center in this country and on behalf of the 5 million known diabetics in the United States who are potential candidates for the severe vascular complications of diabetes.

Mr. Chairman, thank you for the privilege of addressing this distinguished committee.

Mr. FLOOD. Thank you, Doctor.

Dr. Richard Schwarz?

Dr. SCHWARZ. The obstetrician-gynecologist is presented with a different perspective of diabetes. Prior to the insulin era, the combination of diabetes and pregnancy was essentially nonexistent, as the uncontrolled diabetic was either infertile or aborted spontaneously, if she did conceive. Now, with better understanding and control of at least the metabolic aspects of their disease, diabetic women are establishing and carrying pregnancies, and in so doing, bring forth a different array of problems.

It has been estimated that 1 in 3 to 400 pregnant women have diabetes.

In viewing this combination of events one must consider first the impact of pregnancy on diabetes, second the impact of diabetes on pregnancy, and finally the effect on the offspring.

As concerns the effect of pregnancy on diabetes, if one uses the common standard of insulin requirement, there is a significant worsening of diabetes during the course of pregnancy; however, in most cases the requirement returns to prepregnancy levels following delivery. Unanswered questions, however are whether insulin requirement truly reflects the state of the disease, and whether or not pregnancy may accelerate the disease at other levels, such as the vascular or renal. Clearly, patients with advanced renal or retinal disease are at considerable risk during pregnancy. At the other end of the spectrum is the genetically predisposed patient whose disease first becomes apparent as the result of the diabetogenicity of pregnancy. For her this may well be a preventive medical happenstance in that it may serve as a warning to avoid obesity and the later development of adult onset diabetes.

When the diabetic achieves a pregnancy it is a far greater undertaking than it is for her nondiabetic peers. She must expend more time, money and emotional energy, all with a markedly decreased chance of a successful outcome. The diabetic is at increased risk of such complications as pyelonephritis, polyhydramnios and toxemia, and has a perinatal mortality rate, despite the best of obstetric and pediatric care, which is at least three times that for the nondiabetic.

Ten to fifteen percent of babies born to diabetics are either stillborn or die within the first 30 days of life.

The diabetic offspring, if live-born, has a threefold increase in congenital malformations; sixfold if one considers only the lethal defects. In addition, the newborn is subject to jaundice, hypoglycemia, hypocalcemia, respiratory distress, and birth injury because of increased size. There is also an increased chance that the child will ultimately develop diabetes, although the genetic pattern, or probably patterns, of diabetes are so poorly understood that there is no solid basis for advising the patient about that risk.

Finally, when dealing with the pregnant juvenile diabetic there is the acknowledged but usually unspoken concern that she may well

not survive to see her child mature as she faces the ravages of the vascular, renal and ophthalmologic effects of the disease.

In gynecologic practice there is perhaps a more subtle view of diabetes. The gynecologist, often cast in the role of a primary care physician for women, has the opportunity of detecting diabetes, whether his suspicion is raised by persistent vaginitis or glucosuria, or simply because he evaluates blood sugar as part of his periodic health evaluation. He also recognizes the association of diabetes with certain other entities, particularly carcinoma of the endometrium.

Perhaps in the end these perspectives seen by the obstetrician-gynecologist more than anything raise a number of questions. What are the genetic patterns of diabetes and how should patients be counseled? What is the mechanism whereby diabetes leads to an increase in congenital malformation? What is the releationship between diabetes, ovarian function and vascular disease? The interplay between diabetes and pregnancy may truly represent a microcosm of diabetes and its protean human manifestations. To understand it may be a giant stride toward the overall understanding of diabetes. To understand it requires carefully planned, coordinated, clinically relevant and obviously funded research. Although there have been great strides in the funding of diabetic research, I urge the distinguished members of this committee to continue and expand this commitment, and particularly to cover the interim period between now and funding through the Diabetes Commission. I would also remind the committee members that, although there has been established a National Diabetes Commission, there is no representative of the discipline of obstetrics and gynecology on that Commission to foster those areas of research I have touched upon.

Mr. FLOOD. Why not?

Dr. SCHWARZ. I do not know, sir.

I thank you for the opportunity to underscore for you one circumscribed area of the impact of this ubiquitous problem of diabetes mellitus.

Mr. FLOOD. Thank you, sir.

Dr. Field?

STATEMENT OF DR. RICHARD A. FIELD

Dr. FIELD. Thank you for the opportunity to address you and this committee. I will forego the qualifications, as they are a matter of record, and begin with my story.

You have heard many of the aspects of diabetes already. You know that it has been 53 years since the discovery of insulin. You know of the optimism that that generated. That the problem of diabetes was going to come under control, that the diabetic would be normalized has unfortunately not come to pass.

The underlying cause of the foreshortened survival is a bodywide deterioration of the very smallest blood vessels caused by a relentless thinning of their walls, a narrowing of the passageways for the flow of blood.

There has been a monumental amount of investigation into seeking and defining a biochemical or a molecular or some interrelating disturbances of sugar, fat, and protein metabolism in the diabetic. At the

present time there is no proven translation of any of the known facts which explains this deterioration which occurs in every small blood vessel in the body and brings about a multitude of problems that Mr. Stenzler has cited.

The evidence at hand is most consistent with the theorem that the blood vessel damage is directly related to the duration of the diabetes.

Let me characterize for you what happens with a diabetic. On the average, 12 to 20 years of symptom-free existence transpire under our present capabilities of treatments before any problems or disabilities of the underlying advancing small blood vessel changes begin to appear.

These changes are going on silently all the time in the youngster, in the adult, and in anyone who displays this disturbance of metabolism.

Thereafter, or some time between 12 to 20 years, slow but relentless progression manifestation of vascular deterioration takes place. Damage to the eyes, the kidneys, the heart, the nervous system, and peripheral circulation occur. Then after another 5 to 10 years on the average, early death ends the misery of the blindness, the incapacitating kidney function, painful losses of function of the nervous system and usually there is a progressive deterioration in the capacity of the heart. This is frequently punctuated by acute fatal heart attacks.

Let's admit that everybody has to die of something some day. But in diabetes we are dealing with a prolonged situation of disability, incapacity over a prolonged period of years and we are doing so in bulk, involving as many as 10 million people.

In 1955, another advent took place. The oral antibiotic agents were shown to be able to reduce high blood sugar levels in the older diabetic population. Again great optimism flared up. It was hoped that a convenient treatment method for a very large population was at hand and it would improve their outlook in regard to long-term diabetic vascular complications and disease.

I won't try to raise the controversy created by this study as to the possibility that such treatment with oral agents increases the death rate of diabetics.

But let me emphasize the finding of this university group diabetes program which is often overlooked in the heat of the dispute on mortality.

This important finding to me is perhaps the crux of the findings of the project. That is the fact that the treatment did not benefit the patients in regard to preventing the development or the retardation of progression of the manifestation of the vascular deterioration.

Clearly then the oral agents are not the answer that we are seeking. Of all the various health problems you can think of, this has to be the most insidious and long term. It's small wonder that under these circumstances the general public, the governmental representatives, and the millions of diabetics themselves are unaware of the enormity of the existing problem and the gravity of the threat to the health of the Nation.

The identification of diabetes as a root problem is further beclouded by the isolation of various segments of the condition, either into heart disease, kidney disease, and so forth, and gets recorded in vital statistics by the organ which caused the terminal failure. It still has to be put together into one single disease.

I feel quite safe in venturing the guess that diabetes causes more mortality, direct and indirect, more morbidity, more disability, more economic loss, more family and social disruption than poliomylitis, cystic fibrosis, muscular dystrophy, multiple sclerosis, and cerebral palsy all combined and put together. It rivals and perhaps surpasses cancer in regard to morbidity and economic losses since malignancy, by and large, is a short term problem while diabetic disability stretches over decades.

I can support these contentions by citing to you a survey which was done of the diabetic population of the Massachusetts General Hospital in 1957. Every record that was coded for diabetes was examined. The incidence of diabetes in the hospitalized population was 7 percent. If the patient were a diabetic, his chances of being hospitalized were greater by twofold than a non-diabetic of a similar age. Once he got into the hospital, he stayed significantly longer than the non-diabetic population and he stood much less of a chance of getting out of the hospital alive.

The chances were at least one out of five that the diabetic would return and be readmitted during the same calender year. If he ever did get out of the hospital, the chances were 50–50 that he was not better off functionally than when he arrived.

One diabetic out of 14 had a previous amputation. A similar number required amputation or vascular surgery during the hospitalization. Fifteen percent of the total cost of services to diabetics derive from amputations and vascular surgery.

The hospital bill for diabetics is substantially larger, by 50 percent, than for average patients. If an amputation is required, it is double that for other patients. Of the total costs of hospital care for the diabetics, one-third is paid by the patients and insurers; one-third is paid by the community through its taxes to Government; and one-third the Massachusetts General Hospital chalked up as free service. If you project those to 1975 incidence rates, since diabetes is increasing in frequency, and our new inflationary monetary standards, we can guess that over 12 percent of the current patients in the Massachusetts General Hospital have diabetes and that the total annual cost is in the neighborhood of $2 billion and that the cost to the taxpayer is approximately $700,000 at this one hospital alone.

In Boston, the Massachusetts General Hospital is only one of seven or eight major hospitals and we are very fortunate to have the Joselyn Clinic which deals almost exclusively with diabetes. Thus in Boston alone the cost of hospitalization of diabetics must be enormous, at the very least $25 million a year.

I think we have a major medical crisis ahead with this condition. It has been our experience in the past that medical science, both Government and health authorities, do not mobilize their efforts until after a catastrophic event occurs. I think we have here the possibility of averting such a health crisis by the year 2000 if we will take timely application of research. I think it's research that has to be done.

I am an advocate of education. I am an advocate of coordination. The problem in diabetes is that we don't have any of the key answers. I think they can be only derived from research.

Therefore, Mr. Chairman, I support in the strongest possible terms Mr. Heinz's suggestion that a specific addition of 3 percent to each of the several Institute budgets be made.

Thank you for your attention.

Mr. FLOOD. Thank you, gentlemen.

STATEMENT OF DR. ROBERT KUGEL

Dr. Robert Kugel, Chairman of the Council on Child Health.

Dr. KUGEL. Mr. Chairman and members of the committee, my name is Robert Kugel and I am currently vice president for Health Sciences at the University of New Mexico in Aubuquerque. I am also serving as chairman of the Council on Child Health of the American Academy of Pediatrics, an assignment I have had for the past 5 years. Because of my deep concern about child health and for the important role which the National Institute for Child Health and Human Development (NICHD) has played and will continue to play in promoting child health, I am pleased to have the opportunity to make a few comments to you pertaining to the role of the Institute.

IMPORTANCE OF CHILD HEALTH

Within the period of less than a lifetime we have seen dramatic changes occur in the pattern of diseases which affect children. Poliomyelitis, a dreaded scourage of only a scant 25 years ago, has now been reduced almost to oblivion through the application of knowledge gained from research. Open heart surgery in children, once thought to be impossible because of inadequate technical achievements, is almost commonplace in major medical centers throughout the country.

Despite these striking advances, I believe we have an inadequate national commitment to continuing progress in some of the difficult areas which confront us today. There are many reasons why this interest in child health has been lagging, but two are worthy of some special mention.

One reason is a neverending one—the child always must have an advocate. Children do not develop their own campaigns for comprehensive programs for immunization and early detection of disease, nor do they have the significant lobbies such as one finds with the Veterans' organizations and senior citizen groups. I want to be one of the voices which you will hear urging that we do more, a great deal more, for children during the course of the next decade. What better time to launch this type of effort than fiscal year 1976, our national bicentennial year!

A second reason why we seem to lag in our commitment to children is because we do not have a national plan for child health. Although I salute all of the programs currently under way at NICHD, I must point out that they do not add up to a national plan. This is no fault of the Institute because no mandate has been given to them, nor to any other agency in our Federal Government, to develop a national plan. A few years ago there was no national plan to combat mental retardation, but a study group appointed by President Kennedy to develop a national action plan changed all that. A similar effort should be made with reference to child health. I would propose that such an effort be undertaken.

A CENTER FOR POPULATION RESEARCH

This important Center in NICHD continues to have a major impact on developing new knowledge in reproductive biology and studies of population growth and development. As yet Americans have insufficient understanding as to why there should be population control. It is difficult in my home state of New Mexico for example to impress on people the need for limitation of population when they are confronted with wide open spaces and sparse populations. This same observation can be made for a great many States in mid-America. Much more effort needs to be directed in giving people explanations as to why they should change their behavior. Certainly it is important to link population control with food supply. Relatively little effort seems to be made in trying to give people this understanding.

In addition various contraceptive measures are now coming under attack because the safety aspects are uncertain in the minds of many people. Clearly it is important to pursue a wide variety of techniques for both the male and the female but it is also important to indicate to the public what the risks are and this type of information is inadequately disseminated at the present time.

CENTER FOR RESEARCH FOR MOTHERS AND CHILDREN

This new Center which has recently been developed in NICHD, appropriately has an accent on prevention. Important though prevention is, we frequently seem to deny it as we glamorize new treatments for a variety of illnesses and disorders. The knowledge about nutrition and the ways in which poor nutrition will affect the next generation is inadequately transmitted to our children, especially those young teenagers who will soon become mothers. Our efforts must be substantially increased to promote the dissemination of knowledge in ever more effective ways. Closer coordination with schools would be important if this objective is to be achieved.

In addition to concern for the mother and the child, new effort should be directed to the father. The role of the father in the nuclear family is changing and yet little effort has been given to helping young fathers understand their role as being more than a biological one. If families are to be strengthened, attention must be given to the fathering role as well as the mothering role.

Learning disabilities constitute an area of growing concern for our society. The individual who cannot read well will be handicapped in a significant way, regardless of where he lives or under what set of circumstances. Greater understanding of the impact of emotional problems on learning must also be studied and ways found to prevent or ameliorate them. The multiple etiology approach to learning disabilities needs to be understood if we are to make significant headway into this disorder. A combination of such factors as poor environment, emotional stress, and biologically deficient brains all need to be studied if progress is to be made in this disorder.

Mental retardation continues to be a problem for our society. Great strides have been made in the recent past but the ravages of poverty continue with their unrelenting impact on our society. The President's Committee on Mental Retardation has suggested that by the year 2000

mental retardation can be reduced by half. Because two-thirds of all the mentally retarded individuals of today would fall into the category of cultural-familial mental retardation, there could be no conceivable way we could significantly reduce mental retardation unless an even more vigorous attack against poverty is made.

There are some significant examples of how this can be done and I would cite one of my own efforts undertaken when I was at the University of Iowa. This study, Children of Deprivation, was published by the Children's Bureau in 1967. By combining the professional efforts of physicians, educators, psychologists, home economists and others, one can change some of the forces that surround so many children who are being reared under the pernicious influences of poverty. The frequently associated mental retardation can be ameliorated or eliminated.

DISSEMINATION OF KNOWLEDGE

Although the efforts of NICHD are laudatory in bringing new information to various practitioners concerned with child health, we need even more. Not only should we continue our standard efforts at knowledge dissemination through the medium of national meetings and scientific publications, but we must explore other techniques for giving information, utilizing educational television, quick spots on commercial television having information about nutrition and providing for greater emphasis on child health in our schools. The techniques for disseminating information are certainly understood but they have not been vigorously applied to the health field as yet.

Mr. Chairman, I want to indicate my wholehearted support of the proposed budget for the National Institute of Child Health and Human Development. I believe these projections are realistic. However, I have suggested that we need to do significantly more in our efforts to promote good health among the children of the Nation. I would urge that you give still greater thought to the implications of advancing our dissemination of knowledge and developing a national plan for child health.

Thank you for the opportunity to address you.

Mr. FLOOD. Thank you, Dr. Kugel.

STATEMENT OF WILLIAM HUTTON, EXECUTIVE DIRECTOR OF THE NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Thank you, Mr. Chairman.

The National Council of Senior Citizens, representing over 3,000 senior citizens clubs across the Nation, is most pleased to have the opportunity to testify before this committee.

Our membership is primarily comprised of people across our land who have toiled over many decades to help build America to a position of leadership among nations, but our much vaunted high standard of living is being so rapidly eroded among elderly Americans that one can say without much contradiction that nearly all of the little industrial nations of Europe do much more for their older people than this great Nation of ours.

We have come today to ask that this committee help the elderly of this land live more wholesome lives through the appropriation of

money for specific programs in the Departments of Labor and Health, Education, and Welfare.

Today there are over 21 million people 65 years and over in our Nation. In 1950 there were only 12,294,698 people in this age group. By 1985 it is estimated that the population 65 years and over will have grown to 26,659,000 and by 1995 to 30,307,000 or approximately 12 percent of the population at that time as compared to slightly over 10 percent of the population today. (Bureau of the Census, Population Estimates and Projections, Series P–25, No. 541.)

For many of this large portion of people that are our elderly, the "golden years" are more like tin-can years—and rusted at that. As of March 1974, 3,354,000 or 16.3 percent of the 20,602,000 elderly at that time were below the low-income level. (Bureau of the Census, Characteristics of the Low-Income Population: 1973, Series P–60, No. 98.)

The chance of living in poverty is greater for the elderly than any other age group in America. Nearly 1 in 6 people 65 and over lives in poverty compared with 1 in 10 people under age 65. Further, the number of near poor is estimated to be great. In 1971, over 50 percent of the elderly had incomes of less than $5,000 per year (Administration on Aging, "New Facts on Older Americans"). To give an additional fact of the need of the elderly, the Social Security Administration estimated in 1973 that approximately 4.6 million aged people would be eligible to receive benefits from the supplemental security income program, including State supplement only. (Design for Dignity: Supplemental Security Income for Aged, Blind, Disabled, Book 1, July 1973.) Tragically, as of February 1975, only 2.5 million aged are receiving payments under the SSI program. (Supplemental security income program: Data update March 24, 1975.)

The need for special services for the elderly, however, is not only related to their inability to pay for services. Limited physical health and mobility act as huge roadblocks to an elderly person who must depend on our regular ways of carrying out daily tasks such as getting to and from the doctor, shopping for food, taking advantage of services, caring for house and personal needs, and very importantly, visiting with friends.

And even if an elderly person has fairly good health, the interests we take for granted may be closed to them because of the insidious discrimination on account of age. A 60-year-old person has a very difficult time getting a job, being enrolled as a degree candidate in a school, obtaining credit, getting car insurance or finding knowledgeable legal help on problems particular to the aged such as social security law.

One of the most direct and very beneficial programs that has recently been started for the elderly is the nutrition program, title VII of the Older Americans Act. This program, readily accepted by the elderly, is helping many people 60 years and over get at least one good meal a day, 5 days a week. Many older people are unable to provide good nutrition for themselves because of the lack of money, transportation to and from grocery stores, absence of cooking facilities, and loneliness and despair. The nutrition program not only provides the very important nutritional sustenance, it also provides friendship, education, information and social activities through the concept of communal feeding in a supervised environment.

Currently the nutrition program is providing 228,000 meals per day—but there have been estimates that up to 1 million different older people are being served each week under this program, with at least one hot meal per week. However, there are 4,410,000 people 60 years and over living in poverty (Bureau of the Census Characteristics of the Low-Income Population: 1973, series P–60, No. 98). What do you say to an elderly person who has stood in line for several hours to get the only meal of the day only to find that the food is all gone?

In this particular time of economic crisis—when there is little chance for older poor people to be helped by their unemployed relatives and friends—it is essential that efforts be made to increase appropriations so that a better average than 1 in 4 of our elderly poor gets an opportunity to have one decent hot meal a week.

The National Council urges that $200 million be appropriated for the title VII nutrition program along with $10 million for purchase of section 32 high protein foods as authorized in the House-passed Older Americans Amendments of 1975, H.R. 3922. This would allow for at least a doubling of the current program, and possibly even more, as some of the nutrition sites will expand their programs and overhead costs will be lowered.

The National Council was very elated to hear that Congress has persuaded the administration to bring the level of the nutrition program up to $150 million by the beginning of the new fiscal year through the use of funds carried forward from previous years. In view of the foot-dragging tactics that the administration has practiced in releasing of the nutrition funds, the National Council would also urge that Congress direct that the administration must bring the nutrition program up to the $200 million appropriation level immediately after this appropriations bill is enacted.

In conjunction with the administration of the nutrition program and of utmost importance for coordination of services to the elderly is the title III, State and community programs. The State agencies on aging are designed to be the focal point in the State on behalf of the elderly and to plan, coordinate, and evaluate programs. In conjunction with the State agencies, 412 area agencies are coordinating and making more readily available resources and services to the elderly in their immediate communities. As anyone who has ever wandered through the governmental bureaucracies at any level can tell you, finding the service you need can be very frustrating. A saving in both time and money can be accomplished if a coordinated program is at hand.

That there is a very real need for these knowledgeable title III spokesmen and elderly advocates at the local and State level, has been shown by the ludicrously low token contributions from State and local revenue sharing that has been spent for the aged. According to the Office of Revenue Sharing, U.S. Department of the Treasury, (February 1975), only 4 percent of general revenue sharing was spent on social services for the poor OR aged for 1973–74.

The H.R. 3922 authorizes $180 million for title III State and community programs. This amount of money is particularly needed to continue the coordinated administrative structure for meeting the needs of the elderly and to initiate the new title VIII programs as contained in H.R. 3922. The title VIII programs could help fill some of the many gaps in services to the elderly so that they may maintain

the highest degree of independence possible and for many, delay the need of a costly nursing home.

In conjunction with title III, the National Council felt the legislative authority invested in title II, the National Clearinghouse on Aging, would be effective in serving the elderly population. Through the use of the Office of Human Development salary and expense money and some title IV (Older Americans Act) money, the National Clearinghouse has been able to already help through the setting up of an information and referral service and in the printing of information helpful to the elderly themselves and to people working with the elderly.

We would suggest that a direct appropriation be made to title II. We have heard that they are presently spending approximately $1.5 million, but have been unable to provide as much service as they might. The National Council is often used as a "clearinghouse" and although we will continue to provide anyone with as much information as we have, we do not have the time or financial support to be able to help every aged American either directly or indirectly.

It would be a true help to have one Federal office to turn to that could provide special help with any problem in the aging field.

We are sure all of you are very familiar with the title IX older American community service employment program. It was only through your efforts and persistence that part-time work opportunities are being made available to older people across the Nation. It is true that under title IX only $10 million has really gone out to the older workers, but except for Congress support, title IX would not be alive today.

The Department of Labor called a meeting last Friday, May 9 of all title IX national contractors—of which we are one—to announce the Department's decision for spending the $12 million fiscal year 1975 appropriation. They plan to move the Operation Mainstream program, now funded under title III of CETA, at an annual rate of approximately $26 million to title IX. The $12 million will allow the current 12,225 Operation Mainstream and title IX enrollees to continue in their jobs through October 17, 1975. This plan is contingent upon Congress enacting authority to waive the title IX allotment formula for those States that have more Mainstream enrollees than the title IX allocation formula would provide for. This authority is contained in H.R. 3922 and in the Emergency Employment Appropriations Act, H.R. 4481. As you well know, H.R. 4481 contains additional funds so that each state could receive the higher of either their current Operation Mainstream level or the title IX formula level. The additional funding was initiated in this good committee to overturn the Department of Labor's previous policy decision to throw the over 9,000 Mainstream enrollees out of their jobs this June 30. We wish to thank you very much for recognizing the need to continue this program.

However, as the National Council has testified for many, many years, there are hundreds of older people who are able to work and who want to work, but are unable to find jobs on the regular labor market. Many of these wise older people know the value of community services and delivering services to other disadvantaged people in their own communities on a part-time basis brings much joy and

fulfillment to them along with a very badly needed pay check. Surely it is also worth noting that the majority of enrollees are able to use our senior citizens community service employment programs to keep themselves off the welfare rolls. Thus, to a large extent, this is not new government expenditure, but merely a transfer payment, what we in my former country of England say, "What you lose on the roundabouts you gain on the swings." In this particular case we are giving people an opportunity to work, do dignified work instead of receiving their money on welfare.

Even before the current recession the need for this program was evident. When we first started the demonstration program in 1968, we had seven applicants for every job opportunity. Now the waiting lists of both applicants and communities that are requesting the program are so long that we have stopped counting.

In the last year, April to April, the unemployment rate for people 55 years and over jumped from 2.6 to 5.1 percent. This however does not really tell the true story because as older workers lose their jobs and are unable to find new ones—even during better times—they become discouraged and drop out of the labor force. In 1950 there were approximately 10 million people 55 years and over employed. By 1970 there were over 14 million employed. As of April 1975, there were just 13½ million working. Even the number of workers 55 to 64 years has dropped slightly from a high in 1972 of almost 11 million to 10.6 million in April. All employment numbers are seasonally adjusted and are taken from the Bureau of Labor Statistics—Monthly Statistical Updates. There is a strange statistical phenomenon that happens with old workers—as the number of older workers employed drops, so does the number of unemployed.

And, as in the case of general revenue sharing, CETA manpower revenue sharing assistance has meant very little to older workers. During the first half of fiscal year 1975, people 55 years or over received less than 3 percent of the available manpower assistance.

Not only, though, do we gain by giving older people a choice between welfare and a useful job, these part-time paid community service workers provide social and community beautification services that surely assist other people to live better lives.

The authorization for title IX as contained in H.R. 3922 is $100 million, the same as it was for fiscal year 1975. That amount of funding is needed and it can be readily put in the pockets of approximately 30,300 older people in exchange for their useful work. I might add that as all the people on these programs are at or below the poverty guideline, that the money doesn't just sit in their pockets. It is quickly spent for necessities—not nested away under the mattress—so this is a good way to help our economy.

In conjunction with providing opportunities for poor older people to earn a little extra sorely needed money, the Foster Grandparent/Senior Companion program has been able to provide help in this area in return for personal services to institutionalized children and older people. This program should receive its full appropriation of $40 million so that it may enroll more older people and also pay them more than the current miserly $1.60 per hour—they should be paid at least the minimum wage.

Along with the work programs, consideration should be given to the Age Discrimination and Employment Act. In 1974, the Employment Standards Administration of the Department of Labor was involved with 7,500 compliance actions and 3,000 full investigations—a 27 percent increase over 1973. The number of complaints brought in during 1974 tripled from 1969 and they are estimating a doubling of the complaints in 1975 over 1974. Yet, the administration is requesting that the number of staff positions for enforcement of the act be kept at 81, the same as it was in fiscal year 1975. We would like to see at least a 50-percent increase over the $2.168 million requested by the administration for enforcement of the Age Discrimination and Employment Act.

Title V of the Older Americans Act, multipurpose senior centers, has never been funded since its enactment in 1973. As we travel around the country we see the very inadequate store fronts and run down buildings being used as senior centers. For many older people, the senior center is one place they can go that does not cost money once they get there. In many communities, the elderly have fived up places on their own. If some funds were made available, we still think the elderly would want to do as much as they could themselves. The national council would like to see $10 million made available to assist in the repair and alteration of existing facilities so that there will be a suitable place for seniors to gather and receive services.

There are other programs that can affect the lives of the elderly today and 10 or 50 years from now. Just as in any other field, new and better ways to run programs have to be sought, new knowledge can be gained through research and people need to be trained in their special field.

There is an acute need for adequately trained personnel in the aging field. First, there are not enough people attracted to working with the elderly and second, many of the people who do work with the elderly are not skilled in the knowledge and techniques needed to bring the best results.

We think that at least $16 million should be appropriated for title IV–A of the Older Americans Act.

We also recommend that title IV–B receive $16 million to carry out research and demonstration to improve ways of solving various problems facing the older adult.

Title III, model projects, have a definite place in the aging field so that programs on a small scale may be tried and honed close to perfection and then duplicated on a larger scale after they have been evaluated and shown to be effective. We recommended that the current appropriation be increased enough to continue ongoing projects and to allow for new model projects to be initiated.

Specific areas of concern such as housing needs, special transportation and continuing education projects have been funded under title III, model projects. The national council has conducted a title III model project to develop legal resources for older persons since January 1974. Our project is the only program in the country to provide technical assistance and training to State and area agencies on aging to assist them in providing legal services for older persons who need and deserve them. We are gratified that Commissioner Flemming has announced that he will release up to $1 million this fiscal year to fund programs in law and aging.

Commissioner Flemming has recognized that his first priority is to provide for a nationwide capacity like we have been providing in HEW region III through State and area agencies. We are applying for an expansion of our program—legal research and services for the elderly—so that we may continue our work throughout the country and replicate the successes we have achieved in Pennsylvania, Maryland, Virginia, Delaware, West Virginia, and the District of Columbia.

Last year the Research on Aging Act established the National Institute on Aging. Although the elderly of today may not reap the benefits, the biomedical, social, and behavioral research that could be conducted in this institute should proceed so that as the young of today grow old, they will not be subjected to as many ills and burdens as the elderly of today must carry.

I know our members wish this research to go on, because if there is one thing that the Nation's elderly have in common, it is that they wish for everyone to live a better life. We do not proclaim to be experts in this very technical research field, however, the budget request of $16.19 million pales in light of the $106 million for the National Institute of Child Health and Human Development. Are the years from 60 to 70 any less important to the people living them than the younger years?

From the surface of this testimony you might be led to believe that we feel every conceivable program for the elderly should be given additional funds and that the "belt tightening" that has been asked of all citizens should not apply to the elderly. That is not the case.

But we are genuinely concerned that America's older poor not be required to carry an unfair share of the weight of this current economic albatross. When we testified about a month ago before the Senate Subcommittee on Aging in relation to extensions of the Older Americans Act we did not ask for new programs to assist the elderly although we can think of many. What we said was—

> We have come before the Congress many times now on the Older Americans Act. First, to urge the enactment of it and then to suggest improvement. The most significant improvement we wish to see this year is in the appropriations.

We thank you very much for giving us time to appear before this distinguished committee.

Mr. FLOOD. Thank you very much.

TUESDAY, MAY 13, 1975.

PENNSYLVANIA GOVERNOR'S COUNCIL ON DRUG AND ALCOHOL ABUSE

WITNESS

DR. RICHARD HORMAN, EXECUTIVE DIRECTOR

Mr. FLOOD. Dr. Richard Horman, Executive Director of the Governor's Council on Drug and Alcohol Abuse, Harrisburg.

Dr. HORMAN. Mr. Flood, thank you very much for the invitation to be here.

I am Dr. Richard Horman, Executive Director of the Pennsylvania Governor's Council on Drug and Alcohol Abuse. In addition to that position, I am the President and Chairman of the Board of the Council of State and Territorial Alcoholism Authorities, Inc. Unfortu-

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nately, the invitation to testify before this committee came after the CSTAA Board meeting. Consequently, my comments do not necessarily reflect the consensus of the Board.

It is tempting for a person of my position to wish to review every aspect of the NIAAA budget. It is tempting to become distressed about the lack of sensitivity of the administration as it pertains to one of this Nation's most serious public health problems. However, I recognize that in the interest of time, some clear and precise statements are required.

It has only been since the early 1970's that the State and Federal Governments working together have responded to the problems of alcoholism. Yet, alcoholism is a basic and ingrained component in American culture. Moreover, it is a problem that historians have documented as being a significant problem for the preceding six cultures that have been on this planet. It is a problem that affects every home in every community in every State and territory under the jurisdiction of this Congress. Yet, recognizing the extent of the problem, the administration proposes not to merely maintain the existing programs, but they propose to cut the existing 635 federally funded programs treating 200,000 people to a mere 351 programs treating 120,000 people. At the same time that this proposal is being made, we are all experiencing a significant downturn in the economic health of the United States. It has been my experience as a clinician and during my years of public service as a State alcoholism director, that as unemployment increases, so does the rate of alcoholism.

I just noticed, by the way, in your own home district in Luzerne and Wyoming Valley, most of the alcoholism in and around the Luzerne-Wyoming Valley has increased as much as 100 percent since last December, intakes, new admissions.

As men and women are laid off from their jobs, they become bored, frustrated, and angry. The use of alcoholism represents for them a significant escape from the anxiety that they experience as a consequence of the economic recession.

In the last year of the Nixon administration, Mr. Nixon proposed a significant cut in the NIAAA budget. However, an enlightened Congress, upon the recommendation of this esteemed committee, saw fit to restore some $46 million to the NIAAA budget.

I might also recall for you that this budget was very much involved in legal matters as it pertained to the impoundment.

Unless you take the initiative, I am convinced that the Ford administration will continue the Nixon policies as they concern this important health problem.

The second area of concern that I wish to highlight to you concerns the administration's proposals as they relate to the responsibilities of State and local governments. I do not quarrel with the administration's statements that there must be a shared responsibility between State government and the Federal Government as it pertains to dealing with this problem. I do object, however, to the administration's proposals to literally "dump" the alcoholism program on the States and local municipalities with little time to develop alternative funding resources. Moreover, as you are aware, most States derive their revenues from personal income taxes, State sales taxes, and corporate taxes. It is these types of taxes that are most severely affected by our

current economic recession. The States are in no position to pick up the multimillions of dollars that would be required to continue funding the alcoholism effort at the same level as 1975.

There is an implication in the statements of Mr. Weinberger and Dr. Cooper that suggest that the States are at this time failing to support the alcoholism effort. Gentlemen, I do not know of a State that is not making an appropriation and an increasing appropriation to the alcoholism effort. Moreover, I do not know of a State that has the resources available to make the new matches on Federal dollars that are being proposed by this administration. In the President's budget message he says, "Responsibility for the program must now shift to the States and localities." I vehemently disagree. The responsibility to fund these programs must be viewed indefinitely as a shared responsibility. Because the Federal deficit is increasing, it should be no reason to drop these programs as a Federal responsibility. I personally do not understand why the administration is dealing with the alcoholism program in such a unique fashion. For some reason, the administration has proposed a unique policy as it pertains to this health problem. I have not heard any comments to suggest that the States and municipalities should assume the costs of the Medicaid program or the Vocational Rehabilitation program. Why then is this program, alcoholism program, a basic health service, singled out as a program to be handled merely by the States and municipalities?

Since the administration, by its actions, is refusing to see the responsibility of the Federal Government to provide services to those persons afflicted with this health problem, I can only urge this committee to take up the leadership that the Ford administration has failed to provide. There can be no question that unless NIAAA's budget is funded to at least the level of fiscal year 1975, we will face an even greater increase in health problems relating from alcoholism, not only health problems, of the problem of alcoholism itself, but the tremendous ancillary problems caused by the abuse of alcohol.

Mr. FLOOD. How will title XX of the new Social Security Act help support the alcohol program?

Dr. HORMAN. The substantive legislation provides for a variety of services for alcoholics as well as drug abusers.

Mr. FLOOD. The new title XX?

Dr. HORMAN. It does provide authorization. The problem we are facing, though, is that the administration is proposing a change in the matching formula.

As I understand the formula would change so that, instead of 75 percent match, next year it would be 65 percent Federal and 35 percent State, and the following fiscal year 50–50.

I would again say it is this type of strategy of the administration that is cutting down on the availability of funds for services, because the States do not have the money.

Mr. FLOOD. Then what effect will this administration budget request have on the alcohol abuse prevention activities?

Dr. HORMAN. Well, the current proposal as it relates to us—title XX, first of all, because of the restrictions in the way that the planning must be done provides that prevention efforts must be client-specific, which means if you are working with a group of children in prevention, you must be able to delineate who is eligible under the

public assistance programs, which is an impossibility, it cannot be done.

You cannot separate children in a classroom, those eligible through public assistance, they can get it, those who are not receiving some form of public assitance cannot get the services.

In terms of the NIAAA budget, the current cut would provide for a decrease in the budget for the National Center for Alcohol Education, which is one of two major programs, it would decrease that budget by approximately 20 percent and it would decrease the budget of the National Clearing House for Alcoholism Information by 75 percent.

Those are the only two major significant efforts funded by the Federal Government pertaining to the prevention of alcoholism.

Mr. FLOOD. Thank you very much.

Dr. HORMAN. Thank you, sir. It is good to see you.

WEDNESDAY, MAY 14, 1975.

NATIONAL MEDIATION BOARD

WITNESS

EDWARD J. HICKEY, GENERAL COUNSEL, RAILWAY LABOR EXECUTIVES' ASSOCIATION

Mr. FLOOD. The committee will be in order.

Mr. Edward J. Hickey, general counsel of the Railway Labor Executives' Association is our first witness this morning.

Mr. HICKEY. Good morning, Mr. Chairman.

I have a prepared statement, copies of which have previously been distributed to the committee.

Mr. Chairman and members of the subcommittee, my name is Edward J. Hickey, Jr. I am a partner in the firm of Mulholland, Hickey, and Lyman which serves as general counsel for the Railway Labor Executives' Association on behalf of which I appear here today in opposition to certain language in the appropriation measure for the National Mediation Board's budget for the fiscal year 1976.

The rail unions, whose chief executives comprise the Railway Labor Executives' Association and who represent the overwhelming number of employees in the railroad industry, are the following:

American Railway Supervisors' Association; American Train Dispatchers' Association; Brotherhood of Locomotive Engineers; Brotherhood of Maintenance of Way Employes; Brotherhood of Railroad Signalmen; Brotherhood Railway Carmen of the United States and Canada; Brotherhood of Sleeping Car Porters; Hotel & Restaurant Employes and Bartenders' International Union; International Association of Machinists and Aerospace Workers; International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers and Helpers; International Brotherhood of Electrical Workers; International Brotherhood of Firemen and Oilers; International Organization Masters, Mates and Pilots of America; National Marine Engineers' Beneficial Association; Railroad Yardmasters of America; Seafarers International Union of North America; Sheet Metal Workers' International Association; Transport Workers Union of America;

United Transportation Union; and the Railway Employees' Department, AFL-CIO.

This list includes every standard national organization, with the exception of the Brotherhood of Railway Clerks, who represent employees in the rail industry.

The particular language to which we object and seek to have eliminated restricts payments by the Mediation Board for compensation and expenses of neutral referees or arbitrators appointed by it under section 3 of the Railway Labor Act to 75 percent of the total costs for such services. Absent substantive amendments sought to be obtained through this rider to the appropriation measure, such a restriction would plainly be in contravention of the present provisions of the Railway Labor Act in section 3, first (g) and (1), section 3, second and section 12 which require full payment of such costs by the Mediation Board.

As explained by Chairman George Ives of the Mediation Board to this subcommittee when he appeared before you on April 30, this change in appropriation language from the customary text consistent with the requirements of the Railway Labor Act originated in the Office of Management and Budget and its impact is to shift 25 percent of the cost of railroad disputes under section 3 of the Railway Labor Act from the Government to the parties using the services. Because the restrictive language presupposes its approval by the Congress, the appropriation amount for section 3 disputes is trimmed by 25 percent or $300,000. Accordingly, we seek not only the elimination of the restrictive language but also the restoration of the $300,000 which would change the total amount to be appropriated for section 3 disputes from $1,198,000, as stated by Chairman Ives, to $1,498,000. One further point not mentioned by Mr. Ives in his testimony before this subcommittee which probably requires consideration is the fact that because the fiscal year is being changed in 1976 so as to commence in October 1 for the fiscal year of 1977, the resulting lag of 3 months would require, I am informed, an additional $75,000 or a total of $375,000 to be added to the $1,798,000 in order to restore the amount required to pay the costs of referee fees and expenses in section 3 disputes as now required by the Railway Labor Act.

Now let me explain, if I may, the reasons which prompt the rail unions represented in the Railway Labor Executives' Association to oppose these amendments to the Railway Labor Act through the medium of this appropriation bill and justify, we believe, your disapproval of such amendments and restoration of the budget reductions which, as I have already pointed out, are predicated on the assumption that the amendments will be approved by the Congress.

First, let me support what I mentioned briefly at the beginning of my statement—that substantive amendments to the provisions of the Railway Labor Act will result if the language restricting payment by the Government to 75 percent of the costs of neutral referees in section 3 disputes remains in the appropriation bill.

Section 3, first (g), which concerns resolution of disputes on the right of national labor organizations to participate in the selection and designation of labor members of the National Railroad Adjustment Board, provides that the neutral member shall be designated and compensated by the Mediation Board.

Section 3, first (1), which concerns deadlocks between carrier and labor members in the compulsory arbitration of grievances or disputes over the interpretation or application of agreements concerning rates of pay, rules, or working conditions, provides that the Mediation Board shall, in the event any division of the Adjustment Board fails to agree upon a neutral referee to resolve the deadlock, select such referee "and shall fix and pay the compensation of such referees."

Section 3, second, which concerns the appointment of neutral members of special boards of adjustment, commonly known as public law boards, to relieve congestion of the Adjustment Board divisions and expedite resolution of disputes otherwise referable to such divisions, similarly provides that the neutral members of such public law boards "shall be compensated and reimbursed for expenses by the Mediation Board."

Finally, section 12 of the Railway Labor Act provides as follows:

> There is hereby authorized to be appropriated such sums as may be necessary for expenditure by the Mediation Board in carrying out the provisions of this act.

Now why is this curtailment of the Government's financial support of neutral arbitration in section 3 disputes so vigorously opposed by organized railroad labor? A bit of history is important here. As shown by the House and Senate hearings and committee reports on the 1934 amendments to the Railway Labor Act, the rail unions voluntarily surrendered their right to strike in disputes involving grievances and the interpretation or application of collective bargaining agreements (called minor disputes) and agreed to compulsory arbitration of such disputes with provision for the assumption of the costs of neutral referees and arbitrators by the Federal Government through the Mediation Board. Since that date, efforts have been made from time to time to persuade Congress to eliminate or curtail such Governmental support and impose the costs of neutral arbitrators upon the parties to the disputes in addition to their payment of the costs of the partisan arbitrators who compose the adjustment boards, including the Nixon administration emergency disputes bill of 1970 and an aborted service charge proposal of the Office of Management and Budget last year. Thus far, Congress has rejected such efforts and honored its commitment of 1934.

Another argument against any tinkering with the Government's full assumption of the costs of neutral arbitration in section 3 disputes is that it would probably trigger retaliatory efforts in some union circles to persuade Congress to repeal compulsory arbitration of minor disputes entirely and restore the right of employees to strike in such disputes just as they are permitted to do in other industries subject to the Taft-Hartley Act.

A third argument of significance, it seems to us, is that any dilution of the Government's financial support of neutral arbitration in section 3 disputes is inconsistent with the overall design and purpose of the Railway Labor Act to provide Government financed neutral arbitration throughout the act, even in major disputes, whenever parties can be induced to pursue it in lieu of calling strikes.

By way of illustration, section 7 of the Railway Labor Act provides that whenever a controversy between carriers and their employees is not settled by agreement or through reference to the adjust-

ment boards or through mediation, it may, by agreement of the parties, be submitted to an arbitration board, the neutral member or members of which shall be selected by the parties to the controversy or, if they fail to agree, by the mediation board. Section 7, third (e) provides that any such neutral arbitrator shall receive such compensation as the mediation board shall fix, together with his traveling and subsistence expenses.

In like manner, section 10 of the act which deals with the appointment of Presidential boards to resolve emergency disputes, provides that the compensation and expenses of the members of these boards shall be paid by the Government.

A fourth and vitally important reason why railroad labor opposes this curtailment of Government-supported neutral arbitration in section 3 disputes is that the economic impact of shifting 25 percent of such costs on the parties to the disputes, in addition to what they already expend for their own partisan arbitrators, would more severely penalize the rail unions, whose members seek and need the arbitration process to resolve disputes over contract interpretations and grievances rather than the carriers who rarely invoke it and can sit tight in a controversy secure in the knowledge that the employees cannot strike and arbitration will be more costly for such employees. Moreover, this increased financial burden of arbitration will be visited upon us at a time when rail labor can least afford it in the face of increasing consolidations, sharply reduced personnel, and mounting costs of everything. In short, the amendments would discourage arbitration of disputes.

There are few, if any, reasons of merit which we have heard advanced in support of the proposed reduction of Government support of neutral arbitration of section 3 disputes. The obvious one, that it will save the Government some money, is far outweighed in our view by the opposing reasons we have already discussed. We hope you will share that viewpoint and will remove the restrictive language amending the Railway Labor Act and restore the amounts which I previously indicated in this statement are required to permit continued operation under existing law.

I want to thank you for your invitation to appear before you and discuss this matter and will be pleased to attempt to answer any questions you might care to put at this time.

Mr. FLOOD. Thank you very much.

Mr. HICKEY. Thank you, Mr. Chairman.

MAY 14, 1975.

NATURAL FAMILY PLANNING FEDERATION OF AMERICA

WITNESS

DR. JOHN J. McCARTHY, PRESIDENT

Mr. FLOOD. Dr. J. J. McCarthy, president, Natural Family Planning Federation of America.

Dr. MCCARTHY. Mr. Chairman, I am Dr. John J. McCarthy, a practicing obstetrician and gynecologist and medical director of the natural family planning program sponsored by the diocese of Pittsburgh. I appear here today on behalf of the Natural Family Plan-

ning Federation of America of which I am president and chief medical officer. On behalf of the federation I would like to comment on H.R. 4925. My remarks will be directed primarily to title II, the Family Planning and Research Act of 1975.

Since 1968 the Congress of the United States has appropriated under this legislation well over $750 million in order to make "comprehensive voluntary family planning services readily available to all persons desiring such services." The express intent of Congress seems to have been that these funds should be made available in such a way as would allow a person to receive without constraints or preconditions the family planning method of her choice. With such clear direction from Congress, it was considered by myself and my colleagues in the field of natural family planning that the natural methods of family planning would be funded under the conditions set forth in this legislation.

Unfortunately, as each year passed, we found it increasingly more difficult to identify any of the Federal money actually utilized to provide the natural methods. In fiscal year 1975, we could only find a total of $350 thousand specifically granted for the natural methods. Approximately $100 thousand of this amount was awarded for the development of training materials. Of the remaining $250,000, $160,000 of it is being used in two programs in Pennsylvania. The remainder was provided in grant amounts of $10,000 to $15,000. Further investigation revealed that even these amounts were not accurate. For example, one program in region 1 (Boston), though funded at an annualized level of $30,000, after 6 months of operation, had not received the first Federal dollar to support the program.

When inquiries were made to DHEW regarding this seeming inequity, we were informed that the natural family planning methods were available in every federally funded family planning program in the United States. However, DHEW reported that because there was no patient demand for service, no dollar expenditures could be identified. It is not our purpose to question DHEW as to the demand within family planning programs. All we know is that between 1970 and the present over 200 agencies, organizations, and, in some instances, individual couples have been organized or have sprung up in order to meet the needs of people throughout the United States. Last May (1974) selected representatives of 50 of the organized natural family planning programs came together and formed the Natural Family Planning Federation in order to cope with the ever-increasing demand for the natural methods.

Our efforts to date have not been successful because the federation has been informed no Federal moneys were available to support the natural methods. Last September, for example, the federation submitted a proposal to DHEW region 6 (Dallas) which would have served the needs of the citizens of Louisiana, Arkansas, New Mexico, Oklahoma, and Texas. The federation was informed that no funds could be found to support the program. In region 3 (Philadelphia), which includes Pennsylvania, West Virginia, Maryland, Virginia, Delaware, and the District of Columbia, nine natural family planning programs have submitted requests to DHEW for support of natural family planning programs. In addition, these included requests for technical assistance in designing the proposals so as to meet DHEW regulations.

To date, technical assistance has not been provided. The standard answer has been that no funds are available for the natural methods. The same number of requests, or more, have been made to every Federal office in the United States with the same negative results.

We have utilized DHEW's formula for determining the number of women in need of subsidized natural family planning services. The number under 100 percent of poverty ranges from a very conservative 650,000 to a more realistic number of 900,000. An additional 350,000 to 650,000 may be added if 150 percent of poverty is used as the cutoff for determining eligibility. Applied to the total number of women in need of subsidized family planning services, these add up to at least 12 percent of those for whom funds are requested from this committee. Yet, although those who desire to use the natural methods represent at least 12 percent of the total need, less than one-third of 1 percent of the appropriated funds have been used to meet their needs.

In view of the legislative intent so clearly spelled out by Congress, that family planning services be made available to all persons desiring such services, I would request on behalf of the Federation that funds be made available for those agencies seeking to provide services in the natural methods and earmarked in such a way as to insure that they will be used for natural family planning. Without adequate and specified funds, those who desire to use the natural methods will not be able to receive the very services that this legislation has guaranteed.

Thank you.

Mr. FLOOD. Thank you, Doctor.

MAY 14, 1975.

PRIMATE RESEARCH CENTERS

WITNESSES

DR. GEOFFREY BOURNE, YERKES REGIONAL PRIMATE CENTER, EMORY UNIVERSITY, ATLANTA, GA.

DR. PETER J. GERONE, DIRECTOR, DELTA REGIONAL PRIMATE RESEARCH CENTER, TULANE UNIVERSITY

DR. ARTHUR T. HERTIG, ASSOCIATE DIRECTOR FOR RESEARCH AT THE NEW ENGLAND REGIONAL PRIMATE RESEARCH CENTER

DR. WILLIAM MONTAGNA, DIRECTOR, OREGON REGIONAL PRIMATE RESEARCH CENTER

Mr. FLOOD. Our next witness is Dr. Geoffrey Bourne, Yerkes Regional Primate Center, Emory University, Atlanta, Ga.

Dr. BOURNE. I have taken the liberty of bringing with me three colleagues. We hope our combined testimony is going to be within the space of time that you have allotted to us.

My colleagues are Dr. Peter J. Gerone, Director, Delta Regional Primate Research Center, Tulane University; Dr. Arthur Hertig, Associate Director for Research at the New England Regional Primate Research Center near Boston; and Dr. William Montagna, Director, Oregon Regional Primate Research Center.

The comments I am going to make are going to be very brief and to the point.

I have a prepared statement which I would like included in the record.

Mr. FLOOD. Without objection, that will be done.

[The above statement referred to follows:]

STATEMENT OF DR. GEOFFREY H. BOURNE

I am Dr. Geoffrey H. Bourne, Director of the Yerkes Regional Primate Research Center at Emory University, Atlanta, Ga. I have been associated with the Primate Center program since 1962. Our Center is one of seven Centers in the program and has a special responsibility for carrying out research on the three great apes: chimpanzees, gorillas, and orangutans, as well as research with monkeys. The great apes are all now on the endangered species list. Our collection of these apes is the greatest in the world and no other country has a collection even remotely approaching ours and no country with the possible exception of the Netherlands has a group of these great apes available for medical research. In the history of the world there is no record of a collection of apes such as this and now it will be impossible to duplicate it.

Our studies on great ape reproductive physiology have been so effective that we have been highly successful in breeding these animals and will be able to keep these three species going probably indefinitely.

Using our apes we have developed a diagnostic serum for leukemia and an anticancer serum for melanoma, which is being tested on humans. We have demonstrated that the reproductive physiology of the chimpanzee is almost identical with that of human and therefore can serve as a human model, and that it is possible using a computer language to carry out complex and meaningful communication with a chimpanzee (the computer system used for this is now being adapted for use with autistic and other children with whom there is a communication problem).

The reproductive physiology program is now in a position to manipulate the physiologic mechanisms to form a basis for new and improved methods of human contraception and the basic knowledge obtained about this program will probably also contribute to successful treatment of human infertility. Other successful projects using apes have demonstrated that among a number of young chimpanzees fed milk from leukemic cows, two developed leukemia. Another project has developed a temperature telemeter which can be implanted in the body and will broadcast continuous information concerning the body temperature. Chimpanzees have also been used to elucidate some factors in the body responsible for rejection of human grafts and for the study of the effects of drugs on the mind. We supply blood and other body fluids and tissues to investigators all over the world.

These studies which have been mentioned are simply a minute fraction of the work which is carried out at our center; in fact, in 1974 there were 111 major projects carried out in the 7 primate centers, all of which had an important bearing on some aspect of human health and welfare. The staff of these centers published 715 scientific papers and 10 books on the results of their investigations. The centers housed in 1974, 8,640 nonhuman primates.

We believe that there is no question that the centers represent an important part of the Federal Government's biomedical research programs and that they have more than justified their existence and the public funds invested in them.

The great importance of the primate centers to the country has been demonstrated recently in connection with the drastic cutback in rhesus monkeys available for import into this country. Rhesus monkeys are required by drug companies, N.I.H., and the Food and Drug Administration not only for medical research purposes but for the production and testing of vaccines and for testing of drugs and foods. They are absolutely vital for the production of a number of vaccines. Rhesus monkeys come from India and up till last year that country exported 50,000 a year of which 30,000 come to the United States. Last year, however, the Indian Government reduced their total exports to 30,000 and guaranteed 10,000 of these to the Soviet Union and 5,000 to other countries, this left 15,000 for the United States, half our requirement, which places us in a very serious position.

There is a possibility that the Indian Government will reduce still further the total number of monkeys exported. If the Federal Government had not already established the primate centers and in general promoted primate research throughout the country this 50 percent cut in our rhesus monkey imports could have been catastrophic. The primate centers had studied the reproductive physiology of rhesus monkeys and the husbandry of breeding using a variety of methods. They were all set therefore to start breeding rhesus monkeys them-

selves which some of them are now doing and to make available their knowledge to permit others to set up breeding projects. N.I.H. has now let contracts to a number of organizations to breed rhesus monkeys and their projected production is over 7,000 animals per year, which represents half the deficiency and this is only a beginning.

As the rhesus monkey and other primates get scarcer, the importance of the primate centers expertise will become progressively greater, but the present state of funding of these centers is such that their very existence is endangered and the fickle and precarious nature of the funding is such that it is driving good people away from the centers and making it more and more difficult to recruit good people for their staffs. The National Institutes of Health is very aware of the importance of a stable funding base for the centers with some protection against inflation, but this does not appear to be shared by the administration. The primate centers' budget is not only not being increase to cope with the inflation, but for the last 2 years has been cut by $600,000.

Last year the House and Senate in their wisdom restored $250,000 of this amount, but in the coming fiscal year we are faced again with the prospect of the same $600,000 cut on top of the crippling inflation. If we cannot get this cut restored and a substantial sum added to cope with the inflation of the last few years we are faced with the necessity of wholesale discharge of personnel, a catastrophic loss of morale, voluntary departure of good people, the abandoning of some vital medical research projects, and the curtailment of others.

An independent committee set up by NIH has recommended that the Primate Centers should receive this year the sum of $12.8 million for direct costs and with approximately $1.6 million added for indirect costs, the total is $14.4 million. This figure has been approved by the Council of the Division of Research Resources of the National Institutes of Health. Last year and in the present budget, however, the administration has designated the primate centers to receive a total of only $10.9 million which is $3.5 million under the recommended amount.

By using all our reserves, making every economy and utilizing the quarter of a million dollars which Congress restored last year we barely survived, but if we have to face another year at this level it may damage the whole Primate Center program irreparably.

We earnestly request this subcommittee to endorse the NIH evaluation of our worth and our operating requirements by adding the sum of $3.5 million to the primate centers budget which NIH recommended and which is part of the Animal Resources Branch budget of $16.7 million. We are fully cognizant of the difficult financial situation in this country at this time and the many legitimate and worthy demands on the public purse, but what we are asking for will make the difference between a successful operation and near disaster and it represents less than the cost of a single helicopter left behind in Vietnam.

Dr. BOURNE. The centers have had no significant increase in funding for some years now. Last year and in this year's administration budget there is a cut of $600,000. The effects of this cut on top of the inflationary effect of the last few years is likely to be catastrophic. Even this year one of the centers has had to make a significant cutback in its professional technical personnel.

I think the continuation of these cuts, plus the inflation, is going to endanger the very existence of some of these centers.

This is very unfortunate at the time when primate centers are more than ever necessary and now especially due to the cutback in Rhesus monkeys sent to us from India, in which the number of animals sent to us have been cut back by half and most of the cutback has been diverted to the Soviet Union.

The importance of the Rhesus monkey is that it's the major animal used in testing of vaccines, drugs, and other biomedical research. It's extremely important to our health and welfare.

From the financial point of view, let me say that an independent committee, set up by NIH and backed by one of the Councils, the Council for the Division of Research Resources for the National Insti-

tutes of Health, has recommended that the centers be funded at a level of $12.8 million for direct costs and $1.6 million for indirect costs, making a total of $14.4 million.

The administration, however, doesn't seem to have the message of the importance that we have to the biomedical research program and has designated only $10.9 million to keep us going in the coming year, which is a deficiency of $3.5 million.

We respectfully request that your committee consider adding this $3.5 million to the budget of the animal resources branch and designate that it is for the primate centers. Thank you, sir.

Mr. FLOOD. Thank you. I would like to ask Dr. Gerone to speak to that matter.

STATEMENT OF DR. PETER J. GERONE

Dr. GERONE. I am with the Delta Primate Center in Louisiana.

Mr. Chairman, I too have written testimony which I would like included in the record.

[The statement follows:]

STATEMENT OF PETER J. GERONE, SC. D., DIRECTOR, DELTA REGIONAL PRIMATE RESEARCH CENTER, TULANE UNIVERSITY, IN FAVOR OF THE PRIMATE RESEARCH CENTERS' PROGRAM

Mr. Chairman: Before I describe the work and the needs of our primate center, I would like to stress why research in monkeys and apes is so important. These animals, like man, are primates—which means they resemble man in more ways than do other animals. Therefore, research done in nonhuman primates relates more directly to man than the same research done in lower species. This can have big payoffs in terms of immediate application to human patients. I will give a good example of that in a moment.

The relatedness of monkeys to man stimulated the establishment of the seven primate centers in the United States. More recently, an even greater emphasis has been placed on research with nonhuman primates. This stems from two growing public demands: The first is that more caution be exercised in human experimentation. It is no longer possible to go from mouse experiments in the laboratory to the patient in the hospital. The second demand is that drugs and vaccines be adequately tested for safety and efficacy before they are used in man. To satisfy these demands, a great deal more research and testing must be done in nonhuman primates. Even well-established vaccines, such as the polio vaccine, must be periodically tested in monkeys.

Much of the research that will eventually help the patient must go through some phase of primate testing. It is unrealistic to hold up the results of billions of dollars of biomedical research because a few millions are needed to open a bottleneck.

Let me describe some of the activities you support at the Delta Regional Primate Research Center, a part of Tulane University. At our center, we emphasize research in infectious diseases (including cancer) and neurobiology. We also have programs in the fields of anatomy, biochemistry and reproductive physiology. Besides our own internal research programs, we are collaborating with a number of scientists from other institutions in such areas as heart disease, surgery, pulmonary disease and bioengineering.

One question we have addressed is why a virus causes cancer in one person and not in another. Monkeys have given us a good model for such studies. A virus discovered some years ago at the New England Primate Center will produce tumors in some species but only infects other monkeys. At our center, we are looking at the defenses of the animal that does not develop cancer. This might provide the key for prevention of cancer in susceptible species.

Most common childhood diseases have been conquered by vaccines. There is one notable exception, however, and that is chickenpox. Why don't we have a chickenpox vaccine? One of the more important reasons is that we've never had a laboratory animal that can be used to test such a vaccine. A newly recognized

virus that caused an outbreak in a species of monkeys at our center may provide the answer. It is closely related, if not identical, to human chickenpox virus and produces obvious diseases in those monkeys.

Our center is involved in research on the type of hepatitis that frequently results from transfusions. Aside from man, the chimpanzee is the only animal that develops the disease. Our work is part of a larger project to produce a vaccine. The other type of hepatitis, usually traced to contaminated food or water, can be reproduced in only one species of South American monkey. It has become almost impossible to import these animals but we need them for research. Scientists from our center are in Brazil at this very moment trying to negotiate the release of 100 pairs of the monkeys so they can be brought back to the Delta Center for breeding.

I mentioned earlier that research in monkeys can be more quickly translated to clinical application. A dramatic example of this recently occurred in our laboratory. Our urologist who was studying kidney diseases in monkeys used an instrument to observe abdominal organs through an extremely small incision. The device is called a laparascope. It occurred to him that the same technique might be used to examine patients with kidney cysts. About 2 percent of such cysts are malignant and, in the past, surgery was required to determine the condition of the cyst. Now, using the laparoscope, in the physician's office, the cyst can be diagnosed without radical surgery. The new procedure will eliminate thousands of needless operations a year.

Our neurobiology program is concerned with changes in the brain that result from a variety of influences and insults. For example, how does aging affect the brain? What is the damage to the brain that results from head injuries such as inflicted in auto accidents? Does malnutrition of the pregnant mother retard brain development in the young? What is the residual damage of the brain following certain virus infections during pregnancy? What are the neurological events which lead to motion sickness and how can they be prevented? These are all questions now under consideration in our research program.

I could describe many other core research programs but it might be best to say just a few words about our collaborative ventures. We have a surgeon who is using our animals and facilities to study the regeneration and repair of nerves damaged in accidents.

In another project, we are testing a variety of substances that might be used as artificial blood vessels to replace damaged arteries and veins.

These tubes are tested in monkeys to evaluate their compatibility with live tissues and blood. In still another project we are feeding special diets to monkeys to determine their influence on heart disease.

To give you an appreciation for the full breadth of our collaborative program, I would like to mention another project designed to test artificial tooth implants in baboons. This research is vital to the many thousands of people who need but are unable to wear false teeth because their jaw bones resorb leaving no foundation to hold the dentures. In this project, vitreous carbon implants are being imbedded in the bone which can later be capped as teeth. The success of studies in primates has already prompted limited human trials.

Our center, like the others, has demonstrated an important role in the biomedical community. All these programs are threatened because Federal support has failed to keep pace with rising costs. At our center alone we have had to eliminate necessary jobs (a cutback of 10 percent) when we should be increasing staff. More jobs will be eliminated next year if our budget isn't increased. Under such conditions we will not be able to sustain current programs, let alone expand to meet new needs.

Eliminating jobs has far-reaching effects that go beyond the research project with which the positions were associated. These cuts cause anxiety and insecurity in our people. When such conditions prevail, the natural tendency is to look for more secure positions. Our best scientists are the very ones who will leave first and we cannot afford to lose our best talent at a time when our needs are greatest.

As a primate center we have an obligation to help solve the national shortage of nonhuman primates for research. There are three main sectors whose needs must be met: the Federal Government, other research laboratories, and the primate centers themselves. The only answer is domestic breeding of the required animals.

The Delta Primate Center has a contract with the Food and Drug Administration to set up a breeding colony of 1,000 rhesus monkeys. In a few years

they will produce about 500 babies per year which can be used to test drugs. The FDA, the Center for Disease Control and the NIH have combined their resources to finance an operation at our Center to obtain and breed the South American monkey which is needed for hepatitis research.

These contracts pay for most but not all of the costs of these enterprises. Much of the professional support of these projects is borne by the primate centers program. These breeding programs will only scratch the surface of Federal needs. They will not help the other research laboratories nor will they provide monkeys for our own use. As a center we are a long way from becoming self-sufficient in terms of monkey supply because we have not had the funds to do it.

We are facing a serious crisis and we need your help. It should be clear from our testimony that these centers are important in virtually every aspect of medical research: cancer, heart disease, aging, infectious diseases, birth defects and pollution—among others. The dollars spent at these centers can solve many human problems—yours and mine—those of our children and our grandchildren. It is a worthwhile investment.

Dr. GERONE. The value of monkeys and apes in biomedical research has been recognized for years. Now this is even emphasized more because the public is demanding more caution in human experimentation and in the Federal licensing of drugs and vaccines. As a matter of fact, much of the region that will eventually help the patient must go through some phase of primate testing.

It seems to me that it's unrealistic, therefore, to hold up the results of hundreds of millions of dollars of biomedical research funding and results simply for a few million dollars that are needed to do the primate work.

At the Delta Center, which is part of Tulane University, our main emphasis is in infectious diseases including cancer, although we have programs in many other areas. Besides our in-house research programs, we collaborate with scientists from other universities that deal with heart disease, surgery, bioengineering, pulmonary diseases and so on.

We are also breeding monkeys for Federal agencies. We are trying to learn why some individuals develop cancer as a result of a virus infection whereas others merely become infected.

We are working with hepatitis because only select species of primates, other than man, will show clinical illness. One of these hepatitis viruses will only go in a single species of South American monkey. At this very moment we have scientists in Brazil who are trying to negotiate the release of 100 pairs of these monkeys to be brought back to our center for breeding.

A technique which is detailed in my written testimony was developed at our center that will eliminate thousands of needless operations for patients with kidney diseases.

We are addressing such questions as how does aging, how do head injuries, malnutrition, and virus infections in pregnant mothers affect the brain. We are testing materials which might be used as artificial blood vessels.

We are implanting artificial teeth in baboons in an attempt to help the thousands of people who need dentures but can't wear them because of bone resorption. These programs are being threatened because Federal support hasn't begun to keep pace with the rising costs. At Delta we have already suffered serious cutbacks when we should be increasing our staff. We had a 10-percent cut for the coming fiscal year. More jobs will be eliminated next year if the budget isn't increased. Under such conditions we are going to have trouble main-

taining our current programs, to say nothing of expanding to meet the new needs.

These cuts have caused anxiety and insecurity in our people. When such conditions prevail, naturally people begin to look for more secure positions and we will lose our best scientists first. At a time when we need these people the most, we cannot afford to lose our best talent.

We are facing a serious crisis and we need your help. I think it's going to be clear from our testimony that primate centers are important in virtually every aspect of biomedical research. The dollars spent are going to help human problems—yours, mine, our children, and grandchildren—and I think it's a worthwhile investment.

Mr. FLOOD. Thank you.

Dr. Hertig?

Dr. HERTIG. I am Arthur T. Hertig, M.D., Shattuck Professor of Pathological Anatomy, Emeritus of the Harvard Medical School and Associate Director for Research at the New England Regional Primate Research Center.

My colleagues have given you very splendid reasons and overall views of the importance of primates in research, but I would like to make four points very briefly in the time that is allotted me. I am very grateful to be able to say these few words.

The first point I would like to emphasize is the unique nature of the nonhuman primates. They are the closest related to the human. With human experimentation coming under progressive fire from all sides, the only kinds of experiments that can be done with meaningful relationship to human problems is in the primates, the monkeys, and the higher apes.

These centers are the world's greatest collection. This is not boasting, Mr. Chairman. These centers have the greatest collection of expertise on the problems of primate care, research, conservation of these endangered species, and meaningful experiments which relate to human problems.

To illustrate what we are doing at the New England Primate Center—and you have already learned from the other two gentlemen that the numbers of experimental procedures which relate to humans are legion, and encompass the entire body—we have six which are going on at our particular one on hypertension, drugs, the administration of synthetic female hormones which cause trouble in the female fetuses of mothers who have been given this diethylstilbestrol. We have made a significant breakthrough in the viral cause of cancer in primates. Finally, we have shown the reasons why some primates from South America, the owl monkey, do not breed well in captivity.

We have a threefold reason for being. We can experiment and do things which are in relationship to humans. We have a program which has to do with the conservation of these endangered species. There are several reasons why they are endangered. Their natural environment is being cut down and there are political reasons as to why we cannot import these animals.

Finally, the expertise which is established in these seven centers is unique in the world. I think everybody agrees upon this because other countries are using this magnificent program which was started by Congress only about 15 years ago. They are duplicating these in very many parts of the world, including Asia, India, South America, and so on.

Very briefly, with respect to hypertension for which we had no cure when the late, beloved, Hon. John E. Fogarty was a Member of Congress, we have gotten techniques at work to show how hypertension develops in the small South American monkey, and therefore we can understand in a meaningful way how this mysterious disease affects a great many humans and causes stroke, heart disease, and so on.

With respect to drugs, which is a great problem now, we have established mechanisms whereby we can make drug dependent animals and can experiment with the various mechanisms of combating this really significant problem. Very little money has been spent on that in this sense, but a great deal has been spent on controlling the influx of drugs into the country.

Then there is this horrid disease, cancer of the young female genital tract, which is apparently related to the administration of Diethylstilbestrol, the synthetic female sex hormone for endangered pregnancies. Some years later these terrible cases are cropping up and we are working on the problem of showing how this develops in the female offspring of monkeys. There is a problem, having not only to do with the production of congenital abnormalities but the production of cancer.

We have established a breakthrough on the cause of cancer by viruses. We have shown that one species of South American monkeys—which harbors the virus and is not affected by it—when that same virus is put into another nonrelated South American monkey it develops a fatal cancer in 100 percent of the cases.

This, Mr. Chairman, is the first breakthrough of a primate virus and how it is inocuous in one primate and is fatal in another.

Finally, it's very difficult to breed some of these primates in captivity. We have shown that it's a matter of the chromosomes, which are the units of heredity in the cell. We have shown that there are some subspecies of the owl monkey and their chromosomes are entirely different in size, shape, and number. If you breed the male and female that have the same chromosomal type, we do very well in getting these little owl monkeys, which are exquisitely sensitive to virus cancer, to glaucoma, which causes blindness, and also to malaria. These diseases are still not conquered in parts of the world.

Finally, I showed in my own work that the virus of measles causes miscarriage and death in the pregnant native monkeys of India. Now they are vaccinated at the source. That is an illustration of how these centers engage in conservation as well as in experimentation.

I thank you very much, Mr. Chairman, for the opportunity of presenting these data.

Mr. Flood. Dr. Montagna?

Statement of Dr. William Montagna

Dr. Montagna. Mr. Chairman, I have also submitted a written statement.

My colleagues have covered much of the subject that I would have covered. I am going to spend only a minute or two reiterating some important points.

That is, with a program as large as the primate centers, to be deprived of the $3½ million at a time when we have to cope with the rising inflationary conditions and also it must be understood that with

a static and steady decreasing budget, our request for this $3½ million is not for funds to expand but rather to continue an existing program.

The primate center programs have a unique place in the world of medical research today, as Dr. Hertig has so eloquently and briefly mentioned.

Part of their responsibilities is to institute breeding programs which will make available needed experimental animals and provide also a lasting resource of species which are threatened with extinction.

Thus, the World Health Organization, the citizens groups interested in the species conservation and others see in our work a fulfillment of the aims of the primate centers.

Russia had the first primate center in the world in about 1925. Our own program began about 1960. Our centers are now certainly second to none in the world. Today, France, Germany, Japan and others are planning national primate centers and have sent a representative to each of our various centers to learn from our expertise. This, therefore, seems not the time in history to let our primate center program fade into oblivion.

Thank you very much.

Mr. FLOOD. Thank you very much.

[The statement follows:]

STATEMENT OF WILLIAM MONTAGNA, PH. D.

Mr. Chairman: Together with my colleagues I come to plead the cause of the primate centers. Their achievements are now legion and need not be recounted in detail. Suffice it to say that our mission, indeed our entire raison d'etre, is to investigate nonhuman prmates so that we may better understand the normal and diseased states of man. To the layman, the pertinence of biomedical research is sometimes obscure, but even a nodding acquaintance with the work of the primate centers should dispel all doubts. Within the primate center programs, research is geared to nearly every major disease of man: (a) cardiovascular and neurologic, (b) metabolic and immune, (c) parasitic, (d) degenerative, (e) nutritional, and (f) aggressive diseases such as cancer. By now, the success of the seven centers is widely known. What is less well understood is that much remains to be done and that unless we constantly upgrade our knowledge of primate biology, we will fail to recognize those unexplored areas of medical research in which nonhuman primates could very well prove to be the best surrogate models for human beings. Moreover, we need more information on the safe use of drugs and every other form of therapy now used for human ills by first determining their value in nonhuman primates.

In the many areas of medical research where ethical and morals considerations preclude the use of human beings as experimental subjects, nonhuman primates are very often the only logical substitutes. Where we pay lip service to this fact, we have scarcely begun to exploit its immense potential for improving the human condition. Perhaps our failure to do so can be traced, at least in part, to our realization that to extend our use of nonhuman primates in biomedical research involves us in another problem, that is, a further diminution in the dwindling supply of ape and monkeys which is threatening several species with extinction. But here again the primate centers hold out the best solution since from our inception we have been aware that the breeding of primates is one of our major responsibilities. Slow but steady progress toward augmenting the supply of threatened species is a characteristic of each of the seven centers.

Surely, then, one of the most forward-looking decisions ever made by Congress was to establish primate centers in 1960. Throughout the intervening 15 years, the regional centers have matured into highly productive scientific laboratories and have thereby attested to the wisdom of that decision. Whether they can continue in their service to man depends on two commitments for the future: (1) the guarantee of an adequate supply of animals and (2) the guarantee of adequate funds.

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As long as man lives he will have health problems, and the need for medical research will always be imperative. Problems related to reproduction and its control, problems associated with the degenerative changes of old age will persist whether we cure cancer and heart disease or not. In fact, the added longevity which is a bonus of such cures will add to these problems. In a free society which abhors the use of any of its members as experimental subjects, nonhuman primates are indispensable for the solution of that society's medical problems. We must, therefore, provide our viable institutions with replenishable sources of primates which will ensure their continuous operation into the 21st century. Adequate funding of the primate center program, which in terms of the total national budget is miniscule, is the only—I repeat only—guarantee of this operation.

The Members of Congress are well aware of the ethical problems associated with fetal research and with the use of human subjects, for example, prisoners, as experimental models. In recent times, such practices have come under the close scrutiny of Congress whose Members are aware of the danger that research, however well intended, may violate individual rights. Without taking issue with current decisions on these matters, we always maintain that the dignity of man be preserved above all.

During the recent controversy over the use of human fetuses in research, several outstanding physicians were called to oppose the ban on such research. In order to strengthen their arguments, some of them emphasized the differences between man and monkey and by implication the need for using human fetuses. We, on the other hand, insist on the remarkable similarities between them and the absolute necessity of fetal experimentation on nonhuman primates, not, however, excluding research on human material when ethical questions are not an issue. The types of control which scientists exert on nonhuman experimental models could never be achieved with human subjects.

Especially in some areas of human fetal pathologies, monkeys are the most desirable experimental subjects. (1) In studies of respiratory distress syndrome, the dynamics of amniotic fluid, and the possible beneficial effects of glucocorticoids, monkey fetuses are excellent models because the monkey placenta is as permeable to glucocorticoids as that of man. (2) Because of the structural and functional similarity between the homechorial intervillous circulation of human subjects and monkeys, the latter are invaluable models for the regulation of uteroplacental blood flow. (3) They are also excellent for studies of premature labor and the regulation of myometrial activity because human and nonhuman mothers share similar patterns of labor; amniotic fluid pressures, relationships between myometrium, placenta, and amniotic fluid; cervical dilatation; response to oxytocic agents and prostaglandins; response to prostaglandin inhibitors and other pharmacologic agents which relax the smooth muscle of the uterus.

The main causes of perinatal mortality and morbidity in man are defective fetal growth, asphyxia during labor, premature birth, and hyaline membrane disease in the newborn. Of these, premature birth is by far the most common and threatening. Hyaline membrane disease is related to premature delivery, fetal lung immaturity, and a deficiency of the surfactant that stabilizes the lung alveoli. Intrapartum or neonatal anoxia is almost always associated with any of the above conditions, all of which can, under some circumstances, contribute to cerebral palsy or mental retardation in the neonate.

The primate centers are fully aware of these problems, perhaps more so than any other single health institution, and each of them is contributing unique data which are expanding our knowledge of the problems and providing insights into their cure and prevention. We at the Oregon Regional Primate Research Center are deeply involved with the problems of perinatology; the three areas mentioned below are examples of only some of the most important.

1. We have developed a chronically instrumented and stable fetal preparation in rhesus monkeys which enables us to study the endocrine and vascular factors which regulate parturition and oxygen transfer to the fetus.

2. According to our data in rhesus monkeys, changes in the cardiorespiratory parameters (heart rate, blood pressure, blood gases, and blood flow) of the fetus during labor are related to intrauterine pressure patterns. The relation between the changes in blood flow across the placenta and the intensity and frequency of uterine contractions can be extrapolated to human labor, and thus the relative safety of such drugs as oxytocin and prostaglandins, now used to induce labor in women, can be established. We have shown that, within prescribed dose ranges, prostaglandins and oxytocin have nearly identical effects on these

parameters with no apparent adverse effects on the progress of labor, provided that the intensity and frequency of the contractions are maintained within certain limits.

3. In treating premature labor in rhesus monkeys, we are demonstrating that prostaglandin inhibitors such as indomethacin (an aspirin-like anti-inflammatory agent) can be used safely and efficaciously. Indomethacin prolongs parturition in rhesus monkeys, a good indication that prostaglandins are important regulators of myometrial activity and the initiation of labor. Preliminary results suggest that this drug may also be useful in the treatment of early premature labor in human beings, but the complete safety of its use by human subjects must be established before definitive data are published.

Despite the pertinence of the research in all seven centers and their continuing progress, the prospect for each of us is extraordinarily bleak, principally because of the ever-present specter of financial cuts in the future. Although the seven centers have achieved impressive stature worldwide in their respective fields, they are perennially badgered by reductions in their operating grants. Despite ever-increasing achievements in our laboratories and the success of our investigators in competing for project and project-program grants from Federal and private sources, our core grants shrink yearly. Last year we were budgeted to receive $10.9 million, which was in fact $1.6 million below the $12.8 million recommended by the Council for direct cost only ($14.4 million). Lest we be forced to forfeit all, we hereby request that $3½ million be restored so that the budget will total the $14.4 million level recommended by the Council. Without this support, we shall lose irreplaceable staff and abort promising programs, and the entire effort and achievements of the past 15 years will have been for naught.

May 14, 1975

CANCER

WITNESSES

MRS. GRACE MONACO, NATIONAL LIAISON CHAIRMAN, CANDLELIGHTERS ASSOCIATION

MRS. BEVERLY McGAUGHY, INCOMING PRESIDENT AND COFOUNDER OF THE METROPOLITAN WASHINGTON AREA CANDLELIGHTERS GROUP

Mr. FLOOD. Mrs. Grace Monaco, the National Liaison Chairman of the Candlelighters Association.

Mrs. MONACO. Good morning, Mr. Chairman. I am very happy to be here and have the opportunity to talk to you again on the impact of federally funded programs on the treatment of children with cancer.

We have a prepared statement which we would like to submit and have reproduced in the record.

[The above-referred to statement follows:]

STATEMENT OF THE CANDLELIGHTERS

Mr. Chairman and members of the committee: My name is Grace Ann Monaco, I am representing "Candlelighters," a national organization of families who have or had children with cancer in 20 States. This statement is the product of Candlelighters groups. It also reflects information obtained from other parents groups who have responded to questionnaires on the status of the cancer programs in their respective areas and the effect of Federal funding efforts on those programs. I am accompanied by Mrs. Beverly McGaughy, the incoming President and cofounder of the Metropolitan Washington area Candlelighters group.

As Candlelighters have indicated in previous appearances before this committee, we feel that we are in a good position to inform you on the effect and results of your funding efforts from the consumer point of view. We wish to bring to your attention those areas in which Federal funding has had the most noticeable impact on our children's lives and those which we feel merit your further attention either through program redirection, emphasis or increased funding levels from this committee.

Let me first extend on behalf of all of us our deep gratitude and appreciation to you, Mr. Chairman, and the members of this committee for your continuing efforts on behalf of all persons afflicted by cancer. Your unflagging interest in cancer research and the translation of this research into tangible programs for detection, treatment, and rehabilitation of cancer victims throughout the country has widened the benefits of the whole cancer effort. We know that the lives of our children have been, and are continually being extended, and in some cases, preserved through the cancer research efforts which this committee has supported through the National Cancer Institute.

Our testimony reflects the provisions of the National Cancer Act, as amended in 1974, and the positions taken by this committee in terms of funding and program, in its appropriation for the National Cancer Institute for fiscal year 1975.

With respect to the overall amounts, the $605 million requested by the President for fiscal 1976 is substantially below the amount necessary to sustain, and completely inadequate to carry forward, the national cancer program contemplated by the authorizing legislation. In dollars it is $86 million or 12 percent below the fiscal 1975 appropriation, and if one looks to the inflationary factor alone which is currently 12–15 percent, the amounts to sustain the program at the $691 million fiscal 1975 level are $775–796 million and thus the budget proposed for fiscal 1976 is an actual reduction of 25–27.6 percent below the fiscal 1975 appropriation. Translated into reductions by program areas, the request would result in the following reductions, even excluding the inflationary factor:

Area:	*Percent reduction*
Cancer cause and prevention research	10
Detection and diagnosis research	13
Treatment research	12
Cancer biology	3
Research manpower development	22
Construction	50
Cancer control	9

Clearly, if we acknowledge the true inflation rate, maintenance of the status quo in the cancer program requires an appropriation of $775–796 million; the forward momentum of the program requires an appropriation of about $850 million.

Answers from National Cancer Institute representatives during your hearings on the budget request, substantiate the serious and destructive impact of the proposed appropriation reduction on the consumers of the cancer program. For example:

(*a*) *The number of potential cancer treatment chemical compounds entering the screening program would be reduced 20 percent.*—Fewer drugs for clinical trial would be identified and fewer drugs would be available for clinical investigation. The impact—the number of drugs to reach clinical trial stage each year would be reduced from 10 to 7—that is a critical reduction. The lifeline of children and many other cancer patients now in treatment is largely the chemotherapy program. Further, the time it takes for these new drugs to be utilized in the actual treatment of cancer patients would be increased by 2 or 3 years;

(b) Clinical research into the use of BCG and other chemicals to help each person's immune system fight cancer cell growth would be reduced;

(c) Important research studies on the role of diet and nutrition in reducing the morbidity and mortality from cancer would be significantly delayed; and

(d) Overall, the portion of approved grant applications that are funded by the institute would plunge from a healthy 64 percent in fiscal 1975 to less than 20 percent in fiscal 1976.

Personnel Requirements: Impoundment of Personnel

We would like to raise with the committee this most pressing and serious problem. The National Cancer Amendments of 1974 provide that the Director of NCI supply, in conjunction with his budget request, an estimate of the number and type of personnel needed for the implementation of the national cancer program. This procedure was included in the amendments to identify the real personnel requirements of the program and to enable the Congress to provide realistically for meeting those requirements.

This statutory requirement is well grounded. Since 1971, cancer program funding has increased by 328 percent but the President's Office of Management and

Budget (OMB) has only permitted an increase of 25 percent in personnel. Efficient and productive utilization of the funds appropriated cannot be achieved unless there are hands and brains to do the work.

If what happened to NCI's personnel in fiscal 1975 at the hands of OMB is repeated in fiscal 1976, then the Congress is faced with a new and pernicious type of impoundment—impoundment of personnel.

In fiscal 1975, NCI by directive, estimated its personnel requirements at the $691 million level to be 1,975 positions. As of the recision hearings held by this committee in early 1975, only 1,852 positions had been permitted to NCI by OMB and this number, by June, will be reduced by attrition to 1,815 with no replacement personnel permitted. This action affects all kinds of people—administrators, researchers, secretaries, technicians, lab assistants, and other vital workers. It makes no sense to hamper highly educated scientists by denying them adequate support personnel.

This personnel impoundment has already interfered with implementation of the National Cancer Amendments of 1974. According to those amendments, the role of nutrition in all aspects of cancer intervention procedures was singled out as an area requiring special emphasis. Funds were appropriated for that purpose. However, because of the OMB position ceiling, not one person has been allocated specifically to carry out this program.

We believe that OMB should not be permitted to thwart the will of the Congress and the legislative process by its arbitrary refusal to allocate positions. NCI has estimated that 2,052 positions are required to implement its fiscal 1976 program at the authorized level of $898.5 million. We believe you should inquire into the basis for this estimate. If it is found justified, we hope your report on the appropriation for fiscal 1976 will indicate the number of positions which should be permitted to NCI to implement its program and if necessary, legislation should be passed which would remove NCI from OMB's personnel position jurisdiction. We all know that allocating money without people to use it effectively is poor employment of funds and unfair to the taxpayer.

Just as NCI cannot properly implement the national cancer plan without sufficient personnel, contract or grant recipients are similarly hampered by lack of enough funds to cover personnel and by the failure of NCI to establish and enforce staffing ratios and guidelines in its dealings with grantees and contractors.

Last year, we pointed out the importance of adequate staffing for conducting the most intensive and productive clinical trials. These points are equally pertinent to this year's testimony. At present, there does not seem to be any consideration given in the NCI funding process to the ratio of patient to clinician. Obviously, there are only so many patients that a single physician can treat and monitor comprehensively at one time. Medical care suffers from an increased ratio, and the quality of monitoring and reporting, an obviously critical function of the clinical trial, suffers too. Therefore, we request that the appropriation be increased to permit clinical staffing at a level that will reflect the same percentage of the total appropriation as in fiscal year 1976—5.4 percent. Further, NCI should be directed to established a patient/physician ratio for its clinical trial programs and to provide for additional clinical trial staff at trial centers where an unrealistic, overburdened patient/clinician ratio exists. The following example will show the critical need for such a requirement.

At a major comprehensive cancer center, the division of pediatrics has funding to support just one clinician for 120 patients. There is no nurse to assist this one clinician. There is no full-time secretary. This interferes with the reporting of experimental therapy side-effects, dosage readjustments, etc. This is particularly crucial for families who live a distance from the center and rely on telephone or letter communications to monitor their children in between scheduled visits.

The potentially hazardous effects of this understaffing are obvious and need not be belabored here. In summary, the monitoring of the research subjects is weakened in an understaffing situation with the potential of serious accidents to the participants in the trial program increased and the quality and scope of compiled data must surely suffer.

Candlelighters recommend that a tangible basic assurance of adequate care be given to consenting research subjects so that they will not be subjected to unnecessary risks or left in mid-stream after entering a federally funded program that might suffer funding cuts. This basic assurance for all research subjects would exist if a table of organization which specifies the needed ratios of physicians and support personnel was devised and used as a guideline in hospitals conducting clinical trials.

Specialized personnel: The key resources for making the national cancer plan work

Authority to initiate a highly needed program in cancer clinical education is given to NCI by the 1974 National Cancer Act Amendments. This program is required to expand and improve efforts in cancer education and teaching at both the undergraduate and graduate levels in schools of medicine, dentistry, public health, and osteopathy and in specialized cancer institutions. In fiscal 1975, $5 million is available to fund 84 grants in this area. At the fiscal 1976 level funds would be reduced to approximately $2.5 million and would be insufficent to continue ongoing programs in this area, much less initiate new ones.

This program is absolutely vital for assuring early detection, accurate diagnosis and skillful treatment of cancer. Without it, the primary family care physicians and pediatricians being trained today will not be sufficiently prepared to treat their patients. The first line of defense in cancer control is the primary care physician and pediatrician. Full funding of this program is essential to provide this line of defense.

The second line of defense in the cancer program is the specialized personnel. Our testimony for fiscal 1974 and 1975 dwelt on several definite purposes that training grants and fellowship programs serve in relation to the conquest of cancer (considerations that remain highly important):

A. They provide the increase in skilled manpower available to implement the cancer program on all levels.

1. During training they provided the additional personnel needed by the clinical trial centers to insure that those trials are carried out completely, the subjects monitored sufficiently and the results reported comprehensively.

2. At the National Cancer Institute, young researchers at the peak of their ideas work with established researchers and through their fresh ideas spur them on to greater creative efforts.

It was our strong belief and that of the authorizing and appropriations subcommittees concerned with the cancer program that the Manpower Training Act of 1975 would provide the answer to the specialized personnel problem. You recall that in fiscal 1975, the NCI request would have phased out postgraduate and clinical training programs. Only $5 million were originally budgeted for this phase out. However, with the court orders in 1974 directing the release of impounded funds, the grants were restored to $10 million. The 1976 budget request in effect amounts to a phase-out again since the proposal would reduce this program by 40 percent with the deleterious effects noted above.

To provide such a meager level of training and fellowship support is to short circuit the cancer program now and for the future. Without sufficient manpower to implement the program, increased funding is useless and a waste of money that this country cannot afford.

Cancer control

The cancer control and rehabilitation program is the key for the translation of research results into programs that reach all the people who need them. This is the vehicle to get the programs from predetection screening through treatment, rehabilitation, and continuing care to the people through their comprehensive or specialized cancer centers, community hospitals and primary-care physicians. This division is now fully operative. A guarantee of 95 positions and $68.5 million from this committee will insure that results in the translation of research results into meaningful patient benefits will be seen by 1977–78, if not before. The administration budget calls for only 49 positions and funding of $45.6 million.

This program is the product of the particular concern of the Congress to get results to the people. It is working. Candlelighters feel that some of its innovations should be called to your attention as your own personal citations in the war on cancer.

For example, the community saturation program, new in 1975, applies all tested and acceptable procedures and methods of cancer prevention, detection, diagnosis, and pretreatment evaluation, treatment, rehabilitation, and continuing care in a defined community population. These communities will learn to utilize their own resources; that is manpower, facilities, and funds, as well as the NCI's support, to implement the program. This year approximately 23 million people will be involved with cancer control projects through the community saturation program. A reduction of funding in this program now would be critical because of the keen interest generated in the 32 communities which will be

implementing the program as well as resulting in the delay in implementation.

Also in the control area as related to the management of the pediatric cancer patient, a book on the care and feeding of the child with cancer is ready for release, plastic coated, which shows that the division is in touch with the realities of family life. Also a book on dealing with leukemia children is ready for distribution. This book was written by a journalist mother in Ohio who has experienced pediatric cancer in her family group. Members of the Candlelighters have critiqued this book and found it to be very helpful, so much so that we have asked NCI if we could give xeroxed copies of it to our parents now instead of waiting until it is printed.

A further effort in the cancer control program this year lies in cancer control communication—the national dial access program. This program, designed with the public's right-to-know philosophy in mind, will provide free access to all of the latest cancer-control techniques via a regional telephone network soon to be established throughout the United States. This project to promote more effective communications among physicians, health professionals, and the public through the cancer centers program would be greatly impaired at the 605 million dollar level.

Also the control program has initiated research and demonstration efforts to show practicing physicians that patients can greatly benefit from well-designed programs to deal with psychosocial problems accompanying the disease of cancer.

Comprehensive cancer centers

The 1974 amendments to the National Cancer Act provide for an expansion of the number of comprehensive cancer centers from 17 to 35. This expansion which will take 5 to 10 years to implement will go a long way toward insuring the best quality cancer care to most of our population.

You are well aware that NCI does not "fund" cancer centers as such, rather it provides some organizational seed money when the center is designated. As recognized by NCI, the core support funding provides only a small part of the operational costs; the remainder are supplied through individual research grants, center grants, contracts, fellowships, training funds et cetera, which must be obtained competitively.

Utilizing the Miami Comprehensive Cancer Center as an example, let us illustrate the problems relating to available personnel, core-support funding, and the level funds available for competitive grants and contracts as applied to the development of a comprehensive cancer center.

While the Miami Center is served by a splendid and innovative staff, problems peculiar to a new cancer center are inhibiting the full potential of this staff and the facility from surfacing:

(1) Severe personnel shortage—120 pediatric oncology patients serviced by one clinician; 1,000 radiotherapy patients serviced by two clinicians.

(2) No designated bed space for cancer patients at the country-run facility, which has a prevailing bed shortage. Some pediatric oncology patients are admitted to a university-owned hospital when there is no bed space at Jackson Memorial Hospital, with added risk because there is no doctor on duty during the night. And at Jackson Memorial Hospital—the pediatric oncology arm of the Miami Center, there are so few private or semiprivate rooms that leukemia patients with suppressed immunity from toxic therapies are often put in six-bed ward rooms where again they are exposed to additional risk.

(3) No oncology nurses. No nurse to assist the pediatric oncology clinician. With the prevailing nurse shortage, the research subjects often don't receive the added attention and monitoring they require.

We must point out, however, that we are not advocating increased comprehensive center funding for the sake of improved treatment per se. The centers are supposed to be demonstrating to all the physicians, hospitals, and medical personnel within its designated geographic area how the best intervention procedures can improve and/or prolong patients lives. Obviously, if they are not giving the best care because of lack of funds, they can hardly demonstrate it to others. Furthermore, they will quickly lose their credibility and thus their audience, defeating the whole program.

A further example of the inadequacy of core-support funds and thus insufficient support to center staff lies in an area we covered in our testimony last year—neurological evaluation of pediatric cancer patients.

Our concern for this program has grown since last year. A canvass of our membership has revealed that the problem of severe neurological system side-effects from massive chemotherapy and radiotheraphy is more prevalent than

we knew. Here in the Washington metropolitan area there are examples of children, normal at the time of diagnosis, who have become progressively retarded as the result of the neurological effects from cancer treatment. These are still only a small percentage of pediatric cancer patients but when your child is one of those affected, percentages become unimportant We need to know more about how to prevent this from happening and neurological evaluation is one of the means to achieve this.

The clinician who furnished us the most support last year in presenting the facts for neurological evaulation has not been able to apply for Federal funding the very project which he initiated nationally, due to the frustrating but tangible consequences of working for a moderate-sized center that doesn't staff a professional grant writer, nor additional medical personnel to temporarily or partially relieve this clinician of his 70-plus hour weekly schedule servicing the immediate needs of his patients and their families. He thus cannot draft an exacting proposal for funding without sacrificing the care needed by his patients. Additional core-support funding should go a long way toward providing the backup personnel which will permit the fledgling centers to compete on an equal basis with the established centers for Federal funds. Without additional core-support funding, in cancer institutions, as in ordinary life, it seems that the rich will get richer and the poor go their way—more disgruntled than ever.

Nutrition program

Our testimony last year before the authorizing committee pointed out that NCI's nutrition program was practically nonexistent. For this reason the National Cancer Act Amendments of 1974 directed NCI to improve its performance in these areas. The amendment required NCI to gather information on the relationship between nutrition and cancer and make this information generally available. OMB's position freeze has made it impossible for the Institute to assign personnel to deal solely with this program. They have assigned some personnel to bits and pieces of the nutrition area but this takes those personnel away from other projects where their time is also required. Even with this inadequate and unresponsive robbing Peter to pay Paul approach, some beginnings are being made. The role of diet is gaining prominence in the investigation into why some persons get cancer and others do not. A program is being developed on the effect of dietary profiles; definition of the role of dietary components as determinants of carcinogenesis in men and animals; and definition of the role of diet and nutrients as determinants in cancer development. The lower funding levels for fiscal 1976 will delay the initiation of research studies in this important area.

Further, we advocate devoting some research effort toward discovering the basis for some folk nutrition claims that eating particular natural substances prevent the occurance of cancer. Recent evidence indicates that vitamin A can prevent certain kinds of cancer and that with some additional effort, a chemical could be synthesized that would have the cancer-prevention properties of vitamin A but would not be as toxic in large amounts. It makes just as much sense to us to try systematically to find a cancer-preventing chemical as to look for a cancer-curing drug.

Another aspect of nutrition research particularly important to parents of cancer patients is the importance of diet of children undergoing treatment, either with chemotherapy, radiation therapy, or surgery, Should parents change the diet after surgery or radiotherapy to prevent the tumor from re-appearing? Should the diet be changed because of the powerful drugs used continuously in chemotherapy? Are my child's dietary needs different than other childrens' who were lucky enough to avoid cancer? These questions should vigorously be investigated with a strong nutrition research program.

The cancer program.—What should it do, and the question of health priorities.

Cancer research, as we see it, should be aimed at finding the basic scientific answers that will enable the Nation to cope with how cancer is caused and how it works, and should also devise ways to save and prolong lives and make life more livable, while the basic answers to cancer questions are being sought. With this in mind, the National Cancer Act of 1971 and the 1974 amendments to that act have established definitive goals for the cancer program and have indicated the levels of support necessary to achieve those goals. This committee has supported appropriation levels desighed to work toward these goals and this support has permitted the cancer program to build up considerable momentum toward their achievement.

Candlelighters greatly appreciate the impact of this committee on the cancer program. We note that Benno C. Schmidt, chairman of the President's Cancer Panel, recently said "The fact is that more and better basic biomedical research has been supported by the NCI during the past 3 years than ever before in history. The same is true of clinically-oriented research." We believe continuation of such momentum is necessary if the cancer effort is not to grind down to a mere holding operation. Now, more than ever, it should be given a chance to build on that momentum, and to take advantage of it—the cancer-control program being an excellent example of potentially achieving real payoff from years of hard research effort.

We also understand that basic biomedical research and so-called "targeted" cancer research are inextricably interrelated. As you are well aware, there is a current controversy as to whether the increased cancer spending has caused a slowdown in othe areas of biomedical research financing. If this is the case, we suggest that the remedy for this problem does not lie in dismantling or slowing down the cancer program. Rather, we strongly support an overall increase in health research spending.

We realize that the most effective use of current knowledge in diagnosis and treatment procedures holds the only real hope available right now, for the present cancer patient. We know from personal experience that the program is having beneficial impact for those afflicted with cancer; many of our children have lived or are living longer than they would have survived a decade ago, and it is our understanding that many of those being diagnosed with children's cancer today have still better survival prospects. We are also gratified to learn that the fruits of children's cancer research have great promise for "spinoff" application to other cancers.

Meanwhile, it is a matter of considerable concern to Candlelighters that in the search for short term answers to the cancer problem, some research programs, particularly in cause and prevention, that are extremely important to the ultimate defeat of the disease, not be deemphasized. We also know that in the long run, it is basic research which will give us the final answer. We are encouraged by the work that NCI is doing in basic research—such as cell biology study, and its efforts to determine what substances cause cancer. We urge that such work be given still stronger emphasis in the future.

Further, the emphasis this country has placed upon health research and the demonstration of health delivery systems is beginning to pay off in ways that reach beyond the well being of this country's citizens. It has given us a readily marketable export in medical care delivery systems. The most recent example of this is the $200 million medical-care facility in Riyadh, Saudi Arabia, in which all the prime contractors for systems and construction were American. Thus from your investment in the research and demonstration needed to develop these systems, you can see the beginnings of a business return which will have an increasingly favorable impact upon this country's balance of trade.

Mrs. MONACO. I will summarize the high points of our testimony.

Mrs. McGaughy, who has accompanied me, will address herself specifically to the nutrition program which was inserted in the National Cancer Amendments in 1974 and the impact of the fiscal 1976 funding levels on the nutrition program.

In general, our testimony deals with the level of funding, the effects of the proposed funding level of fiscal 1976 on cancer programs, what we call the impoundment of personnel and the effects of that impoundment on the cancer program, the ways and means to acquire the specialized personnel that the cancer program needs, comprehensive centers, the nutrition programs, the directions the cancer program has taken, the effect of these directions and the way we would like to see these directions improved and something that has recently come to our attention and which we are particularly concerned about on the positive side, that is, a nonmedical effect of the cancer program and, indeed, of our whole spectrum of federally funded health activities.

That is, the research and demonstration programs, which have been funded through the efforts of this committee, are now beginning to

pay off in efforts which we believe will give us a plus in our balance of trade with the export of medical care service and delivery systems.

Let us first look at the positive aspects of what has been happening in the cancer program. These are treated in detail in our testimony. I will only deal with two which I think you will find particularly important because of the interest you have expressed in them.

In the childhood cancer programs great strides have been made in the intervention procedures which have been used with the children to increase their time.

Further, there is something else that has happened just in the last 2 years which we find particularly gratifying: Not only the chemical intervention procedures, the radiological intervention procedures, surgical intervention procedures, but the new emphasis through the cancer control program on rehabilitation and continuing care as applied to the cancer patient and, of course, from our aspect particularly, to the childhood cancer patient.

This was an area that had been on the back burner, so to speak, but it is an area that, with increased concentration, we have seen leads to a much longer, a much more normal, a much more productive life span for all cancer patients and a much more emotionally normal existence for the cancer patient and the cancer patient's family.

Also, with respect to the cancer control program which has only just gotten off the ground, we can see a really great effort put forth in the community saturation programs which I know you are familiar with.

This committee has talked time and time again of getting the results of the cancer research out into the communities, getting it to the people who really need these effects and getting them out to the people who aren't right within the reach of a comprehensive cancer center. We know how long it is going to take to get comprehensive cancer centers throughout the country. We want to be able to see results out in the boondocks, so to speak, now.

Through the community saturation programs, in which the cancer control program has begun to make in-roads, 32 communities starting next year will have the opportunity, with the help of NCI, of utilizing 50 percent of their own funds and 50 percent of Federal funds, with contingency plans to take over funding completely when the Federal programs are funded out, to bring together the very best in community resources, community hospitals, and the primary physicians, and be instructed through NCI in the best intervention procedures, the best detection procedures, the best continuing care and rehabilitation procedures and through joint lay and medical efforts really reach out into the rural communities and into the mountain communities, into the areas that have been the stepchildren of cancer efforts.

These are two of the more significant effects of the cancer control program. More effects are detailed in our testimony.

We mentioned also in the summary part of our testimony that our country's very excellent medical care delivery systems. Recently on national media and in the press we have seen one example, that is of Saudi Arabia, purchasing American expertise, American medical health facilities, American construction know-how to erect a $200 million medical care facility. This is only one example of what we believe is going to be a snowballing effort in the developing countries, countries which have the oil dollars, et cetera, to take something that has

been developed here and utilize our American expertise overseas. This will start to give us a business payoff, a balance of trade payoff, from the federally funded health program. It is very gratifying to see this beginning.

Turning now from the very good effects and going into some of the unfortunate bad effects which we see in the cancer program if the funding level that has been requested is sustained. I will take one example of this, because it's a very crucial example, which deals with the lifeline that that the cancer program serves to our children and to most cancer patients.

Under the proposed funding levels, the number of cancer drugs, the lifeline drugs which are extending lives are going to be reduced from 10 to 7 per year. The amount of time that it's going to take for those drugs to reach the patients in actual treatment is going to be extended by 2 to 3 years.

You have seen over the years the strides that the increased funding and the increased perfection of the chemical chemotherapy treatment and surgical treatments have made on the prolongation of life of the cancer patient.

If we start to cut back now, many people who could be around when they develop sufficient knoweldge of the system to perfect even more drugs, to extend life, to put cancer, let us say, almost into the status of what diabetes was 30 years ago, and which is certainly within our reach now, will not be around to see the results.

A correlary of this, the cutback effects on the number of drugs we are going to see applied to patients on the short run, is also the games that we are seeing being played with the personnel who are required to implement the cancer program. As you are aware, Mr. Chairman, you have increased funding 328 percent in the last 5 years. Yet the implementing personnel has only been increased 25 percent. We need both the hands and the brains to do the work of the cancer program.

Not only do we need the hands and the brains out at NCI to administrate and to take part in the research programs, we need sufficient personnel on the clinical trial aspect of this program in order to monitor what is happening. It doesn't do us a bit of good to fund a demonstration program when we don't have enough personnel at the payoff consumer level to find out what is happening to the patient.

Unfortunately, if the number of personnel who are presently available for clinical trial purposes out in the field on these grants and contracts continues to be depressed, we are going to really have a treatment program and not the demonstration program that the Federal Government is funding.

It does very little good to put all this money into clinical trial and demonstration programs if the results are not going to be reported back to the people who need that information.

Of course, if you are not monitoring these patients who are subject to these intense chemotherapy interventions as completely as you can monitor them, the additional side effects are devastating.

One of them we mentioned to you last year—neurological side effects from chemotherapy and radiotherapy which could be offset if you see the problem early enough. We thought last year that it was a very minor problem. Feedback from our groups across the country this year indicate to us that the magnitude of this problem is far greater

than anything we had anticipated before. We will have more to say to you on this as our information develops.

Mr. FLOOD. Your time problem is pretty serious.

Mrs. MONACO. Could I turn to Mrs. McGaughy?

STATEMENT OF MRS. BEVERLY McGAUGHY

Mrs. MCGAUGHY. I want to talk about nutrition, which is a new program this year. They are making good starts, we think. I was privileged to go to the first workshop where they determined the state of the art and trying to decide where to go. I was amazed to find out that some of the studies they were citing as a basis of where to go from there were from the 1940's, which meant that those studies which they think are worthy of being followed up could have been followed up 30 years ago but they have been sitting there, lying fallow because nothing has been done in nutrition until now.

I would like to point out that in the field of nutrition, there is not one person assigned full-time because of the personnel freeze. They don't even have a secretary.

The scientists themselves, those who have been interested in it for years, commented on the fact that they are very happy that they are now able to do something in this field. In the past they have had no funding and no interest at the national level to support their work.

I would like to tell you about chemoprevention, which is a basic research component of nutrition. Have you heard the term yet?

Mr. FLOOD. Oh, yes.

Mrs. MCGAUGHY. Chemotherapy is chemoprevention using drugs. We have been fortunate to hear from some of the scientists who are working in this field. It has been well-established that vitamin A in large doses can help prevent cancer, but it's much too toxic in its natural form.

They are now working on synthetic analogs, synthetic derivatives of vitamin A which they are having success with in live animals in preventing cancer. They are almost ready to test it on high cancer-prone-type groups, who have a very high likelihood of getting cancer. This is the kind of program that will also be slowed down by a lack of funds.

Again, in talking the these scientists they have told us under questioning that they are also hampered by lack of secretaries and laboratory technicians.

EYE RESEARCH

WITNESSES

HON. JOHN YOUNG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

DR. MAUMAENEE, PHYSICIAN

Mr. FLOOD. Thank you very much.

Now we have the pleasure of having one of our colleagues, Congressman Young of Texas, who looks awfully healthy. Mr. Young.

Mr. YOUNG. Mr. Chairman, Mr. Roybal and members of the committee, it's a rare privilege and pleasure that I have to come here today, Mr. Chairman, with your indulgence and the committee's, to introduce

a person who will later be a witness. This person happens to be not only a great and wonderful friend of mine, but also my physician.

Without embarrassing him, I would say to you that in this field of ophthalmology, his reputation and professional standing is world-wide. I can attest to it by the fact that I can see. But I am not the only one. People of all walks of life, of all status, and calling in this Nation, as well as all over the world, are able to see because of him.

Mr. Chairman, I have to be in my office to meet with the EPA on an important matter, so it's absolutely vital to my district or I would stay here.

Mr. Chairman, it's my honor and privilege to present Dr. Maumaenee to you and to commend to you, to the Congress, and to the people of this Nation, whatever it is he has to say to you on the matter pending before you.

Thank you very much, Mr. Chairman.

Mr. FLOOD. Thank you, Congressman Young.

Dr. MAUMAENEE. Mr. Chairman, I have submitted a written statement. I would like to read a little bit of the first of this statement and then to discuss some problems in ophthalmology in the time that you have allotted me, sir.

Mr. Chairman and members of the committee, like most others who appear before this committee, I come to plead a special cause. As a physician, scientist, and teacher, I have spent my adult life in dealing with diseases of the eye, with conditions that too often culminate tragically in our most feared disability—blindness. I am here today because I see unprecedented opportunities at hand to study these diseases with an intensity never before possible, and to acquire knowledge of conditions that we cannot now cure or prevent. We are in danger of missing these opportunities through lack of adequate support for eye research. It is, therefore, with a great sense of urgency that I request your committee to approve this citizens' budget request of $77 million for the National Eye Institute.

I know there are many requests for funds before you, and that each is accompanied by convincing evidence of need. You are faced with the problem of weighing cost against available funds. The question is: How much can the American people afford to invest in efforts to save their sight? Let us look first at what we are paying today for visual loss, in both human and financial terms. It is an enormous price.

Almost half a million Americans are legally blind.

Ten million suffer from significant, uncorrectable visual impairment.

Of these, 1½ million are so severely handicapped that they cannot read ordinary newspaper type with either eye, even with glasses.

More than 500,000 major eye operations are performed in the United States every year.

More than $1½ billion is dissipated each year in loss of income due to blindness, not counting a corresponding loss of tax revenue to the Government.

More than $1 billion is paid out by Federal and State governments each year in direct aid to the blind. This does not include the cost of special education, medical care, and rehabilitation borne by families of the blind and other private sources.

The Public Health Service has stated that $2.4 billion is "a low estimate" of the annual cost of blindness and visual disability. The present cost probably exceeds $3 billion.

If we were to create a chart to illustrate national expenditures related to visual failure, we might divide it into three segments. At one extreme would be blindness and serious visual disability. The billions spent here are essential for necessary services and rehabilitation programs for the blind, that they may live useful lives without sight. In the center we would place the delivery of medical care—diagnosis, medical and surgical therapy, prostheses. These are funds spent with much hope, for they help preserve the sight of an increasing number of those with potentially blinding eye diseases. But the cost here also is enormous. At the other extreme, and lagging far behind in financial expenditure, is eye research. Yet this is the one area in which a comparatively small investment can save the billions expended in the others.

These billions of dollars are being lost from our national treasury year after year. The wise investment in eye research proposed in this $77 million budget for the National Eye Institute will provide the essential stimulus for a realistic attack on these tragic and costly eye diseases. For fiscal year 1975, the Eye Institute has operated at a level of $38 million for vision research and its administration, about half the amount it requires. It has not even had the full benefit of the $44,133,000 appropriated by Congress, due to administration action. By all measures, this is an unfortunate situation.

The money that you appropriate for the National Eye Institute is the primary source of eye research support for all the medical schools throughout the United States, where the great bulk of eye research takes place. These institutions are the backbone of our efforts to prevent blindness. In the past decade, and especially since the Congress wisely established the National Eye Institute in 1968, they have advanced eye research to a point of capability that has never before existed. In every section of the country we now see strong, well-programed eye research departments where a short time ago only a few institutions had any capacity whatever for fruitful investigations. At the heads of these departments are aggressive, decidated leaders of opthalmology, highly trained in all aspects of their profession and eminently qualified to direct the full-time research staffs that have at last been mobilized for a concentrated attack on blinding diseases. Millions of dollars of private funds have been poured into the creation of modern eye centers and the development of a whole new technology for study and treatment of the eye. With the help of this committee and the Congress, we have set the stage for advances in our knowledge of eye diseases unprecedented in the history of medical science. Shall we now see all these constructive efforts frustrated by our failure to furnish the modest degree of essential support suggested in this budget?

I would like to talk to you today about the capability of these institutions, and the capability of the splendid scientists who are working within the intramural programs of the Eye Institute. I would like to report to you briefly on some of the goals already achieved in saving sight and on the significance of just a few of the brilliant concepts now being pursued that offer realistic hope for extraordinary progress.

If you consider the nature of the eye you will understand why there was so little progress in preventing blindness until research expanded man's capabilities. The very structure and function of the eye presents

an obstacle unusual in biomedical research. Unlike most other organs of the body, one cannot biopsy the eye's visual cells without endangering vision. One cannot experiment physically with a functioning human eye, or take it apart and put it together again, or put its living cells under the microscope for comparative study at various stages of disease. Nevertheless, the physician, the scientist and the surgeon of today are finding extraordinary new ways to overcome these obstacles for diagnosis, treatment, and research.

The eye is a unique structure. It's impossible to take a biopsy of the seeing eye without destroying the eye, so we are greatly handicapped in this field of study.

One of the methods with which we are now attemping to alleviate this is by clinical pathologic studies by examining patients who have eye disease and then getting them to will their eyes to the eye bank. This is a long and expensive study because we have to have a great number of people. We never know when they are going to die, or when these eyes are going to become available for study. By doing this, we will obtain some of the pathologic specimens in the active stage of the disease and we can advance.

We have also developed methods of looking at the eye by injecting fluorescein and indocin and dyes and watching this circulate in the back of the eye so we can study the physiology of the blood vessels and various blinding eye diseases, such as diabetes, sickle-cell anemia, hypertension and macular degeneration.

We have developed ultrasound techniques for studying the exact measurements of the eye and detecting tumors and also radioactive isotopes for detecting tumors in the eye. We are developing some non-invasive techniques to get around this very difficult problem of not being able to biopsy specimens in the eye.

The introduction of fluorescein, first reported some years ago at my own institution and now in widespread use, permits us to observe the actual flow of blood through the tiny vessels of the eye's delicate vascular system. Deep within the back of the eye, these vessels carry nourishment for the vital retinal cells without which we cannot see. By injecting a fluorescent dye into the bloodstream in the arm of a patient, we now can observe and photograph its passage through the retina. Abnormalities that affect the eye's tissues and destroy sight are revealed. We can pinpoint areas of breakdown and weakness and apply treatment to a host of retinal disorders with far greater precision and success.

The fluorescein techniques that make therapy possible also enable the researcher to see aspects of the retina never before observable in life, and he records them for study through still photographs and motion pictures, continuously enlarging his ability to extract and use essential information. Other amazing new processes are being developed and pressed into action to observe what once had been hidden, to measure and evaluate once immeasurable processes. One scientist has adapted a weak laser beam to measure the speed of the flow and the oxygen content of blood circulating in the retina, important information in comparative studies of the normal and diseased eye. The rapid advance of neuro-ophthalmology, utilizing computerized electronic devices to tell us what is happening in the visual cells, is opening

wide fields for investigation of the entire visual process and brain. Developments in ultrasound technology now employ sound waves to move harmlessly through the eye's orbit, telling us of the presence of tumors and other obstructions and their exact size and location. We are breaking through the natural barriers of the living eye, exploring its structure and function, watching internal processes as they take place, all without invading a single cell or exposing the patient to physical trauma.

The impact of eye research on medical science is beyond question. Looking into the eye we see a microcosm of the body's circulatory system. Our findings can tell us much about that entire system, providing important insights into diabetes, hypertension, strokes, sickle-cell anemia and other killing and crippling disturbances. Moreover, research into the visual process, taking us deep into the cells and tissues of the brain, is providing an ideal route to knowledge of the central nervous system, with all the possibilities that holds for the management of multiple afflictions.

I see this new capability in ophthalmology leading us to answers in the management of now incurable diseases such as retinitis pigmentosa and macular degeneration. I believe we are capable of protecting youngsters from congenital defects of the eye, from amblyopia and strabismus and the numerous childhood visual afflictions that mark so many for a life of extreme handicap and, too often, blindness. And I am convinced that we can make it possible for the aging to face the longer life span that has been given us without fear of living those years in darkness.

Let us look very briefly at some practical results of our present research capability. Cataracts have been a major cause of blindness since the beginning of time. We still do not know the causes and as a result almost all people suffer from clouding of the lens if they live past 60, and many thousands lose their sight each year. But, while we are searching for ultimate answers, research is producing ever more effective surgical techniques for removing the clouded lens. We have reached the point where more than 400,000 cataract operations are performed in the United States each year, with greater than 98 percent success. More than that, it is no longer necessary to immobilize patients in hospital beds for a week or more, as once was the case. With newly-developed procedures, the cataract patient may now only be hospitalized overnight, or at most for a few days. When you consider that each hospital day involves a cost of from $180 to $200, you begin to recognize the enormous impact of eye research on medical economies. The cumulative saving that now accrues from the elimination of just one day of postsurgery hospitalization for 400,000 cataract patients is enough to pay the total cost of this proposed eye research budget for the entire fiscal year 1976.

I would not have you believe that all the inherent problems of cataract can be solved by surgery, however successful. It is a spendid and costly stopgap that averts blindness for many until we find ways of preventing cataracts from forming. Despite reduced hospital stay, the present annual cost of cataract surgery is estimated at approximately $1 billion. Under this budget, cataract research can be greatly accelerated, permitting the expansion of promising work such as that of an outstanding scientist at the National Eye Institute who has pro-

duced opacities that resemble sugar cataracts in rabbit eye lenses in test tubes. He has found an enzyme inhibitor which prevents the clouding and is presently expanding his investigations to humans and to more common forms of cataract.

I am delighted to say that Dr. Gene Kinoshita, working in the National Eye Institute, has just recently discovered a specific enzymatic defect in congenital hereditary cataracts in mice. This is the first clue as to exactly what causes a cataract in a mammal. We hope in time to be able to transfer this to man and to preventive methods and not have to do extractions of the lenses.

Great advances have been made in operative techniques for vitreous hemorrhage and retinal detachment surgery, so now we can go in and remove bloody vitreous that had hemorrhaged from various types of vascular lesions. For people who 3 or 4 years ago were hopelessly blind, we can restore their vision to some degree.

For years, glaucoma has ranked among the leading causes of blindness—and it will continue to blind where it is not treated. But research has made it possible for the eye physician to provide therapy for most patients, if the disease is discovered early enough. Acute, narrow-angle glaucoma now can be cured permanently by a highly successful surgical procedure. The testing of thousands of drugs and combinations of drugs has produced medications that effectively reduce pressure associated with the most common form of the disease, open-angle glaucoma. A small, biodegradeable capsule has been developed that we hope will simplify the treatment process. Placed under the lid of the eye, the capsule is designed to disintegrate slowly over a matter of days, producing a steady flow of medication, making multiple daily applications of eye drops unnecessary. Within the scope of our present knowledge, those who have lost any part of their sight through glaucoma will not regain it. Yet probably half of the more than 2 million Americans who have glaucoma do not now know that they have the disease. It is most important that our research into causes and preventives be pursued aggressively.

Advances have been made in glaucoma to the point where, if a person is followed adequately medically, less than 1 percent of people who have glaucoma should lose an appreciable amount of vision or go blind.

Genetics are a great problem in ophthalmology. Of all the severe genetic disabilities, at least 50 percent of these people have severe eye problems. There are likewise many eye problems that are solely related to genetics and to the eye alone. We are just beginning to make inroads into studying these problems. It will be a long time before we will be able to solve them, but at least we are beginning these studies.

Probably the most difficult problem we face in ophthalmology today is the emergence of diabetic retinopathy as the most rapidly increasing cause of blindness in the United States. There are more than 4 million diabetics and their number is constantly increasing. Life-saving insulin has achieved a modern miracle in preventing their early death, but gradual deterioration within the vascular system, including the retina, is a common occurrence with the passage of time. As a result, we now find an estimated 60,000 Americans legally blind from diabetic retinopathy. Unless we meet the responsibility

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of protecting diabetics from serious visual loss, all our gains in the fields of cataract, glaucoma, and other eye diseases will very soon be wiped out by a new and vastly greater population of those blinded from diabetes.

Attempts are being made to treat this disease with laser therapy, using the beam to seal off hemorrhages and proliferating cells that eventually may destroy the retina's function. But this is only a holding action—a limited technique unsuitable for a significant portion of the patient population. Even where successful, the effect may be of short duration, with recurrence of the destructive manifestations of this tragic disease. The National Eye Institute is now conducting a nationwide clinical study involving 15 medical centers and 1,600 patients, to evaluate the long-range effectiveness of various forms of laser treatment. This is an important study. But our ultimate hopes must be placed elsewhere, in basic studies of the nature of the disease and the chemical changes that occur in the course of its progress.

Macular disease is a disease of the aged and one of the primary causes of loss of reading vision. As you probably heard yesterday, this is certainly a major cause of diabetes from the vascular changes.

We are using photocoagulation to destroy the bleeding blood vessels, but we need to know the cause of this.

We have heartening news on this score in the findings of a brilliant biochemist working at my own institution. Using an experimental model that causes vascular disease, this young scientist has identified a protein that is associated with the destructive growth of blood vessels in the retina. This is a first step down what must be a long road, opening up a new field for exploration that may some day lead to a chemical inhibitor that will interrupt the disastrous progress of the disease.

We hope to find an antienzyme which can be used to prevent this type of neurovascular disease. Retinitis pigmentosa is a serious problem. It's a hereditary problem. It's very complicated in that the eye is an extension of the brain and has all of the complicating factors in studying it that the central nervous system has. The eye has been used because of this unique structure of being the one area where the brain extends to the point where you can actually see it and work with it. The work of Hubble and Weasel at Harvard have shown that preventing animals from seeing in the first year of life will prevent that animal from ever seeing. They have now by enzyme use technique been able to follow the visual impulses by radioactive type isotopes through the lateral genitalia of the body and to the precipital lobe of the brain and can show the defect in these neurons and axons in animals that have been deprived.

So we are beginning to understand the relations this brings to research that is being done in the eye.

Dr. David Robinson at my Institute is doing very exciting work again with the brain in looking at extraoccular movements, the movements of the eyes. By very sensitive techniques he can determine whether the lesions occur in the brain and has determined that the cerebellum is the repair machanism for defects in the brain. You only notice neurological defects when the cerebellum can no longer correct these areas. He is an engineer. We think this is a method by tearing the brain down piece by piece where he hopes to see how to put it back together. By

using the eye and its unique structures he hopes to learn more about the brain and more about neurological lesions.

There are people today who are capable of providing the answers we seek—scientists of extraordinary talent who are putting together the essential bits of information that will lead to an understanding of why and how we see, and how we can protect the billions of diverse but interacting cells that form the visual process. They are opthalmologists, pathologists, anatomists, biochemists, physiologists, pharmacologists, immunologists, physicists, engineers—outstanding workers in disciplines too numerous to enumerate. These are the present-day workers in the field of sight. They have been attracted to eye research because they recognize that there has never before been given to man such promising opportunities to preserve the precious gift of sight. The concepts the ideas, and the working plans of these scientists are embodied in this budget. They are dependent upon the decisions made by this committee and the Congress for support of their work.

I could speak at far greater length about this tremendously complex world of eye diseases and the aggressive steps we are taking toward their eventual management—but I know there are many calls on your time. I could cite the problems of uveitis, one of the most serious and difficult infectious conditions for the eye physician to manage; of corneal disorders that affect the clear, outer layer of the eye and distort or destroy vision; of tumors that invade the cavity of the eye; of eye muscle defects, that hinder the coordination of eye movements and often lead to one-eyed blindness or worse in children. There is a whole world of trauma, of viral and bacterial infection, of genetic defects and structural disorders—an array of disparate disease entities, all of which can destroy sight and all of which demand the full attention of trained scientists. We must give adequate support to these people and, of equal importance, we must continuously provide for the training of a new generation of scientists to sustain the progress already achieved.

I therefore urgently request that this committee recommend approval of the proposed citizens' budget of $77 million for the National Eye Institute for fiscal year 1976. It contemplates expenditures in the following program areas which may be broken down into five general disease categories. These are: Retinal and choroidal diseases, $25,611,000; corneal disorders, $12,336,000; cataract, $6,105,000; glaucoma, $9,185,000; and sensory-motor disorders and rehabilitation, $15,258,000. To carry on the important laboratory and clinical research that takes place within the Eye Institute's intramural program, we ask for $5,600,000. Since the responsibility of administering this entire program is obviously a heavy one, we request that $2,905,000 be approved for Research Management and Program Services. Included in the amounts already mentioned is $10 million which the Institute requires if it is to develop and implement programs for transforming new discoveries in research into the effective delivery of patient care. The nationwide clinical study of diabetic retinopathy treatment is a splendid example of what such funds are expected to accomplish.

To summarize, it is proposed that the Congress meet the needs of the National Eye Institute for fiscal year 1976 by providing $65,580,000 for research and training and $11,420,000 for direct operations. Financial tables related to these requests are appended to this testimony. In view of the staggering human and economic costs of blindness to

the nation, I believe the allocation of $77 million to the Eye Institute at this time is appropriate, reasonable and absolutely necessary.

I wish to thank the chairman and the members of this committee for all their past efforts on behalf of eye research, and to express my gratitude for the opportunity to present my testimony.

Thank you.

NATIONAL EYE INSTITUTE FINANCING

By Activity	Fiscal Year 1975 Operating Budget	Fiscal Year 1976 President's Budget Request	Fiscal Year 1976 Citizens' Proposal
Grants:			
Research	$29,635,000	$24,592,000	$59,211,000
Fellowships	2,653,000	2,653,000	4,375,000
Training	1,994,000	1,994,000	1,994,000
Total Grants	34,282,000	29,239,000	65,580,000
Direct Operations:			
Laboratory and Clinical Research	4,900,000	5,028,000	5,600,000
Research and Development Contracts	2,322,000	2,322,000	2,822,000
Biometry, Epidemiology and Field Services	487,000	487,000	583,000
Research Management and Program Services	2,142,000	2,125,000	2,415,000
Total Direct Operations	9,351,000	9,962,000	11,420,000
Total Obligations	$44,133,000	$39,201,000	$77,000,000
By Program			
Retinal and Choroidal Diseases	$14,092,000	$12,031,000	$25,611,000
Corneal Disorders	6,596,000	5,202,000	12,336,000
Cataract	3,445,000	3,189,000	6,105,000
Glaucoma	5,012,000	4,892,000	9,185,000
Sensory-motor Disorders and Rehabilitation	7,459,000	6,247,000	15,258,000
Intramural Laboratory and Clinical Research	4,900,000	5,028,000	5,600,000
Research Management and Program Services	2,629,000	2,612,000	2,905,000
Total Obligations	$44,133,000	$39,201,000	$77,000,000

NOTE: Fiscal Year 1976 begins July 1, 1975.

WITNESSES

GLENN ALLISON, CHAIRMAN, NATIONAL COALITION FOR MENTAL HEALTH MANPOWER

DR. SIDNEY BERMAN, CLINICAL PROFESSOR OF PSYCHIATRY AT THE GEORGE WASHINGTON SCHOOL OF MEDICINE

Mr. FLOOD. Mr. Glenn Allison, chairman of the National Coalition for Mental Health Manpower.

Mr. ALLISON. Good morning, Mr. Chairman. Thank you for the opportunity. Our witness for the coalition will be Dr. Sidney Berman, who is a clinical professor of psychiatry at the George Washington School of Medicine. He is also a senior adviser on the staff of the Childrens Hospital, Washington, D.C.

Dr. BERMAN. Mr. Chairman and members of the committee, the National Coalition for Mental Health Manpower appreciates the opportunity to submit for the record testimony in support of an appropriation of $125 million for the training of mental health personnel. This appropriation is a major source of funding for the training of personnel in the treatment of the mentally handicapped, in rehabilitation, prevention and education and research. This coalition believes this to be a modest appropriation; considering the fact that this Nation spends $15 billion a year for the care of the mentally ill, the economic loss is more than this and no price can be placed upon the impaired welfare of such a large segment of our population.

Our testimony at this time, and for the past 4 years, once more refutes the position taken by the Secretary of DHEW and the Office of Management and Budget to phase out all mental health manpower training. We know these to be harsh words but, if we look at the record, their reports demonstrate incompetence at best, and downright distortion of facts at worst, in the face of congressional appropriations, court orders and testimony that this matter is a national responsibility.

In the testimony presented to this committee on April 23 by the Department of Health, Education, and Welfare, it is incredulous to hear from responsible men that "training programs have been developed to the point that Federal subsidies are no longer required," and then to say to this committee that although 20 million Americans are affected by emotional disturbances, there will be a shortage of manpower by 1981 of 10,000 psychiatrists, 8,000 psychologists, 7,000 social workers, and 12,000 mental health nurses.

Unfortunately, in spite of the appropriations by Congress to support these training projects and in spite of testimony demonstrating this need, DHEW has, since fiscal year 1972 cut back psychiatric residency trainees from 1,296 to 690 stipends, psychiatric social worker trainees from 1,476 to 718, and psychology trainees from 2,241 to 1,520. Beyond fiscal year 1976, DHEW proposes the final step in the phaseout of all programs. This coalition knows this is downright irresponsibility because the withdrawal of congressional support will cut back by 33 percent all of the adult training programs and by 50 percent all of the child mental health training programs.

As you know, it has been demonstrated that there are no alternative methods of effective funding and only categorical funding has sustained this program. Neither revenue sharing, third-party payments, student loans nor local financing have been effective. While States in the aggregate are making major contributions in this area, they cannot make up for such a deficit as would be created and meet their other pressing needs.

Beyond this, the coalition does wish to call to the attention of this committee a pattern which it has followed over the past 4 years. This committee has, each year, reduced the appropriations recommended by the coalition which we feel would adequately sustain mental health manpower training and, in that sense, this phasedown unfortunately has encouraged the administration's phaseout. This phasedown has been ever more ominous with the pressure of inflation; $110 million, which this committee funded for fiscal year 1973 in 1972, would require $143 million in fiscal year 1976 in order to operate the same program.

This coalition wishes to present for your consideration three recommendations. It is felt that these recommendations will provide the greatest number of trainees for the funds available, maintain the basic teaching programs necessary to operate the training projects and prevent the dismantling of the mechanism within NIMH for awarding grants:

RECOMMENDATIONS

1. The coalition recommends the appropriation of $125 million for mental health manpower training. This will support 8,500 stipends, well below the level needed to meet the projected mental health manpower requirements of this Nation.

Although the coalition strongly urges the funding of $125 million, it wishes to advise that the absolute minimum recommended appropriation would be $110 million; $110 million represents the appropriation necessary to hold the line in maintaining in fact the training programs although it would provide for only 5,568 stipends in all categories of training. The coalition feels that anything less than this would have a devastating effect upon this program by dismantling the basic support functions required for training purposes.

The second recommendation to retain the administrative management programs necessary to administer these funds and so it is recommended that this committee of Congress make clear its intent that allocation of awards will be based upon appropriate peer review of applications—that is, formally chartered initial review groups or committees as well as by the National Advisory Mental Health Council—and that this process will be carried out in a timely manner.

3. The coalition also recommends that, at this time, the allocation of stipends for psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses be in ratio to the projected manpower needs as established by NIMH. Any dislocation of this ratio may cause an imbalance of the quality of the delivery of service and an imbalance in the structure of the training programs.

Mental health, as you know, is the most pressing of all national health problems and requires strong congressional leadership to inspire the best in this Nation to deal with it. On behalf of the mentally

handicapped we present this petition for your support and ask for favorable response to our request.

Mr. FLOOD. Thank you very much.

[The complete statement follows:]

TESTIMONY OF NATIONAL COALITION FOR MENTAL HEALTH MANPOWER ON LABOR, HEALTH, EDUCATION AND WELFARE APPROPRIATIONS FOR FISCAL 1976, PRESENTED BY SIDNEY BERMAN, M.D., MAY 14, 1975

American Academy of Child Psychiatry
American Association of Chairmen of Departments of Psychiatry
American Association of Directors of Psychiatric Residency Training
American Association of Psychiatric Services for Children
American Nurses' Association
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
Council on Social Work Education
National Association for Mental Health
National Association of Private Psychiatric Hospitals
National Association of Social Workers
National Association of State Mental Health Program Directors
National Committee Against Mental Illness
National Council of Community Mental Health Centers

The National Coalition for Mental Health Manpower represents national organizations with a responsibility for the training of the mental health personnel of this Nation. It is alarmed at persistent attempts by the Department of Health, Education, and Welfare and the Office of Management and Budget to phase out mental health manpower funding. In spite of impelling testimony to the contrary and congressional appropriations over the past 5 years, neither the Department of Health, Education, and Welfare nor any other agencies in this Nation have developed effective alternative methods of funding to replace this rightful and necessary Federal responsibility. Therefore, this coalition again respectfully petitions this committee of Congress to recommend the appropriation of $125 million for training of mental health personnel of all disciplines in the care of the mentally handicapped of this Nation for fiscal year 1976.

This appropriation should be considerably more in order to compensate for the interim inflation as well as to meet the ongoing demands for economic stringency. It does not support the funding required to meet future demands for manpower. The sum of $125 million is specifically requested because, it would support, 8,500 stipends in all the categories of mental health manpower training, qualify approximately 3,200 each year and maintain strong training centers necessary to increase this Nation's pool of mental health personnel.

The coalition also wishes to call to the attention of this committee of Congress, that each year since fiscal year 1972, it has reduced the funds necessary to sustain these programs. (See exhibit A.)

Although the reductions have not been as drastic as those recommended by the Department of Health, Education, and Welfare, these reductions have wreaked havoc among the training centers and have caused a cutback in essential manpower training. This phase down, if continued, will result in an even greater shortage of mental health personnel by 1980 and create an insurmountable problem in the delivery of mental health services in any national health plan which may be operative by then. Therefore, this coalition, out of past experience wishes to recommend that under no circumstance should the appropriation be less than $110 million. This would support only 5,568 stipends of all disciplines at the critical point to maintain these programs. Therefore, this is the rock bottom base line to sustain the ongoing teaching support functions of these training centers and maintain intact training programs of excellence until they are adequately funded.

The coalition urges Congress to continue this support. It strongly opposes the budget recommended by Secretary Casper Weinberger and the Office of Management and Budget who are intent on dismantling this program, thereby placing mental health training in jeopardy. Their recommendation of $45 million for fiscal year 1976 has the same effect as the impoundment of funds and is in opposition to the intent of Congress and court decisions in support of this program. In

no way has the testimony of Secretary Weinberger or his staff refuted the action taken by Congress in funding for mental health manpower or the testimony of this coalition as presented before this committee of Congress in previous years.

ARGUMENT AGAINST ALTERNATIVE FUNDING

It has been demonstrated that none of the alternative methods of funding for mental health manpower has proven effective. Your committee of Congress is aware of the fact that neither revenue sharing, third party payments, student loans, nor similar measures has been effective. None of these measures can make up for the withdrawal of this Federal participation in meeting this need. Also, the current argument that primary care physicians will relieve the mental health manpower shortage also will prove to be in error. With the increase of primary care physicians the demand for mental health services for the more severe forms of mental illness surely will be escalated. If it had not been for congressional funding for mental health manpower, there would have been a cutback of training programs for adult services by 33 percent and of training programs for children services by 50 percent. Only congressional leadership has sustained these programs throughout every State in the Union with standards of excellence.

NEED FOR CATEGORICAL FUNDING

This coalition strongly recommends that mental health manpower programs must be categorically funded or these programs, like the mentally ill, will be placed at a disadvantage. It is a sad fact that there is no way for mental health funding to compete successfully with other forms of funding although mental and emotional illness is the No. 1 health problem in America. Furthermore, since manpower represents a national resource it should be strongly supported by financing at the Federal level rather than through the fees paid by the victims of mental illness. Additionally, a study by the National Institute of Mental Health shows that those professionals trained primarily with Government funds more than compensate this Nation by the services they render to those most in need. Every State in the Union benefits from these programs regardless of their geographic distribution. This is demonstrated by a study made by the American Psychiatric Association. (See exhibit B.)

ARGUMENT AGAINST SURPLUS MANPOWER

Again, this coalition states that at the present time a surplus of mental health professionals is pure myth. The coalition calls your attention to the study by the National Institute of Mental Health which estimates that by 1981 this Nation will require a minimum of 40,300 psychiatrists and only 30,900 will be available. In 1972, there were only 2,268 child psychiatrists in the United States, a nation in which it is estimated that only 5 percent of the children who need psychiatric treatment are able to get it. The same shortage holds for social workers, psychologists, nurses, and other mental health personnel.

The National Institute of Mental Health in testimony before this committee, this past April 23, even if we accept their most conservative figures, stated that by 1981 there would be a shortage of 10,000 psychiatrists, 8,000 psychologists, 7,000 social workers and 12,000 mental health nurses. It is hard to see how NIMH and DHEW can say, "All training programs are proposed for phaseout" and yet "we have a long long way to go," about a "concern of immense dimensions to the Nation—one in 10 of our citizens—or approximately 20 million Americans—who are afflicted by emotional disturbances."

A more detailed study by the NIMH Division of Biometry, based upon a morbidity rate of 10 percent, also estimated that 91,000 psychologists will be needed to provide mental health services by 1980. This estimate assumes that there 91,000 psychologists would be providing their services full time to 10 percent of the population for 6 hours per patient per year. At this time, only 39 percent of the total professional effort of psychologists is in the provision of mental health services. Therefore, even if the present level of training support is continued, and with a manpower pool of 110,000 by 1980, there will be only 43,000 full-time equivalent psychologists available for mental health services, against a projected need of 91,000—a shortage of 48,000. Using this same statistical study, a similar shortage would hold for social workers, nurses and phychiatrists. (See exhibit C.)

Nursing care has always been an enlarged part of providing mental health services in America. Presently there are 37,000 registered nurses in practice in

the psychiatric mental health area. It is estimated that by 1980 58,000 more phychiatric mental health nurses will be needed. This is a total of 95,000 or an increase of 250 percent in 4 short years.

Also there are about 3,700 registered nurses with graduate preparation in psychiatric mental health practice. There is an urgent need now for 5,000 more nurses with this specialty preparation and about 50,000 by 1985.

These figures are based on estimates for providing full time psychiatric or mental health services to 10 percent of the population for 6 hours per patient per year and are from the Division of Biometry of the National Institute of Mental Health, 1973. (See Exhibit D.)

Social work is also an integral part of the mental health delivery system. There were approximately 150,000 social workers employed in the mental health field in 1970. Between 1960 and 1970 growth in employment in mental health, as well as other health settings grew substantially. A substantial growth trend is also projected to continue between 1970 and 1980. In general, the Bureau of Labor Statistics predicts a growth in demand of 50 percent for social work manpower by 1980 compared to the supply of social workers in 1970. This comports with data from "Staffing of Mental Health Facilities—1972" which showed a 5-year growth rate of 26 percent—from 1968–72—for social workers in community mental health centers. Also, the proportion of social workers as part of the professional staff of the centers has grown. In 1972 there were a total of 22,000 mental health social workers in community mental health centers. About 75 percent of these are masters degree holders.

In addition, as of 1973, approximately 50 percent of all students in masters programs were specializing in mental health fields. This is an increase over prior years.

This data is from the Bureau of Labor Statistics, and two studies by the Council on Social Work Education, "Statistics on Graduate Work in the United States" and "Social Work Personnel in the 1970's."

Approximately 80 schools of social work received NIMH funding. The level of funding is about $12 million for them and has in actual terms been reduced by about 10 percent in constant dollars terms. The level has been declining substantially given a 10-percent annual inflation rate.

The national mental health consumer groups also wish to stress the extreme need for the training of mental health personnel and the continuing responsibility of Congress to make these training programs secure. The majority of all mental health personnel trained by congressional appropriations go into full- or part-time public service where they are desparately needed and this is verified by Federal Government surveys. As an example, there are in the United States less than 3,000 child psychiatrists; however, the number of children in State and county hospitals, now about 55,000, has doubled since 1963. These same services for children, the aged, and the economically disadvantaged are not being met and manpower for community mental health centers and other outpatient and inpatient facilities is grossly inadequate.

The cutback in funding for training tends to destroy the very fabric of mental health services. A national crisis in manpower continues to exist. The collaboration of all of these mental health professionals becomes even more urgent in the delivery of services to community mental health programs, psychiatric units in general hospitals, child and adult psychiatric clinics, residential treatment centers, therapeutic nursery schools, et cetera. Funding also is needed to encourage the financially disadvantaged students and students from all ethnic groups to apply for such training. We are challenged with the task of expanding services to meet the pressing needs of all ethnic groups and socio-economic sectors of the population. However, this should be handled by special legislative funding for such programs and not be subsumed under this funding.

NEED FOR MORE MENTAL HEALTH PERSONNEL

This need for skilled personnel to provide care and treatment, to obtain auxiliary personnel, and to conduct research remains a critical problem. Within our stressful changing society, there is an evergrowing demand for services and each victim of mental illness may be a serious economic and social burden, making prevention and early and effective treatment even more imperative. New and changing concepts for early detection and treatment are being developed and will require personnel trained to meet these trends in mental health services. Funding is required to study the role of the paraprofessional in the delivery of mental health services and to develop training programs of quality, leading to accredi-

tation and licensure. Community based care and nondirect mental health services require specially trained personnel to meet these demands for service. And, it is a sad fact that treatment available to children, the aged, abusers of alcohol, and drugs, and poverty stricken, is limited both in available services and competently trained personnel. These programs require adequate staffing that assures the success of sound programatic and administrative planning. Yet the action taken by Secretary Weinberger eliminates all renewals, all new training grants and all supplemental clinical training grants, without any concern for the consequences of this rash act. This untenable position is taken in spite of the testimony presented before your committee for fiscal year 1973 by the Department of Health, Education, and Welfare that "to meet the Nation's needs, more than 25,000 additional mental health workers are desperately needed in our mental health facilities but are unavailable." [Part III, p. 97, hearings.]

Vigorous action on the part of Congress is necessary to prevent the further loss of trainees. The planned DHEW phase out will result in the collapse of all Federally funded training centers. (See Exhibit E) The cutback of psychiatric residency trainees is from 3,373 in fiscal year 1972 to 567 in fiscal year 1976 with no further funding beyond this year. The cutback in psychiatric nurses trainees over the same period is from 1,287 to 690. For psychiatric social work trainees it is from 1,476 to 718 and for psychologist trainees, it is from 2,241 to 1,520. This opposition by DHEW is incomprehensible in view of the catastrophic effect it would have on the care of the mentally ill.

It also is noted that the cutbacks in training stipends are uneven. This may be used to weaken the structure of the training programs which require inter-disciplinary collaboration for their success. If one discipline is phased out and receives no funding, it will cause the others to fall prey to the same fate. Therefore the coalition recommends that the proportion of trainees among psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses be maintained at the same ratio as projected by NIMH for manpower shortages by 1981.

IMPLEMENTATION OF CONGRESSIONAL FUNDING SHOULD NOT BE OBSTRUCTED

The Office of Management and Budget in cutting back on the resources and machinery to fund the federally-supported mental health projects has created intense frustration in these training centers in recruiting trainees and setting up programs to begin by July 1st. Therefore, the coalition recommends that Congress direct that training grants be awarded by formally chartered review groups or committees as well as by the National Advisory Mental Health Council. In the future, at least a 9-month lead time is needed to process and appoint trainees who qualify.

ECONOMIC ADVANTAGE

Any mental patient who is so handicapped that he can't keep a job or goes from one job to another or requires prolonged hospitalization is a serious burden personally and financially to everyone. Whether this country is economically prosperous or oppressed financially, the only humane approach is to keep that person in his rehabilitation. There can be no argument to have him scrounge around for relief in the market-place in good times. Nor can the argument be used that because of budgetary stringencies funds should be sought elsewhere. The mentaly ill cannot be neglected by such spurious reasoning. Effective treatment which maintains the patient's capacity to work, to take care of his home and to contribute to the life of the community is an essential goal in the care of the millions who become handicapped mentally. This is a responsibility this Nation should never avoid.

RECOMMENDATIONS

1. The Coalition recommends the appropriation of $125 million for mental health manpower training. This will support 8,500 stipends, well below the level needed to meet the projected mental health manpower requirements of this Nation.

Although the coalition strongly urges the funding of $125 million it wishes to advise that the absolute minimum recommended appropriation would be $110 million. $110 million represents the appropriation necessary to hold the line in maintaining the training programs and to provide for only 5,568 stipends in all categories of training. Anything less than this would have a devastating effect upon this program by dismantling the basic support functions.

2. To retain the resources necessary to administer these funds, it is recommended that this committee of Congress make clear its intent that allocation of awards will be based upon appropriate peer review of application (that is, formally chartered initial review groups or committees as well as by the National Advisory Mental Health Council) and that this process will be carried out in a timely manner.

3. The coalition also recommends that, at this time, the allocation of stipends for psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses be in ratio to the projected manpower needs as established by NIMH.

Mental health, as you know, is the most pressing of all national health problems and requires strong congressional leadership to inspire the best in this Nation to deal with it. On behalf of the mentally handicapped we present this petition for your support and ask your favorable response to our request.

EXHIBIT A.—TRENDS IN MENTAL HEALTH MANPOWER APPROPRIATIONS, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

National coalition for MH manpower recommendations	Presidential request	House appropriation	Senate appropriation	Final conference appropriation [1]
Fiscal year 1972— $145,200,000	$104, 600, 000	$114, 000, 000	$120, 050, 000	$120, 050, 000
Fiscal year 1973—No specific recommendation	96, 350, 000	110, 000, 000	132, 050, 000	110, 000, 000
Fiscal year 1974—No specific recommendation	72, 376, 000	100, 000, 000	110, 000, 000	104, 500, 000
Fiscal year 1975—No specific recommendation	65, 100, 000	85, 100, 000	104, 099, 000	94, 600, 000
Fiscal year 1976—$125,000,000 [2]–$110,000,000 (minimum) [3]	45, 000, 000			

[1] This column illustrates the deterioration of this vital program. (2-digit inflation not reflected in trend).
[2] Coalition's recommended level for fiscal year 1976.
[3] The figure of $110,000,000 has been cited by the National Coalition for Mental Health Manpower as the bare minimum recommended level of funding to permit the mere sustenance and continuation of this program.

Note: The Coalition was formed in 1971 in response to the Administration's attempt to phase out the mental health manpower program in the National Institute for Mental Health.

EXHIBIT B

Funding for Psychiatric Residency Training: A National Dilemma

AMERICAN PSYCHIATRIC ASSOCIATION

Implications of elimination of NIMH support

When APA informed the Office of Management and Budget that the elimination of this program would be disastrous to the production of psychiatrists, the response was "prove it." This implied demonstrating actual losses to manpower deleterious to the mental health care delivery capacity of the Nation.

As a result, APA undertook the survey, "A Nationwide Pattern of Fiscal Support for Psychiatric Residency Training." The national roster of chairmen of departments of psychiatry and directors of residency training programs were forwarded questionnaires. The survey reported the following results: All 260 psychiatric training programs accredited by the AMA and the American Board of Psychiatry and Neurology (ABPN) were asked to provide specific data on the dollar-value of fiscal support for: (1) stipends provided to psychiatric residents, and (2) associated teaching costs of psychiatric residency training (e.g., faculty salaries, equipment and supplies to expand department capabilities for psychiatric training). Each training center was asked to indicate the dollar amounts privided for the above two purposes by source.

Some 239 out of the 260 AMA–ABPN accredited programs (92 percent) provided usable data for reporting census results. These 239 training programs can be categorized as follows:

Type of sponsorship	Number of programs	Percent of all programs reporting
1. Medical school-based training programs	82	34
2. State hospital-based training programs	57	24
3. Private hospital and/or clinic-based training programs	38	16
4. County and/or municipal-based training programs	15	6
5. Miscellaneous and unclassified-by-sponsorship training programs	47	20
Total	239	100

The total nationwide fiscal support from all sources for psychiatric residency training programs during fiscal year 1971 amounted to approximately $100 million. State and local governments combined with the private sector of the economy (as represented by physician contributions, medical school aid to their own psychiatry departments, foundations, and private voluntary health agencies) contributed 61 percent of this support. The Federal Government provides 34 percent of all fiscal support for psychiatric residency training via NIMH and another 5 percent via other Federal programs (e.g. VA, DOD, HEW, etc.).

Stipend support provided directly to the 4,275 psychiatric residents in training from all sources of training amounted to approximately $49 million while approximately $51 million were devoted to fiscal support of teaching costs. The average dollar-value of stipend support provided to each psychiatric resident in training was $11,647. An additional $12,000 per student was the average for associated teaching costs. Thus the total investment per student during fiscal year 1971 was approximately $23,600. Nevertheless, a substantial amount of this is recovered in patient services.

However, there are important differences between the various types of training programs with respect to the dependence on NIMH for fiscal support. All of the medical school based psychiatric residency programs depend upon NIMH for some or all of their fiscal support. Only about one-half of the State hospital based programs depend upon NIMH (54 percent). Further, medical-support-based programs depend upon NIMH for about two-fifths of their total support (39 percent). State-hospital-based programs look to NIMH for about one-eighth of their total support (14 percent). Medical school based programs depend upon NIMH for about one-half of their resources for psychiatric resident stipends (49 percent). State-hospital-based programs look to NIMH for about one-eighth of their stipend support (14 percent). Medical school based programs receive one-third of their support for associated teaching costs of psychiatric residency training from NIMH (33 percent). State hospital based programs receive about one-sixth percent of their support for associated teaching costs from NIMH (16 percent).

Given the pre-eminent position of NIMH as a source of fiscal support for psychiatric training throughout the United States, it follows inexorably that if NIMH fiscal support for psychiatric residency training is to be "phased out," such action would have a catastrophic effect on psychiatric residency training throughout the country.

The concrete effects of this action on the part of the executive branch of the Federal Government would be as follows: More than one-third of all psychiatric resident positions throughout the country would be lost (35 percent). This amounts to 1,500 positions out of the current pool of 4,275 psychiatric residents in training. Nor will the results of this action be evenly distributed across all training programs. Medical school based programs will lose one-half of their psychiatric residents (46 percent) while the less well NIMH supported State hospital based programs expect to lose only 13 percent of their psychiatric residents.

Thus, the programs of highest quality in the university medical centers where the best American medical school graduates enter psychiatry as a medical specialty will be effectively dismembered while the Nation is left with the poorest training centers, remote from urban facilities, staffed predominantly by foreign medical graduates.

Clearly, psychiatry as a medical specialty will lose if the action proposed by the executive branch of the Federal Government is sustained. But in a time when the Government wants to increase the Nation's pool of licensed physicians by 50,000 (15,000 of which are supposed to be psychiatrists) * * * the Nation's citizens will be the ultimate losers.

This report was circulated to the Office of Management and Budget, referred to in congressional testimony, and presented to key Congressmen and Senators.

Lowered funds for teaching costs would mean that numbers of medical school professors would have to be dismissed. There would be less time for remaining faculty to devote to teaching and to public service.

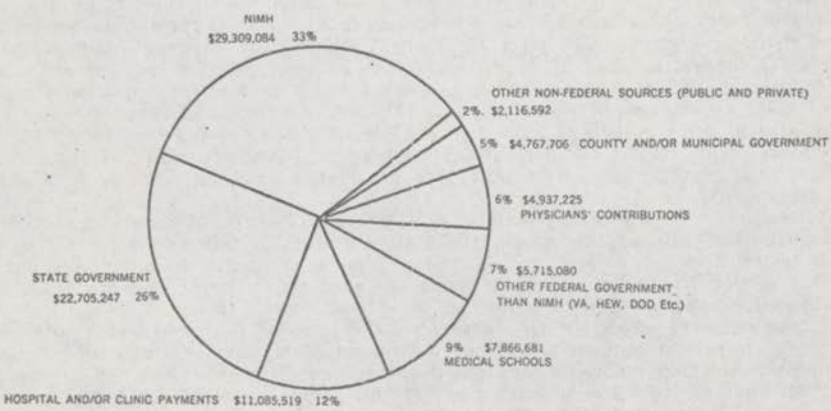
Distraction of faculty from the service setting into private practice will further contribute to the two-class system of service delivery. It is estimated that elimination of the Federal support would result in a loss of from 20 to 50 percent of faculty time for education.

In some cases, residents will gravitate toward private practice in affluent areas in order to supplement stipends which will be reduced or eliminated.

These computations underscore the sizable increases that may be expected in the number of persons needing mental health services and in the manpower required to deliver these services merely as a result of population increases. I might add that the population forecasts are equally significant for the planning of resources to meet problems that the expected increases are likely to produce for medical care, social, welfare, legal, correctional, and other human services.

NATIONWIDE PATTERN OF TOTAL FINANCIAL SUPPORT
FOR PSYCHIATRIC RESIDENCY TRAINING
AMONG 239 RESIDENCY TRAINING CENTERS

*Fiscal Year 1971



*Source: Manpower Division, American Psychiatric Association

FROM: DIVISION OF BIOMETRY, NATIONAL INSTITUTE OF MENTAL HEALTH, 1973

Discipline	1975		1980	
	Required	Expected [1]	Required	Expected
Psychiatry [2]	86,235	30,300	91,004	38,700
Psychology [3]	86,235	30,000	91,004	44,800
Social Work [4]	86,235	25,400	91,004	36,600
Nursing [5]	86,235	35,900	91,004	51,300

[1] Source: Division of manpower and training programs, NIMH.

[2] 1 or more years of psychiatric training.
[3] M.A. or Ph. D. with training in mental health field.
[4] M.A. with training in mental health field.
[5] Some training in psychiatric nursing.

SUMMARY OF PUBLIC SERVICE [1] VERSUS PRIVATE PRACTICE ACTIVITIES OF PSYCHIATRIC RESIDENTS WHO HAVE [1] GRADUATED FROM 8 TRAINING PROGRAMS OVER THE PAST 5 YEARS

Residency program	Number of completing in the past 5 years	Number of residents supported in whole or part by NIMH	Percent of NIMH supported residents in public service	Percent in part-time public service	Percent in solo private practice
Duke University	53	49	81	11	8.0
University of Pennsylvania	53	47	81	8	11.0
Emory University	56	56	52	48	----------
Central State Hospital, Oklahoma	26	10	50	30	20.0
Massachusetts Mental Health Center	135	46	(2)	(2)	1.5
NYS Psychiatric Institute	85	65	46	54	----------
Menninger School of Psychiatry, Topeka	166	33	9	(3)	11.0
University of Colorado		98	59	35	6.0

[1] By public service is meant an average of more than 50 percent of time in spent hospital work, teaching, community mental health centers, the military, and research.
[2] The director, Dr. Jack R. Ewalt, was unable to supply precise data, but he stated that all but 13 of the 135 have spent some time as full time employees in public service agencies and facilities. All of the 135 have spent some time in teaching activities. Only 2 guradates are known to be in full time private practice.
[3] The director, Dr. Philip Wolcott, was unable to supply precise information but stated that most graduates are doing part time public service work. Only 18 are known to be in solo private practice.

RESIDENCY TRAINING PROGRAM, DUKE UNIVERSITY, DURHAM, N.C., EWALD W. BUSSE, M.D., DIRECTOR

Fifty-three residents have completed training at Duke University within the past 5 years. Of these, 49 were supported in whole or in part by NIMH training stipends. The 53 residents are now engaged in the following activities:

Full-time public service:	
Public mental hospitals (14.4%)	7
Military service (9.4%)	4
Government work (16.4%)	8
Community mental health (12.5%)	7
Education (29%)	14
Part-time public service (10%)	10
Solo private practice (7%)	4

RESIDENCY TRAINING PROGRAM, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA., ALBERT STUNKARD, M.D., DIRECTOR

Forty-eight residents have completed training at the University of Pennsylvania over the past 5 years; 43 of them supported in whole or in part by NIMH training stipends. Their activities at present are as follows:

Full-time public service:	
Teaching (31%)	15
Military service (15%)	7
Federal or State mental health services (14%)	6
Community mental health centers and clinics (8%)	4
Advanced training (8%)	4
Research (7%)	3
Part-time public service:	
Teaching and private practice (8%)	4
Solo private practice	5

RESIDENCY TRAINING PROGRAM, EMORY UNIVERSITY, ATLANTA, GA., BERNARD HOLLAND, M.D., DIRECTOR

Fifty-six residents have completed training in the past 5 years, all of whom received support in whole or in part from NIMH training stipends. Their present activities are as follows:

Full-time public service:	
Community mental health centers	8
Hospitals	2
Military service	15
Education	4
Total	[1] 29

Part-time public service: [2]	*Average percentages*
3 graduates, 1967	50
5 graduates, 1968	50
10 graduates, 1969	40
3 graduates, 1970	70
6 graduates, 1971	65
Total—27 graduates (48%) 1967–1971	55

[1] 52 percent.
[2] Public service here includes part-time work in education, community consultation and community mental health centers, clinics, all kinds of hospitals, and research.

RESIDENCY TRAINING PROGRAM, CENTRAL STATE GRIFFIN MEMORIAL HOSPITAL, NORMAN, OKLA., HAYDEN H. DONAHUE, M.D., DIRECTOR

Twenty-six residents have completed training in the last 5 years of whom 10 were supported in whole or in part by NIMH stipends. The activities of these 10 are summarized below.

Full-time public service:	
Community mental health centers	2
State hospital	3
Part-time public service:	
Consultants—State health department	2
Staff, State hospital	1
Solo private practice	2

Of the 16 other residents who were supported by Oklahoma State stipends, their work is distributed as follows:

Full-time public service:	
State hospital	11

Part-time public service:	
Consultant to State school	1
Solo private practice	4

RESIDENCY TRAINING PROGRAM, HARVARD MEDICAL SCHOOL, MASSACHUSETTS MENTAL HEALTH CENTER, BOSTON, MASS., JACK R. EWALT, M.D., DIRECTOR

One hundred and thirty-five residents have completed the program in the past 5 years; 46 of these residents received support in whole or in part from NIMH training stipends.

Of these 135, all but 13 have spent some time as full-time employees in the following agencies and facilities: Military service, Public Health Service, Massachusetts Mental Health Center, Boston State Hospital, Tufts Mental Health Unit, Cambridge City hospital.

All of the 135 have spent some time teaching at State and Federal institutions.

At present, only two graduates are known to be in full-time private practice.

One hundred and thirty-three are in full- or part-time academic or public work. A great many of the graduates now teach one-fourth to one-half time and serve as supervisors of hospitals or clinics.

RESIDENCY TRAINING PROGRAM, NEW YORK STATE PSYCHIATRIC INSTITUTE, COLUMBIA UNIVERSITY, NEW YORK, N.Y., LAWRENCE C. KOLB, M.D., DIRECTOR

Eighty-five residents have completed training here in the past 5 years. Of these, 65 were supported in whole or in part by NIMH training stipends. The activities of these 65 at present are as follows:

Full-time public service: Public mental hospitals, military service, Community Mental Health Centers, education	27
Part-time public service:	
2 graduates	[1] 90
3 graduates	[1] 80
7 graduates	[1] 70
1 graduate	[1] 60
13 graduates	[1] 50
3 graduates	[1] 40
6 graduates	[1] 30
3 graduates	[1] 20
Total 38 graduates, average percent	[1] 55
Solo private practice	None
Solo private practice over 50 percent of time	12

[1] Percent time in public service work.

RESIDENCY TRAINING PROGRAM, MENNINGER SCHOOL OF PSYCHIATRY, TOPEKA, KANS., PHILIP WOLCOTT, M.D., DIRECTOR

One hundred and sixty-six residents have completed training here in the past 5 years. Thirty-three received NIMH training stipend support. Their activities are distributed thusly:

Full-time public service:	
State mental hospital	5
State medical school	2
Community mental health centers	3
Hospitals	5
Part-time public service—(Precise information is not available, but it is our impression that most graduates are doing part-time community service work.)	
Solo private practice	18

RESIDENCY TRAINING PROGRAM, UNIVERSITY OF COLORADO, DENVER, COLO., DOUGLAS B. CARTER, M.D., DIRECTOR

Of the 102 graduates of the psychiatric residency training program in the past five years, 98 have received support from NIMH stipends. These 98 graduates are now involved in the following activities:

Full-time public service:	
Military or public health	30
Education	11
State hospitals	9
Community mental health centers	4
Alcoholism and drug programs	1
Children's programs	3
Part-time public service:	
Education	6
State hospitals	7
Community mental health centers	17
Alcoholism and drug programs	1
Other	3
Solo private practice	6

SUPPLEMENTAL POSITION OF NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, IN SUPPORT OF TESTIMONY BY THE NATIONAL COALITION ON MENTAL HEALTH MANPOWER

The various State and local governments invest more dollars annually than the Federal Government does in training personnel in the mental disability professions.

Even in the one most easily identified mental health profession—psychiatry—State and local governments invest more dollars in training than the Federal Government.

Thus, any repeal, such as this, for continued Federal Government support must be heard in the knowledge that States and local governments already bear the heaviest load in training professionals in the mental disabilities fields.

The State government disability agencies thus make the following recommendations to the House Appropriations Committee:

1. We fully support the position of the National Coalition on Mental Health Manpower.

2. We further recommend that on all Federal training grants for mental health personnel a condition be attached whereby the person trained pay-back service (at a ratio of 2 years for each 3 years of training) in a "treatment" capacity in a "public mental disability program" (State or local; residential or community facility).

3. We further recommend that when Federal health dollars are appropriated for training personnel for service in "rural," "depressed" or "underdeveloped" areas that it be stipulated by this committee that State mental hospitals be considered as qualifying under the above criteria.

4. We further recommend that the NIMH training funds be expanded by $3 million on the condition that such increase be strictly earmarked for initiating and/or expanding the following programs in the training of persons in the mental disabilities professions:

(a) Intensive studies be initiated by HEW on the use of foreign educated doctors in the public mental health system.

(b) Continuing education.

(c) Career ladder programs.

(d) New career programs.

(e) Experimental and special mental health manpower programs (associate degrees, etc.).

(f) Mental health manpower analytic studies (planning and directions for future).

(g) Comprehensive mental health manpower assessment.

WILLIAM HALL, M. D., *South Carolina.*
ROBERT HAINES, M.D., *Kansas.*
HAROLD MCPHEETERS, M.D., *SREB.*

EXHIBIT C

THE NEED FOR CONTINUED SUPPORT OF THE TRAINING OF PSYCHOLOGISTS

Mental illness, when not directly caused by the strains of living in today's complex society, is at the least exacerbated by the resultant "future shock." Society will only become more and more complex and the incidence of mental illness, if unattended, will only become greater.

It has been estimated by HEW's ADAMHA that by 1980 approximately 91,000 psychologists will be needed to provide mental health services. This estimate assumes that only a relatively low 10 percent of the population will be in need of such services. It also assumes that each person in need, or each patient, will receive a total of only 6 hours of treatment during the entire year—91,000 psychologists working full-time to provide 10 percent of our population with 6 hours of service in the year 1980!

However, even that level of mental health service will seem generous when compared with the situation which will exist if the training of psychologists is not supported at least at present levels.

There are now aproximately 80,000 psychologists with an M.A. or Ph.D. If present trends continue, 3,000 Ph.D.'s and 5,000 M.A.'s in psychology will be produced annually. By 1980 that will add 15,000 Ph.D.'s and 25,000 M.A.'s to the pool of psychologists for a total of 120,000. This 120,000 will be reduced somewhat by deaths and retirements, but not to any very substantial degree, since the median age of psychologists is only 42 years, but the resulting manpower pool should aproximate 110,000.

More importantly, only 39 percent of the total professional effort of psychologists is in the provision of mental health services, at this time, in spite of the fact that 30 percent of psychologists hold down two jobs. If this proportion of effort continues, and it apparently seems to be doing so by projection, the pool of 110,000 will result in only 43,000 psychologists supplying mental health services in 1980 against a projected, full-time equivalent need of 91,000—a shortage of 48,000!

EXHIBIT D

THE NEED FOR CONTINUED SUPPORT OF THE TRAINING OF NURSES FOR PSYCHIATRIC MENTAL HEALTH CARE

The American Nurses' Association estimates that there is a present shortage of 143,000 nurses necessary to meet today's needs and there will be an additional need for 100,000 more than that by 1980. In the specific area of psychiatric or mental health nursing, the manpower shortage is just as acute.

Presently, the Division of Miometry of the National Institute of Mental Health reports there are about 37,000 psychiatric or mental health nurses now in practice and it is estimated that this is 5,000 short of what is currently necessary. It is also estimated that in just 4 short years there will be a need for 95,000 nurses with psychiatric or mental health training. It is our firm contention that the President's budget will further increase those needs by cutting the number of trainees from the present numbers of 1,272 to 1,119 for 1976. Traineeships and school programs support must be substantially increased if we are to meet current and future commitments.

Psychiatric nursng will suffer along with other nursing programs if the President's budget is enacted. In fiscal year 1975 there were 113 undergraduate psychiatric nursing programs and 59 graduate programs receiving NIMH assistance. These figures represent a reduction in the number of psychiatric nursing programs in fiscal year 1972 (134 and 52 respectively) when phase out was seriously attempted. In total, the number of psychiatric programs, including undergraduate, graduate, child psychiatry, teach, career service stipend, research trainings, short term special areas, pilot and special projects have been reduced from 208 in fiscal year 1972 to 193 in 1973, and to 176 in 1974. Today we are at a level which is less than fiscal year 1973.

The total picture for nurse traineeships is just as bleak. The Department of Health, Education, and Welfare estimates that in 1972 there were only 27,000 RN's with advanced degrees. Only 3,700 RN's have graduate preparation in psychiatric mental health practice. This represents only 22 percent of the total number of nurses needed to teach and administer.

The National Institute of Mental Health estimates there is a current need of 5,000 RN's with graduate preparation in psychiatric mental health care (1,300 less than we have today). This same study predicts that we will need at least 50,000 by 1985.

Traineeships in psychiatric nursing have slowly decreased over the past several years too. In 1968, for example, there were 1,681 NIMH traineeships in psychiatric nursing (1,316 graduate and 365 undergraduate). In 1975, however, there were only 1,272 NIMH traineeships (989 graduate and 283 undergraduate). If the President's budget is accepted, there will be 153 less traineeships next year than this year. This reduction is particularly distressing because the lack of availability of student assistance as well as the reduction of institutional assistance will cause greater economic burdens on students who wish to become nurses. Several universities have already increased their tuition more than 10 percent this year alone and this does not include what could happen if capitation grants were eliminated. For example:

	September 1974	September 1975	Increase
Catholic University:			
Undergraduate nursing	$2,450	$2,650	$300
Graduate nursing	2,600	2,800	200
Boston University:			
Undergraduate nursing	2,890	3,280	390
Graduate nursing	2,890	3,280	390
Cornell University: Undergraduate nursing	2,050	2,500	450
Georgetown University: Undergraduate nursing	2,600	2,900	300

Graduate level students in nursing depend heavily on Federal assistance to finance their education. More than 50 percent of all graduate students receive Federal assistance in masters level nursing programs. We expect, because of rising tuition costs and increases in the cost of living, many more students will need aid if they are to go on to graduate programs. Unfortunately, there is little help to graduate students from private or State sources.

These statistics support a compelling argument for continued Federal funding for nursing education pograms so that nursing manpower shortages can be alleviated and students entering the nursing profession can specialize in areas in which they are most needed and can provide the type of health care all American's deserve and expect.

EXHIBIT E

NUMBER OF STIPENDS FUNDED BY FEDERAL TRAINING GRANTS FOR FISCAL YEAR 1972–75 AND PROPOSED FOR 1976

	Number in fiscal year—		Number in phase out [1] for fiscal year 1976	Number if fiscal year 1976 is restored to fiscal year 1975
	1972	1975		
1. Psychiatric residency trainees	3,373	1,222	[2] 567	[2] 567
2. Psychiatric nurses trainees	1,287	1,119	690	1,259
3. Psychiatric social work trainees	1,476	1,162	718	1,253
4. Psychologist trainees	2,241	2,065	1,520	2,213

[1] The $45,000,000 requested by HEW for fiscal year 1976 will ultimately achieve the Administration's determination to phase out all mental health training, defying Congressional funding of these programs.

[2] No new appropriations are requested by NIMH for psychiatric residency training for fiscal year 1976. Even if appropriations are restored by Congress, NIMH plans to phase out psychiatric residency training and will divert these funds to manpower programs.

WITNESSES

MRS. MARY AKERLEY, PRESIDENT, NATIONAL SOCIETY FOR AUTISTIC CHILDREN
KATHLEEN DOYLE, NATIONAL AFFAIRS CHAIRMAN

Mr. FLOOD. Mrs. Mary Akerley, the National President of the National Society for Autistic Children.

Mrs. DOYLE. I am Kathleen Doyle, the national affairs chairman for the National Society of Autistic Children.

I would like to present to you Mary Akerley, our very able national president.

Mrs. AKERLEY. Good morning, Mr. Chairman and members of the committee.

I am not going to read our statement but request that it be printed in the record of the testimony.

[The above-referred to statement follows:]

Mr. Chairman and members of the subcommittee, I am Mary S. Akerley, president of the National Society for Autistic Children. For the past 2 years I have chaired the National Society for Autistic Children's National Affairs Committee. I am currently serving on the National Association for Mental Health's Public Affairs Committee, as well as serving as the first vice-president of the Human Services Institute for Children and Families. I am also the mother of an autistic child. I would like to express my thanks to the committee for granting me the priviledge to represent the National Society for Autistic Children before you today.

Autism is a condition which effects 4 out of every 10,000 live births and is characterized by severe problems of communication and behavior as well as an inability to relate to other people in a normal manner. Although autistic children look like normal children and often are very beautiful and graceful, at times they make bizarre gestures and grimaces, flap their hands and walk on their toes. Autistic children often repeat with astounding accuracy such things as television commercials and lists of presidents, perform amazing feats of memory, master incredibly complex mathematical functions but never learn their own name. Some are actually mute, while many others lack the meaningful speech which is a vital component of normal human relationships and communication.

They live in a world apart, seemingly inaccessible. Parents and others write about them as "children apart", "the glass ball", and "the trance children". It is not surprising that children with such characteristics have many behavior problems. Some scream for hours, no amount of efforts on the part of parents can comfort them. Many can go for days with little sleep or food. Autistic children may be frightened of harmless things, such as garbage cans, and on the other hand ignore real danger.

Traditionally, autism was considered a mental or emotional disorder and as a result the research, what little there was, was carried on primarily by NIMH. In only the last 18 months, it has been recognized that autism is a neurological handicap and in view of this discovery it is imperative that new neurological research be started and new innovative habilitative programs be designed in terms of what will help autistic individuals. In other words, the traditional psychoanalytic therapies that dealt primarily with the environmentally caused psychosis concept didn't work. Furthermore, the traditional research that was done has been relatively unproductive in determining the possible causes of autism. Thus, the thrust of our statement today will focus on two basic issues, habilitation and prevention.

HABILITATION

The national society chooses to use the word habilitation instead of rehabilitation because autistic children never have been normal. In the area of habilitation we will first turn our attention to the National Institute for Mental Health. While we stated earlier that NIMH was the principal place where research on autism was carried out and most of it not effective, the institute still has a very definite role to play in the field of autism. Many of the original experimental treatment programs for autistic children were developed either by NIMH or with NIMH support. There is indeed a behavioral component in autism that is appropriate for NIMH to be addressing and we would be extremely disappointed to see efforts in that direction curtailed. We therefore feel that funding for research and training in NIMH should in no case be less than it was in fiscal year 1975. In fact, a modest increase would be appropriate. We are distressed to see that the President's budget calls for a decrease of $19 million. We urge the committee to reject that proposal.

NSAC is particularly interested in the developmental disabilities bill since for the first time autism is specifically included in the language denoting the persons to be served by the legislation. Developmental disability is one of the few items in the President's budget which is encouraging because no cuts are proposed, either real cuts or paper cuts. However, the legislation has never been funded at authorization levels, a fact which the renewal legislation also takes into account and actually proposes significantly lower authorization levels. We would recommend to the committee that main or supplemental legislation funding be adhered to at the authorization levels, which take into account inflation and still remain modest at $40 million for fiscal year 1976 and $50 million for fiscal year 1977.

We would also like to remind the committee that the purpose of this legislation is to devise new programs and fill the currently existing gaps in functioning programs and services. As the gaps are identified and the services needed determined the money must be available to put into the programs or there will be no way the programs can meet their objectives. As more and more clients are identified who can benefit from the deinstitutionalization concept available funding to provide them with the services they need to maintain deinstitutionalization will be a must.

The national society would remind the committee that legislation which would alter the Federal role in public education is still pending. We are referring at this time to S. 6, Williams' bill. It is on record as shown by decisions in numerous State court cases that everyone has a right to a public education. There is a Federal responsibility to assist the States in meeting the goal of a public education for all persons. NSAC fully supports the excess cost formula section of the Williams' bill as an excellent means for achieving that goal.

According to the excess cost formula, every State must spend on a handicapped child what it spends on a normal child. The maintenance language in the bill says that a State gets no Federal aid if it excludes any children. Because the cost of special education is higher, the State can subtract what it has already spent from the total cost of the program, the difference representing the excess cost. Under the Williams' bill, the Federal Government pays 75 percent of the excess cost, the State pays the remaining 25 percent.

At the present time, there is an actual bill in the Senate to extend the Mathias amendment to title VI, grant to States for education of the handicapped and we urge the committee to appropriate no less than $200 million for this legislation. Last years' education appropriation was revised because of the Mathias amendment and even then the appropriations were only one-sixth of the authorization, far too little. We would remind the committee, if you spend $5,000 per year on a handicapped child in school for a period of 10 years a total of $50,000 that figure is far less than the $400,000 figure necessary to keep him in an institution. Not to mention the fact, that in many cases the child will probably become a contributing human being, a taxpayer, rather than remain a vegetable, a certain tax drain.

We would like to see renewal of the Vocational Education Act, which officially expires June 30 of this year, including further provisions to insure that the 10 percent setaside will act as a catalyst toward meaningful State matching. We would further recommend that not less than 10 percent of all public funds spent within a State for vocational education services be spent solely for vocational education of handicapped persons.

The President's budget proposes a decrease of $39 million for community mental health centers. We feel that this is an enabling program as a vital part of the deinstitutionalization effort. We hope the committee will maintain adequate funding for this program. Certainly $200 million is not too much.

NSAC would like the committee to know that it fully supports the $596 million increase in the SSI, fiscal year 1976 budget and regards it as a most valuable program. Along with that thought goes the idea that if people can live in the community and make use of their supplementary income as well as receive proper vocational rehabilitation training, which we also support some of them will indeed begin to maintain themselves, thereby ultimately reducing their SSI payments.

PREVENTION

At this time we would like to turn our attention to prevention. The national society firmly believes the only way at this time to prevent autism is through research. No one knows what cause autism and until we know what causes it, we can't, even in our wildest dreams, hope to prevent it. There were in fact,

prevention programs when autism was still thought of as an emotional disorder, however, in the light of new and recent knowledge that autism is indeed a neurological disability we must begin thinking how to prevent or least minimize the effects of autism in neurological terms.

Our greatest hope lies with the National Institute for Neurological, Communicative Diseases and Stroke and it's ability to conduct new and enlightening research. We would like to sincerely thank the committee for it's attention, interest and support last year, especially the remarks in the report saying that the Institute should begin a program of research on autism. We would further like to report to the committee that the Institute has indeed, even without additional moneys, begun a preliminary effort. We have been advised that there are plans for a workshop this summer at the Institute which will bring together people who are currently doing the most significant research in the field. Their purpose will be to assess what is being done and what directions should be pursued to avoid duplication of research efforts.

While this is commendable, it is only a beginning, all that can be done with the present appropriations. We believe it would be a waste of time, energy and money not to follow up on the findings and recommendations of the workshop. Therefore, we would urge that the committee appropriate to NINCDS the sum of $1 million for research on autism. This figure would fund approximately 20 projects. We feel that this is a most modest and reasonable sum. There has never been a concerted Federal effort for research on autism. Autism has been treated on a catch as catch can basis and in a very real sense, America has a massive debt to the victims of this cruel and puzzling disease. A $1 million appropriation to NINCDS would make an excellent beginning.

The National Committee for Research in Neurological Disorders appeared yesterday before this committee and supported a figure of $193 million for the Institute. NSAC supports that figure and believes that if the Institute is to carry out it's work in any kind of meaningful fashion that is a most realistic figure. Generally speaking, every analysis of the NIH budget that is published says Cancer Institute and other Institutes. The budget for the National Cancer Institute for fiscal year 1976 is proposed at approximately $605 million. This is understandable because cancer strikes almost every family in one form or another. What most people do not realize is so do brain disorders.

We don't mean to suggest that the cancer budget be cut rather that the committee give serious thought to the fact that NINCDS is the Institute designated as being responsible for individuals who are deaf, mentally retarded, epileptic or afflicted with learning disabilities, muscular dystrophy, Parkinson's disease, cerebral palsy, myasthenia gravis, hereditary diseases, spina-bifada, autism and victims of stroke. This is an incredible number of human beings. Most of the individuals mentioned don't die. A concerted effort to alleviate and prevent these disorders through stepped up research at the Institute would be humane as well as economical. The time is now for the committee and the Federal Government to reflect long and hard whether they are willing to turn their backs on so many human beings.

Thank you.

Mrs. Akerley. I would like to very briefly highlight what we have tried to do in obtaining services for autistic children through Federal programs.

The national society believes that it would not be efficient nor economical to seek out categorical programs for autistic children.

We appeared before this committee last year and brought with us Dr. Mary Coleman, who discussed with you some of the current research and described the syndrome of autism, so I am not going to take up your time with that now.

I am sure that you will remember that autism, because it strikes so few victims—4 in 10,000 live births—is not the kind of program that lends itself to a categorical approach. We have therefore looked through the service programs in the Department of Health, Education, and Welfare seeing where our client population could best be served. Very, very often they can be served along with other disabled individuals. This is economical, and it's also therapeutic. Besides being

a community disorder, autism is a social disorder. If you tried to serve autistic people categorically, you would simply re-enforce their social isolation. I present this to the committee this morning because it's the philosophy on which our statement is based.

We are asking for a two-pronged approach to the problem. One is habilitation. We don't use the word "rehabilitation" because autistic persons have never known the privilege of being normal. They are born handicapped and they remain handicapped through their lives. So what must be done is that they must be habilitated.

Prevention is the second general kind of service that we seek. Until you know what causes a disorder, of course, you cannot prevent it. So our prevention thrust is in the area of research. We need to find out what causes this syndrome and therefore how it can be prevented or how its effects can be lessened in the life of an individual.

You will find in our testimony attention given to various service programs. Again I am not going to repeat the whole thing here. There are two points I would like to emphasize.

One, there is an absolutely terrifying move right now, it seems to me, to withdraw Federal support from those programs which have both a Federal and a State mix of dollars. I am thinking particularly of the SSI program, where the administration now is saying the States have to put up more money. They have to move up to a higher percentage in the mix. At the same time, courts all over this country are telling the States they are responsible for the very expensive educational services required by handicapped young people. The States don't know where the money is coming from.

The Federal Government has considered various ways of more adequately funding special education programs, but it really hasn't done anything about it.

Last year we had the so-called Mathias amendment, which proposed over $600 million for special education. This was to be the Federal effort. It was a response to these lawsuits. What happened, of course, is history. The appropriation was $100 million and it was cut back in the President's rescission figures to $50 million. Fortunately, Congress didn't stand for that.

But there is such a gap between what is needed and what is being done that we feel it's important to emphasize this morning that we cannot take away Federal support, such as is being considered with supplemental security in some and, on the other hand, turn around to the States and say, "You have to do more in these other areas."

The kids are going to suffer. What is going to happen if they are not adequately educated? They are going to be institutionalized. I think there are some very helpful figures here.

If we assume 10 years of public schooling for a handicapped person at an average cost of $5,000 a year, that means a Federal effort before the person is 16 or 17 years of age of $50,000 to $60,000. That is a lot of money.

If we don't do that, let's assume we institutionalized the young person and he lives to a normal life span of 65 years, we will have spent $400,000 on the same individual and gotten nothing for the money and ruined a life. So I feel those figures speak very eloquently.

We also wish to report that we support the Committee on Research in Neurological Disorders. That committee appeared before you yes-

terday with a presentation for the National Institute of Neurological and Communicative Disorders and Stroke. That Institute badly needs the $193 million the committee recommended. We support that. We are a member of that committee.

I would like to add this additional piece of information. Last year this committee suggested that the Institute begin research on autism. I would like to report to you, Mr. Chairman, that the Institute has been most responsive and is currently designing a program, the first step of which will be a workshop on autism, to be held this summer.

In discussing with Dr. Tower what would be needed to implement the results of that workshop, he said that a figure of $1 million for that particular project would be a minimum. That would support approximately 20 grants of $50,000 each. It's his feeling that the workshop will indicate specific areas where research could be carried on. This is what he would need to maintain the effort.

$193 million sounds like a lot of money. I think it's interesting that when one looks at various analyses of the Federal budget, which come across one's desk, one sees under NIH frequently two subheadings—cancer and other. It's kind of lopsided.

I would not for one minute suggest this country reduce its effort to find the cause and the cure for cancer. There is probably no family in the country that hasn't been affected by this disease. I would also respectfully suggest to the committee that the Institute of Neurological and Communicative Disorders and Stroke covers just as many families, if not more, when you think of the disease entities for which it is responsible—Parkinson's, cerebral palsy, epilepsy, mental retardation, learning disabilities, Huntington's disease, various forms of deafness, blindness and, of course, stroke, which is the third biggest killer in the United States. Now we have added autism to the list of disorders for which that Institute is responsible.

To ask for $193 million is not an unreasonable figure.

I would also suggest that the people affected by this Institute are expensive people not to care. If one has the misfortune to get cancer or heart disease, one dies or one gets better. If one is crippled by stroke, cerebral palsy, autism or mental retardation, one can have years of disability which require tremendously expensive supportive services. Not to fund the Institute, which could prevent or mitigate such disorders, would be very, very poor economy.

Thank you very much, Mr. Chairman.

Mr. FLOOD. Thank you.

MAY 14, 1975.

EYE RESEARCH

WITNESS

DR. JAY ENOCH, GRADUATE RESEARCH PROFESSOR, UNIVERSITY OF FLORIDA, MEMBER, NATIONAL ADVISORY EYE COUNCIL, NIH, AND PAST PRESIDENT, ASSOCIATION FOR RESEARCH IN VISION AND OPHTHALMOLOGY

Mr. FLOOD. Dr. Jay Enoch, graduate research professor of the University of Florida, Association for Research in Vision and Ophthalmology.

Dr. ENOCH. Mr. Chairman and members of the committee, I appear today at the request of, and with the support of the trustees of the Association for Research in Vision and Ophthalmology (ARVO). This organization represents about 2,100 scientists, teachers, and clinicians having an active interest in eye and vision research. We are deeply concerned regarding the proposed Presidential budget for the National Eye Institute for fiscal year 1976. That budget calls for a substantial reduction in the level of our ophthalmic research effort. I doubt that this is the intent of Congress and the American people. Certainly, the solution to inflation and recession is not to reduce expenditures directed toward solving the problems of blindness and visual disabilities. This neither meets the humanitarian needs of our people or saves the country money.

Support for ophthalmic research in the United States is largely centered within the National Eye Insttiute (table 1). Note that the NEI provides 80 percent of that total effort. Thus, the fate of research in this area is closely tied to the amount of money allocated by Congress to the NEI. Although dedicated and able, private philanthropic organizations simply do not have the resources to take up any significant amount of slack.

TABLE 1.—VISION RESEARCH FUNDING SOURCES FISCAL YEAR 1974

[In thousands of dollars]

	Funding	Percent of funds
NEI	$41,166	80
NIH exclusive of NEI	3,347	6
HEW exclusive of NIH	1,567	3
Other Federal	3,240	6
National Philanthropic and voluntary health organizations	2,484	5
Total	51,804	100

Although authorized by legislation of the Congress in 1968, the National Eye Institute first became an independent and functioning unit early in 1970. The Congress created this important administrative division in response to a clear need for action in this field. I can speak with some authority as I edited a document reviewing national ophthalmic research requirements at the request of the then National Institute of Neurological Diseases and Blindness. The Congress recognized that special action was needed in the field of blindness and vision just as cutbacks in NIH growth and development were being effected. Rather than having an opportunity to correct real deficiencies in programs, facilities, supporting services, manpower and allocation of resources, we have been faced each year with recurrent budgetary crises coupled with continuing inflationary pressures. The problem of blindness and visual impairment require attention, and past deficiencies need to be corrected. We badly need your help.

In table 2, I present the fiscal year 1976 President's budget.

NEI fiscal year 1976 President's budget (by mechanism)

Grants:	
Regular research:	
Noncompeting	$20,313,000
Competing	3,811,000
Subtotal	24,124,000
Special	468,000
Total, grants	24,592,000
Fellowships	2,653,000
Training grants	1,994,000
Research and development contracts	2,322,000
Total, extramural programs	31,561,000
Total, National Eye Institute	39,201,000

The fiscal year 1975 appropriation for the NEI was $44,133,000. Thus the fiscal year 1976 President's budget proposes a reduction in budget of almost $5 million (or 12 percent) in the face of continuing inflationary pressures. Furthermore, the NEI actually requires $27 million ($26,999,000) for ongoing, noncompeting grants alone. An added $6.7 million is needed just to honor these current commitments. Between the budgetary decrease, the large deficiency in funds for noncompeting grants and continuing inflation, without substantial upward revision of the President's fiscal year 1976 budget for the NEI, the ophthalmic research program will be seriously crippled. According to the President's budget we could fund only 15 percent of the valuable approved new or competing renewals of research projects. Think of this not only in terms of opportunities lost in the fight against blindness but in terms of the devastating effect on research manpower. If you were a physician embarking on a career for research against blinding diseases would you consider remaining in a career in which at any moment your work, even if proven to be of great value, might be halted because of widely fluctuating budgets from year-to-year? Can we afford not only to lose 85 percent of approved valuable research ideas as well as a high proportion of scientists from the field? This budget damages not only the present but the future.

Visual disability costs the Nation an enormous sum compared to the NEI budget. State and Federal aid to the blind costs $500 million annually; tax rebates and loss of taxes due to blindness costs $140 million each year, and lost productivity caused by blindness is estimated at $800 million.[1] The individuals affected require special care, special education and special devices in order to function in society. There are 350,000 people in this country who are legally blind; there are far larger numbers of individuals with seriously impaired vision. For example, 1.5 million Americans are unable to read newsprint even with correction. There are some 10 million others who have some degree of uncorrectable visual impairment. The cost in lost productivity, taxes, and maintenance of this substantial population is well over a billion

[1] Data are taken from K. Trouern-Trend, Blindness in the United States, Travelers Research Center, Inc., 1968.

dollars annually. In addition, about 95 million Americans require spectacles or contact lenses for adequate vision (NEI). Among diseases which restrict the ability of Americans to lead productive lives, visual impairments rank third (National Center of Health Statistics, 1971).

Research to prevent blinding diseases and other visual impairment represents the only effective means of reducing these enormous outlays for the visually impaired. Does substantial reduction in the national ophthalmic research effort help resolve these financial and human needs? Surely this is not the case. It seems to us that we must continue our research programs on blindness and visual impairment and correct the deficiencies of the past. Collectively, the extramural and intramural programs of the NEI are a superb national asset, unmatched elsewhere in the world. The National Advisory Eye Council recently requested an analysis of the state of eye research by the vision research program planning committee. Their 2-volume report has just been published and contains a detailed analysis of our current research and program funding. (Vision research program planning, report of the National Advisory Eye Council Vision Research Program Planning Committee. DHEW Publication Nos. (NIH) 75-664 (vol. 1), and (NIH) 75-665 (vol. 2), 1975.) This report identifies opportunities for research in vision and the causes of blindness. Future fiscal requirements are considered in depth. In its citizens' testimony, the Association for Research in Vision and Ophthalmology (ARVO) supports the proposed fiscal year 1976 budget of $75 million developed in this report. We have arranged the budget values (table 3) into a form similar to that presented by Professor E. Maumenee in his testimony for Research to Prevent Blindness, Inc.

TABLE 3.—ARVO PROPOSED CITIZENS' BUDGET, FISCAL YEAR 1976, NATIONAL EYE INSTITUTE

[In thousands of dollars]

	Percent	Amount
By activity:		
Grants:		
Research		[1] 57,679
Fellowships (title 1, Public Law 93-348, 1974)		4,000
Training (being phased out)		1,994
Subtotal grants		63,673
Direct operations:		
Intramural laboratory and clinical research		5,600
Research and development contracts		2,822
Biometry, epidemiology and field studies		533
Research management and program services		2,372
Subtotal direct operations		11,327
Total		75,000
Positions recommended		[2] 184
By program:		
Retinal and choroidal disease	37.4	24,869
Corneal diseases	18.0	11,969
Cataract	8.9	5,918
Glaucoma	13.4	8,911
Sensory-motor disorders and rehabilitation	22.3	14,828
Subtotal	100.0	[3] 66,495
Intramural laboratory and clinical research		5,600
Research management, biometry and program services		2,905
Total		75,000

[1] Includes $26,999,000 in noncompeting grants.
[2] In fiscal year 1975, there were 142 positions available to the NEI for all purposes. The President's budget for fiscal year 1976 calls for only 132 positions. Fiscal year 1976 begins July 1, 1975.
[3] Includes research and development contracts.

This budget can be defended on several grounds: (1) The public has a long standing and very great concern for the prevention of blindness and visual infirmity; (2) research is the valid approach towards reducing the human and financial costs of visual disability; and there are many pressing eye health problems which must be addressed; (3) the program of the NEI needs to be strengthened and balanced; (4) there are real opportunities present for the advancement of ophthalmic research; (5) it is anticipated that there will be a substantial rise (15 percent) in quality research proposals from the vision research community now that areas of special concern and opportunity have been pinpointed in the vision research program planning report (vol. 1, p. 56). In fact, the 2-volume report provides the supporting evidence for the citizens' budget.

NOTE.—In the direct operations budget 52 added positions are requested over the number contained in the President's budget. These are urgently needed to carry out this significant program and to modestly expand the intramural research activities of the Institute and to take advantage of the unique environment for research at the NIH.

In his testimony, Professor Maumenee has outlined several of the pressing problems and opportunities facing ophthalmic researchers. Rather than reiterate his fine outline of problems and opportunities, I would like to draw special attention to certain added matters. The first is macular degeneration, a disease affecting that part of the retina responsible for finest visual function and resolution. This is a problem which most commonly strikes individuals in the prime of life—the so-called executive age. Macular degeneration accounts for 12.6 percent of all new blindness each year. We have no known cure for this disease although some progress is being made in defining the nature of pathological processes involved. Clearly, effort must be directed toward resolving this problem.

Corneal and external eye disease studies also require special attention. The cornea is the transparent outer lens of the eye. This delicate tissue can be attacked by bacteria, fungi, and viruses and is subject to allergic reactions, and, because of its exposed position, physical and chemical trauma are commonly encountered. Maintenance of its transparency and optical integrity are essential for sight. Progress is being made in pharmacological therapy, although much remains to be done, particularly in the treatment of, and handling of herpetic corneal disease. There is evidence that in chemical burns of the cornea, the combination of corneal transplants and soft-contact lens wear provide a relatively good chance of recovery where previously the prognosis was nearly hopeless. Recently, a special microscope originally developed by David Maurice, of Stanford, has been modified and adapted for the routine study of individual cells in the living corneas in patients. This opens a whole new era in the evaluation of normal and abnormal disease processes in man! Such research must be encouraged.

Lastly, I would like to call attention to a remarkable analysis of the organization of the visual neural pathways made by David Hubel and Torsten Wiesel, of Harvard, in their Friedenwald Medal Address at the recent ARVO annual meeting. Their research will clearly advance our understanding of visual pathway anomalies and hopefully result in improved diagnostic techniques. Their results also will help in defining the nature of the pathological process in sensory depriva-

tion amblyopia—a problem of the newborn and young. Hopefully, these developments will lead to new treatment regimens for this important class of patients.

We hope this committee will carefully review the President's budget for the National Eye Institute. We feel it to be defective. In our efforts to resolve anomalies of the visual system, a greater sense of stability is needed. Science just cannot flourish in a continual atmosphere of crisis. Continued annual budgetary uncertainties will only succeed in driving away talented individuals. Certainly, no one wants to build a career on uncertainty. We ask that the Bureau of the Budget and the President's office review their policies toward health and eye care. We merely seek to serve the Nation and to solve the problems of the visually impaired. We need your support and help to achieve these goals.

Thank you.

Mr. FLOOD. Thank you.

FUNDING OF HEALTH PROGRAM

WITNESSES

WILLIAM J. SKINNER, VICE PRESIDENT, COALITION FOR HEALTH FUNDING, REPRESENTING THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

GLENN ALLISON, SECRETARY-TREASURER, REPRESENTING THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

ALFRED ZERNIK, WISTAR INSTITUTE, PHILADELPHIA, REPRESENTING THE ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES

Mr. FLOOD. Mr. William Skinner, vice president of the Coalition for Health Funding.

Mr. SKINNER. Good morning, Mr. Chairman.

I am William Skinner. On my right is Glenn Allison of the National Association of Social Workers, and Alfred Zernik, Wistar Institute, Philadelphia, representing the Association of Independent Research Institutes.

We are pleased to have the opportunity to be here. We have submitted to you a more lengthy statement which we would ask to be inserted in the record.

[The statement follows:]

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Statement Before

Subcommittee on Labor-HEW

Committee on Appropriations

U.S. House of Representatives

on

FISCAL 1976 BUDGET FOR FEDERAL HEALTH PROGRAMS

by

COALITION FOR HEALTH FUNDING

William J. Skinner, Vice-President

May 14, 1975

This statement is presented on behalf of the Coalition for Health Funding, representing 45 non-profit organizations concerned with adequate Federal health appropriations. A Coalition membership list is attached.

The Coalition, now in its fifth year, has annually proposed an alternative to the President's health budget, documented line by line with supporting data. Our members represent a wide cross-section of professional and public concerns in the health field. We meet periodically to assess the status of health funding, which our individual member organizations ascertain through their contacts at the health agencies. At an annual meeting, we review the facts and figures gathered by our members, and begin to devise our estimates. Subsequently, our Board of Directors looks at our aggregate totals, paring down where necessary, so that we may confidently present conservative estimates as the ones we offer today.

This process has been successfully executed for the past five years, enabling the Coalition to arrive at estimates of the minimum appropriations necessary to maintain vital national health programs at viable and effective levels of operation. Although our estimates for fiscal 1976 exceed FY1975 appropriations by some $500 million, this represents only a 10.8% increase, which falls below most inflation estimates.

Our suggested funding would provide quality research, training and services, approximating FY1975 levels, with a small margin of room for growth for a few new or expanding programs. Considering the vast disparity between agency requests to OMB, and the President's ultimate requests (as documented in the Forward Plan for Health), we feel confident that such amounts that this Subcommittee may appropriate above those contained in our recommendations will be well and wisely spent.

Because of a lack of authorizing legislation, we have omitted comment on health manpower development programs at the Health Resources Administration. We will present our recommendations for manpower funding when a bill has cleared the Congress.

The President's fiscal 1976 health budget reveals an alarming lack of concern for health programs, both on an individual basis and as they relate to a comprehensive system of health care delivery. While asking to spend over $350 billion -- the largest budget request in time of war or peace -- the President proposes $4.83 billion for HEW's controllable health programs (exclusive of Medicare and Medicaid which are financing programs, not "health" programs). This represents barely 1.2% of the Administration's overall spending plan.

When these dollar figures are translated into the devastating impact they would have on the health and well-being of our citizens, it is easy to see that the Administration is, at best, unrealistic in its budget proposals for health in the coming fiscal year:

Disease control	down $17 million
Direct service programs	down $78 million
Health research	down $285 million
Mental health, drug & alcoholism programs	down $79 million
Health manpower & resources development	down $481 million
TOTAL HEALTH SPENDING*	DOWN $940 MILLION

*exclusive of Medicare and Medicaid

Our recommendations, briefly summarized in comparison with the President's requests and FY1975 appropriations below, give a more realistic picture of the need for adequate funding.

(fiscal years) ($ in thousands)

	1975 Appropriation	1976 President's Request	1976 Coalition Minimum
FDA	196,356	203,000	220,000
HSA	1,314,795	1,045,435	1,530,129
CDC	149,906	133,311	173,294
NIH	2,090,418	1,805,000	2,295,800
ADAMHA	795,608	653,684	915,611
HRA (less manpower)	481,270	141,600	333,757
Asst. Secy.	75,877	66,968	61,593
RSA	812,945	789,225	876,700

The Coalition is in total opposition to the Administration's plan to absolve itself of responsibility for many of the direct health service programs which it has initiated, and to the suggestion that states and localities find substitute funding for these programs. The growing tendency for the Federal government to begin programs with partial state and local government or private organizational support and cooperation and subsequently to renege on its share of the funding is cause, we believe, for considerable alarm. The government is likely to find few partners for such programs in the future, unless and until it builds assurances of continuity of Federal support into these programs, thereby providing the necessary level of confidence to the proposed partnership.

The Health Services Administration, where much of this reneging occurs, is responsible for most of the Federal government's direct care and service programs. Yet, the Administration proposes funding reduced by nearly $270 million for HSA programs. Many of these make available health services that, otherwise, many citizens would have to go without.

Community health centers are a good example of such services. These centers, usually located in inner-city and rural areas without adequate health care facilities, are the only link, for many citizens, to adequate, immediate care. The Administration speaks about the need for greater accessability to health care, and with typical incongruity, proposes on the other hand to take away this accessability from a substantial number of disadvantaged Americans. The Coalition recommends $230 million for these centers, compared to $200.4 million appropriated in FY1975.

Migrant workers, uncovered by Medicare or Medicaid, and who enjoy limited constituency in the Congress, are also victims of this incongruity. These citizens must rely solely upon Federally-funded health care centers for services, yet the President proposes funding for these centers at a level below even FY1973 appropriations. The Coalition recommends $45 million for migrant health, compared to $23.75 million in FY1975.

These cuts, combined with the planned termination of 314(d) comprehensive health grants to states, would shift the burden of spiraling health care costs to those citizens who can least afford it.

Only a few weeks ago, Administration witnesses testified before this Subcommittee that the United States held the unenviable position of 15th among nations of the world in infant mortality; yet, the same Administration plans to cut programs aimed at improving maternal and child health by some $83 million. The states are, already, barely able to carry out their statutory mandate to establish projects for maternal and infant care, intensive care for high risk infants, comprehensive health services for children and youth, and dental health services for children. Statistics show that two-thirds of chronic handicapping conditions existing among children could be prevented or corrected with proper care. The President's recommended budget levels in this area make such care virtually unavailable to many. An appropriation of $339.75 million is recommended here.

The Administration is ignoring, with equally poor reasoning, those families who wish to limit the number of children they have. Family planning services, and population research, encourage a more conscious determination of family size by concerned parents. Though the HEW Forward Plan for Health called for $250 million in family planning project grants for FY1975, the funding level has remained at approximately $100 million for the past two years. The President would reduce this even further, in FY1976, by over $20 million. The Coalition recommends $135 million for family planning in FY1976.

With the President's proposed funding for the Center for Disease Control, the Administration seems to imply that all the rats have left the ghettos, that venereal disease (which has climbed to epidemic proportions in some areas of the Nation) had suddenly been wiped out, that all the slum landlords had repainted their buildings' interiors with lead-free paint, and that industry suddenly became enlightened to the dangers of occupational health hazards and all the polyvinyl chloride plants had disappeared. We know this is not the case. The host of preventive efforts at the Center for Disease Control are not duplicated by any other Federal agency, and there are no states or localities to make up for the lack of support advocated in the Administration's health budget. An appropriation of $173.2 million could adequately support CDC activities in fiscal 1976.

The Nation's major sponsor of life-saving and life-improving biomedical research is the National Institutes of Health. Its programs of scientific research and its method of review have earned international acclaim. Its creation and maintenance of atmospheres for scientific inquiry has produced 54 Nobel laureates.

Last year, Congress enacted legislation mandating increased NIH research efforts in arthirits, cancer, diabetes, aging and sudden infant death. Also passed was legislation extending essential programs in biomedical research training. Despite these Congressional imperatives, the Administration has proposed a $285 million reduction in funding -- almost 14 percent below FY1975 NIH appropriations.

The Administration's own Forward Plan for Health identified clinical and non-clinical research inflation at 16 percent and nine percent, respectively. Thus, the President's budget request, reducing individual institute funding by nine to 36 percent, will seriously hamper much on-going and future extramural research, sponsored by NIH. The request allows for virtually no research expansion, requiring, instead, serious and significant program reductions. The Institutes need a minimum appropriation, we feel, of $2.295 billion in fiscal 1976.

The Administration fails to place even an historical perspective on health funding by proposing nearly a $150 million cut in programs designed to prevent alcoholism and drug abuse, and promote mental health. Many of our citizens are suffering hardships, due to the economy, which are having devastating effects on their personal lives. Loss of employment, reduced salaries, inability to secure loans and housing -- these problems are injurious to mental well-being, and history shows drug and alcohol addiction, emotional disturbance and even suicide on the rise in such times.

The Administration would diminish general mental health research and training below FY 1973 levels, which could result in an abrupt termination of most psychiatry and behavioral sciences programs at the National Institute of Mental Health. The Coalition recommends $210.2 million for mental health research and training in FY 1976. Federal support of community mental health centers would be confined to continuation grants only, and at a figure far too low to permit these community-based centers to continue their fine record of reducing admissions to more expensive and less caring state institutions. Many low-income citizens would have no access to mental care whatever, without these centers, and we believe $258.2 million would be an adequate appropriation in FY1976

Drug abuse, no longer solely confined to large urban centers, is proposed to be funded at a level which doesn't even account for the inflation connected with sophisticated training and research funded by the National Institute of Drug Abuse. The Coalition recommends $235.2 million to combat drug abuse in fiscal 1976.

The President's alcoholism research budget reveals a total lack of commitment to combatting the human suffering, crime, loss of productivity and loss of life connected with alcohol addiction. Reduction in formula grant funds for state anti-alcoholism projects not only diminishes state monies for local alcoholism efforts, but damages the credibility of the Federal government while increasing state reluctance to establish viable anti-alcoholism efforts. As the unemployment rate continues to rise, attendant despair and frustration is leading to an increase in heavy drinking which is bound to add new numbers to the Nation's more than nine million alcoholics. The programs at the National Institute on Alcohol Abuse and Alcoholism require a minimum appropriation of $184.5 million in FY1976.

At the Health Resources Administration, programs leading to the orderly planning and evaluation of Federal health efforts show a proposed rise in funding for FY1976 only at the National Center for Health Statistics. The Center is the major Federal agency responsible for data on vital events, health, injury, illness, impairments, use of medical, dental, hospital and other care services, and the personnel and facilities which provide these services. The Coalition endores the President's request of $25.6 million.

Health Services Research and Evaluation, on the other hand, is slated for a $10 million cut. Efforts to understand and improve health services organization, delivery and management, and training programs to prepare health administration teachers, are concentrated here. Without these services, the Nation will find it even more difficult to maintain cost-effectiveness in health, especially in regard to increasing the efficiency of hospital management, one of the most critical areas in health care today. The minimum appropriation necessary for these services is $50 million in fiscal 1976.

The activities of the Food and Drug Administration remain of paramount importance to consumers of foods, drugs, medical devices, cosmetics and materials used in the prevention and treatment of disease. Yet the Administration proposes a mere $7 million increase at FDA. The Coalition recommends $220 million in order for the agency to inspect some 60,000 food processors, over 6,000 drug manufacturers and distributors, determine the effectiveness of marketed drug products, regulate the DES content in meat products, standardize vitamin and mineral products, and develop standards for biological products -- to cite just a few of this agency's important tasks.

The Rehabilitation Services Administration has been held level for the past two years after a major decline in funding from fiscal 1972 to 1973. Now the Administration proposes a $25 million reduction in RSA's commitment to handicapped Americans. The President's budget recommendations here would deny the long-standing economic justification of this commitment, which is to transform the non-productive disabled into able, productive citizens. Also, RSA's programs for persons suffering from developmental disabilities -- long a neglected part of our population -- would receive an embarrassingly low level of support. Such a budget as the President proposes provides scant hope for escape from the inappropriate, and often inhumane institutionalization experienced by many of these severely afflicted persons. The Coalition recommends RSA be funded at $876.7 million in fiscal 1976.

The Coalition is disturbed at the proposal to reduce fiscal 1976 health appropriations by nearly $1 billion under current funding. We are equally disturbed at the way in which the President's proposed budget is prepared. Direct operating funds -- the monies with which the grants and contracts from the various health functions are administered -- have been taken from the divisional levels, where they are to be expended, and have been placed in the hands of the agency administrators. Congressional intent, as regards positions, travel, salaries, and equipment, has been distorted and lost to financial mismanagement, thus subverting direct Congressional control over utilization of health appropriations, and contributing to a lack of cost-effectiveness and accountability in health programs.

We feel it is highly detrimental to the future of the country to ask the American people to consider a national budget of some $350 million -- the highest estimate in our history -- with only one percent of it being set aside for controllable health programs.

The American people cannot consider such a budget proposal favorably. We trust that this Subcommittee will display its concern for the health and well-being of all Americans, by disregarding the President's health budget.

Attached to this statement are tables recommending line-by-line alternative funding for each individual health function to be considered by this Subcommittee. The accompanying narrative, which appears in booklets already distributed to the members of this Subcommittee, and to their colleagues, explains the rationale behind each recommendation made.

We know you will give just consideration to these views and figures, and we ask that you bear in mind that our proposed funding for fiscal 1976, with minor exceptions, represents only a maintenance of health services, research and training programs, at FY1975 levels. We also ask that you bear in mind that the President's budget proposals do not represent such a maintenance.

COALITION FOR HEALTH FUNDING

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National Council of Community Mental Health Centers
National Health Education Committee
National League for Nursing
National Medical Assn.
National Student Nurses' Assn.
Planned Parenthood/World Population
State University of New York
United Auto Workers
United Steelworkers of America

(fiscal years) ($ in thousands)

	1974 APPROPRIATION	1975 APPROPRIATION	1976 Budget Request	1976 Authorization	1976 CHF Minimum
CENTER FOR DISEASE CONTROL					
ease Control					
a. project grants					
1. Venereal disease	24,800	28,000	24,800		32,000
2. Immunization	6,200	6,200			11,000
3. Rat control	13,100	13,100**	5,410		14,410
4. Lead-based paint poisoning	9,000	9,000	3,500		9,900
ubtotal, Project grants	53,100	56,300	33,710		67,310
. Disease investigation, surveillance & control	36,667	40,409	43,429		44,055
. Laboratory improvement	8,092	9,368	9,989		10,310
. Health education	900	3,030	3,013		3,330
ubtotal, Disease Control	98,759	109,107	90,141		125,305
upational Health	30,600	31,986	32,181		37,000
ildings & Facilities	2,000	------	------		------
gram Management	6,221	8,813	10,989		10,989
OTAL, CENTER FOR DISEASE CONTROL	137,580	149,906	133,311		173,294
NATIONAL INSTITUTES OF HEALTH					
cer	551,191	691,666	605,000	803,500	727,000
rt & Lung	302,915	324,130	292,794	520,000	360,000
al	45,565	49,864	43,536	OPEN	55,000
ritis	159,447	173,121	148,409	OPEN	190,400
ological	125,000	142,498	114,955	OPEN	156,700
rgy	114,000	119,452	108,711	OPEN	131,300
ral Medical Sciences	176,778	187,400	161,630	OPEN	206,100
d Health	130,254	141,966	106,062	OPEN	140,510
g	------	------	16,190	OPEN	16,190
	41,631	44,133	39,201	OPEN	48,500
ronmental Health Sciences	28,879	34,949	31,113	OPEN	38,400
arch Resources	133,472	127,200	81,058	OPEN	139,900
rty Center	4,767	5,589	4,540	OPEN	6,100
ry of Medicine	25,871	28,450	28,815	OPEN	31,300
dings and Facilities	8,000	3,000	3,000	OPEN	27,700
ctor	12,000	17,000	19,986	OPEN	20,700
TAL, NATIONAL INSTITUTES OF HEALTH	1,859,770	2,090,418	1,805,000		2,295,800

tnotes at end of table

(fiscal years) ($ in thousands)

	1974 APPROPRIATION	1975 APPROPRIATION	1976 Budget Request	1976 Authorization	1976 CHF Minimum
FOOD AND DRUG ADMINISTRATION					
Food, Drug, Medical Device Safety	165,960	196,356	203,000	OPEN	220,000
HEALTH SERVICES ADMINISTRATION					
Community Health Services					
a. Community Health Centers	206,100	200,400**	155,190	280,000	230,000
b. Grants to States	90,000	90,000**	0	160,000	135,000[1]
c. Migrant Health	25,000	23,750**	19,200	80,000	45,000
d. Direct Operations	22,133	------	------	------	------
Subtotal, Community Health Services	343,233	314,150**	174,390	520,000	410,000[1]
Maternal and Child Health					
a. Grants to States	132,678	266,951	193,922	346,500	312,500
b. Project Grants	111,273				
c. Research and Training	21,917	25,917	17,500		24,500
d. Direct Operations	4,340	------	------	------	------
e. Sudden Infant Death Syndrome Information Dissemination	------	2,000		3,000	2,750
Subtotal, Maternal & Child Health	270,208	294,868	211,422	349,500	339,750
Family Planning	103,225	100,615**	79,435	2	135,000
Health Maintenance Organizations	60,000	79,200[3]	18,612	85,000	25,000
National Health Service Corps	13,000	13,000**	12,529		20,000
Quality Assurance (PSROs)	------	37,000	54,682	OPEN	54,682
Patient Care & Special Health Services	116,961	112,684	115,468		115,468
Indian Health Service	234,210	293,153	310,999	OPEN	350,000
Buildings and Facilities	21,000	1,300	13,229		13,229
Regional Office Central Staff	5,602	------	------	-------	------
Program Direction	5,470	31,825	29,569		30,000
Emergency Medical Services	27,000	37,000	25,100		37,000
TOTALS, HEALTH SERVICES ADMIN.	1,199,909	1,314,795	1,045,435 (- 24,671 trust funds)		1,530,129

Footnotes at end of table

(fiscal years) ($ in thousands)

	1974 APPROPRIATION	1975 APPROPRIATION	1976 Budget Request	1976 Authorization	1976 CHF Minimum
		HEALTH RESOURCES ADMINISTRATION			
lth Statistics	19,335	21,000**	25,636	30,000	25,636
th Planning & Development	116,472	183,339[5]	90,000	208,000	90,000
th Services Research & Evaluation	81,778	36,000	26,000	80,000	50,000
al Facilities Construction	197,200	197,200**	0	*	125,000
ram Management	49,784	43,220	43,121		43,121
TALS, HEALTH RESOURCES DMINISTRATION ess manpower figures)	464,569	481,270	184,757		333,757
		MANPOWER -- HEALTH RESOURCES ADMINISTRATION			
th Manpower					
health professions					
a. institutional assistance					
1. capitation grants					
a. MOD	152,500				
b. VOPP	34,777				
2. start-up assistance	6,000				
3. financial distress grants	10,000				
4. special programs	53,500				
b. student assistance	53,900				
c. construction assistance	101,000				
d. dental health activities (special projects)	14,979				
e. educational assistance	14,320				
f. direct operations	3,313				
total, Health Professions	444,289	377,000**			
Nursing					
a. institutional support					
1. capitation grants	36,150				
2. start-up assistance	------				
3. financial distress	5,000				
4, special projects	20,000				
total, institutional support	61,150	59,000**			

note at end of table

(fiscal years) ($ in thousands)

	1974 APPROPRIATION	1975 APPROPRIATION	1976 Budget Request	1976 Authorization	1976 CHF Minimum
	ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION				
Mental Health (NIMH)					
a. research	89,289	93,252	81,445	OPEN	100,200
b. training	110,000	94,600	45,400	OPEN	110,000
c. Community Mental Health Centers					
1. Initial operating grants	37,700	------	0	4	50,000
2. Facilities	15,000	0	0	4	0
3. Planning & Development	7,700	0	0	4	2,000
4. Consultation & Education	------	------	0	4	5,000
5. Continuation grants for existing centers	145,998	213,147	160,200	OPEN	168,200
6. Conversion grants	------	------	------	4	18,000
7. Financial distress	------	------	------	4	13,000
8. Rape Prevention & Control	------	------	------	4	2,000
d. Management & Information	21,335	19,240	19,018		23,000
Subtotal, NIMH	427,022	420,239	306,063		491,400
Drug Abuse (NIDA)					
a. research	36,739	34,000	31,602	OPEN	34,000
b. training	15,182	14,035	3,000	OPEN	10,000
c. community programs					
1. grants to states	15,000	35,000	35,000	*	35,000
2. project grants	160,777	122,000	137,962	*	140,000
d. management & information	15,578	14,864	14,294		16,000
Subtotal, NIDA	243,276	219,899	221,858		235,200
Alcoholism (NIAAA)					
a. research	8,901	10,997	9,047	OPEN	12,000
b. training	7,263	7,847	6,958	OPEN	10,500
c. community programs					
1. grants to states	48,000	52,000	45,600	80,000	65,000
2. project grants	75,332	64,908	45,451	95,000	85,000
d. management and information	5,435	10,163	7,143	OPEN	12,000
Subtotal, NIAAA	144,921	145,915	114,199		184,500
Office of the Administrator	8,443	9,555	11,564		10,511
TOTAL, ADAMHA	819,764	795,608	653,684		915,611

Footnotes at end of table

(fiscal years) ($ in thousands)

	1974 APPROPRIATION	1975 APPROPRIATION	1976 Budget Request	1976 Authorization	1976 CHF Minimum
MANPOWER -- HEALTH RESOURCES ADMINISTRATION (Continued)					
b. student support	59,800				
c. construction assistance grants	21,000				
d. educational assistance	7,569				
e. direct operations	4,119				
f. advanced training (new, FY '76)	------				
g. nurse practitioner (new, FY '76)	------				
Subtotal, Nursing	153,638				
3. Public Health Support					
a. institutional assistance	12,000				
b. student assistance	9,600				
c. direct operations	631				
Subtotal, Public Health	22,231				
4. Allied Health Support					
a. institutional assitance	31,745				
b. student assistance	3,091				
c. educational assistance	1,359				
d. direct operations	1,859				
Subtotal, Allied Health	38,705				
5. Special Educational Projects					
a. Education initiative awards	46,500				
b. computer technology	3,000				
c. direct operations	2,752				
Subtotal, Special Educational Projects	52,252				
Sales Insufficiences	4,000				
Subtotal, Manpower	(715,115)	(438,000**)	(339,000)		
ASSISTANT SECRETARY FOR HEALTH					
Regional management & program direction	12,000	30,992	20,375	OPEN	15,000
Retirement, PHS commissioned officers	34,103	43,422	45,013	OPEN	45,013
Scientific activities overseas	1,312	------	------		------
PHS Trust funds	1,538	1,463	1,580		1,580
TOTALS, OASH	48,998	75,877	66,968		61,593

Footnotes at end of table

(fiscal years) ($ in thousands)

	1974 APPROPRIATION	1975 APPROPRIATION	1976 Budget Request	1976 Authorization	1976 CHF Minimum
	REHABILITATION SERVICES ADMINISTRATION				
. Rehabilitation services & facilities					
a. basic state grants	630,000	680,000	680,000	720,000	720,000
b. service projects	52,600	37,120	13,400	OPEN	43,000[6]
c. research	20,596	20,000	20,000	OPEN	32,000
d. training	15,572	22,200	22,200	OPEN	27,700
Grants for Developmentally Disabled					
a. state grants	32,500	30,875**	30,875	*	36,000
b. service projects	18,500	18,500**	18,500	*	12,000
c. university affiliated facilities	4,250	4,250**	4,250	*	6,000
. Research	15,467	------	------		------
. Training	8,900	------	------		------
OTALS, REHABILITATION SERVICES ADMIN.	798,385	812,945	789,225		876,700

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(fiscal years) ($ in thousands)

SUMMARY: HEALTH BUDGET

	1975 Appropriation	1976 President's Request	1976 Coalition Minimum
Food and Drug Administration	196,356	203,000	220,000
Health Services Administration	1,314,795	1,045,435	1,530,129
Center for Disease Control	149,906	133,311	173,294
National Institutes of Health	2,090,418	1,805,000	2,295,800
Alcohol, Drug Abuse & Mental Health Administration	795,608	653,684	915,611
Health Resources Administration (less manpower figures)	481,270	141,600	333,757
Office of Assistant Secretary for Health	75,877	66,968	61,593
TOTAL, PUBLIC HEALTH SERVICE AGENCIES.	5,093,285	4,048,998	5,530,184
Rehabilitation Services Administration	812,945	789,225	876,700

**Continuing Resolution level.

*Authorization expires June 30, 1975.

Footnotes:

1. S 66, the Health Services bill in the Senate, contains a provision that 22% of overall appropriations for community health grants to states be apportioned for hypertension.
2. Health services bills, currently in progress in the House and Senate, authorize family planning at $110,000,000 and $175,000,000 respectively, for FY1976. Thus, the Coalition feels there exists a sufficient legislative base for a recommendation of $135,000,000.
3. Includes a carry over of $60,700,000 from FY1974.
4. Health services bills, currently in progress in the House and Senate, authorize FY1976 spending for Community Mental Health Centers at the following levels:

($ in millions)	House	Senate
Initial operating	50	100
Facilities	5	15
Planning & Development	3.75	5
Consultation & Education	10	9
Conversion	20	20
Financial distress	10	15
Rape Prevention/Control	7	10

Thus, the Coalition feels there exists a sufficient legislative base for its FY1976 recommendations for Community Mental Health Centers

5. Includes continuing appropriations for Regional Medical Programs ($74,589,000) and Comprehensive Health Planning ($33,750,000) and supplemental funding for Health Resources Planning and Development ($75,000,000).
6. Includes grants for Innovation and Expansion.

Mr. SKINNER. By way of introduction, I would like to remind you that the coalition was formed approximately 5 years ago for the purpose of looking at alternatives to the administration's health budget. We have gone through a growing process. Now over 40 organizations are members of this coalition. We analyzed the President's budget request each year by a process which is the full committee and subcommittee process. We have met twice in full committee with members of each of the organizations. In between times our board has looked at the very fine line items in the budget in the health area. There have been many, many phonecalls and many, many conferences. Finally, we arrived at the figures which you will find in this booklet which we consider in the final analysis to be the minimum level which are necessary to maintain adequate levels of support in the health field.

The the audience today are some of the other representatives of members of the coalition. They are in turn perhaps, testifying or supporting this statement. The organization I represent, the American Association of Colleges of Pharmacy, has a statement which we would also like to give you today to insert at the appropriate place in the hearing record.

[The above-referred to statement follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY ON FISCAL YEAR 1976 HEALTH BUDGET

Chairman Flood and members of the subcommittee, this brief statement supports the use of Federal funds to continue health research to provide health services, and to train health manpower. For this Nation to succeed in fulfilling the promise of its forefathers it must have a healthy people. No national objective should have a higher priority.

The association is a member of the Coalition for Health Funding and endorses the statement and recommendations of the coalition as to the specific amounts of funds necessary for each of the authorized activities, projects, and programs in the health categories.

The main purpose of the Nation's pharmacy schools has been hampered by the delay in the passage of a new health manpower act. The continuing resolution to fund HEW programs through fiscal year 1975 reduces by 20 percent the health manpower capitation grants to pharmacy schools and others. The fiscal year 1976 administration budget proposal reduces Federal funds to pharmacy schools. These reductions come at a time of economic constraints, but also at a time when Congress has urged the schools to do more.

When Federal funds were authorized for pharmacy schools, only small amounts were made available, in exchange for the schools' promises to contribute to improving the health of the people by increasing enrollments and emphasizing certain programs. The schools have exceeded their own expectations in meeting the national needs relative to drug-related health care. At the same time, inflation and economic conditions have made the schools more dependent on the Federal portion of their total income.

In 1975 over 7,080 pharmacy students will graduate. In 1965 there were only 3,692 graduates. With continued Federal assistance, the schools project enrollments of 30,600 students in the 1975–76 school year. In addition, the 1971 Health Manpower Act started a revolution in pharmacy education with its requirement to emphasize clinical pharmacy, drug use and abuse, and clinical pharmacology. The revolution has brought many improvements in health care to thousands of Americans because pharmacy students are now involved in the care of individual patients. While physicians are still responsible for the total health care of individual patients, clinical education has taught both pharmacists and physicians that there are limits to the ability of each to singlehandedly solve every health care problem. When drugs are concerned, physicians and pharmacists are beginning to learn that they can do a better and less expensive job if they work as a team.

Unfortunately, the health manpower legislation is not yet approved for appropriations. The fact that it is not, and that there have been reductions in research and service funds which pharmacy schools are eligible to receive, may mean that many of the recent improvements in health care may be lost. For example, the general research support grants of the NIH's Division of Research Resources will be distributed on a new formula which will reduce the number of pharmacy schools eligible to receive such funds. These funds were intended to assist small research programs and will now be distributed elsewhere. At a time when pharmacy school researchers and educators are beginning to see many positive results of their efforts, the enthusiasm and commitment of the Federal Government is waning.

Because health manpower legislation will be approved in time for at least a supplemental appropriation, the association attaches a table of specific requests for the subcommittee's future consideration.

The coalition for health funding recommends a maximum of $6.3 billion for various health programs now eligible for appropriations. These same programs received $5.9 billion to the appropriations law of fiscal year 1975. The President's fiscal year 1976 request, on the other hand, is only $4.8 billion for the same items. The association believes that the coalition's recommendations are much more in keeping with the needs of the people, and within the ability of the Federal Government to finance. In addition, the association urges that the subcommittee continue to reject rescissions and deferrals of all health funds except when clearly no longer needed.

Pharmacy schools are grateful for this subcommittee's support. If the subcommittee desires additional information, the association will be pleased to respond to your requests.

Pharmacy schools minimum needs for anticipated programs of the 1975 Health Manpower Act

Fiscal year 1976:	*Millions*
Construction	$15.0
Startup assistance	5.0
Capitation enrollment in last 4 years	21.0
Loans (up to 10 percent to meet the needs of disadvantaged students)	6.0
Scholarships (to fiscal year 1973 level)	4.0
Special projects	5.0
Teacher training	1.0
Computer technology	1.0
Total, fiscal year 1976 needs	53.5

Mr. SKINNER. While we are pleased with the work of the Budget Committee conferees and the House action making approximately $2.4 billion more available for health this year, we recognize that it's this subcommitte and the Appropriations Committee which has to carry the process to the final end so that the money is available for the programs.

I think the subcommittee may be feeling a little more justified in spending this $2.4 billion now that we see some economic indicators and predictions for improvement in economic conditions, such as perhaps an increase in tax revenues, perhaps the deletion of inventories by businesses which will mean a recovering process and the slowing of unemployment. We hope that this is true and that this will help us justify spending those amounts which are necessary.

Our figures in our booklet for the coalition contain materials and descriptions of the minimum amounts needed in two programs which are not covered by this subcommittee, the Indian Health Service, and the Food and Drug Administration.

I would like to point out that when you look at these I will give you some more details on how that affects our final recommendations in a moment.

Our total fiscal year 1976 recommendations exceed the fiscal year 1975 appropriations only by about $500 million, including those two programs. This represents a 10.8 percent increase, which we think is very modest below most of the inflation rates that we see today.

The coalition for health funding has not asked for authorizations unless those amounts are absolutely necessary, in our judgment. We think we have asked for reasonable levels.

To compare the tables in our book with the President's request and the authorization, you will find that there are only two cases where our recommendation is matching the stated authorization level. One is on page 49 of the "Retirement Fund for Public Health Service Officers," the second on page 50, the basic statements for rehabilitation services. In all other cases our requests are below the stated authorization level.

The amounts which we have recommended in the specific health areas again are approximately $500 million over the fiscal 1975 appropriation. The President's request, on the other hand, is approximately $1 billion less than the fiscal 1975 appropriation.

In the Health Services Administration, we are asking for $1.53 billion. The President has asked that we shift responsibility for many of these programs to State and local governments.

In the Center for Disease Control, the coalition is asking for $173 million, whereas the President has cut these amounts by $17 million, knowing that we have an increasing venereal disease problem, the need for additional immunization programs in lead-base-paint poisoning.

At the National Institutes of Health the coalition recommendation is $2.3 billion. We think our recommendation, among the various Institutes, represents a balanced program among the various special interests there.

One of the divisions out there, the Division of Research Resources, has some programs which affect small research institutions like pharmacy schools, like the members of the Association of Independent Research Institutes, the Wister Institute. I am talking about the Division of Research Resources, general research support grants and general biomedical support grants.

Because of the lack of enough funds and the need to distribute these funds as widely as possible to support basic capital outlays for beginning scientists, the NIH has revised the formula for eligibility and raised it to a minimum of $200,000 of other NIH and mental health grants to make these institutions eligible for these basic general research support type grants. This is going to have the effect of eliminating a number of small research programs from the program. To overcome that is to increase the amount of money available for that program or direct that the formulas be revised in some other fashion.

In the area of the Alcohol, Drug Abuse and Mental Health Administration, the coalition recommends $915.6 million as the amount minimally necessary to keep programs going.

In the Health Resources Administration, while we are not commenting specifically on the health manpower funds, the Commerce Committee in the House is finishing its markup today on a bill which perhaps will be to the floor in the next couple of weeks. If it is, there will be funds needed for those programs. However, we are recommending

in our request today a total of $333.7 million for facilities construction under the Health Resources Administration budget.

Finally, under Rehabilitation Services, we are recommending $876.7 million. All of these recommendations have been gone over by representative of our over 40 members many times. We think these are very reasonable kinds of estimates.

Our request for the Indian Health Service in our total figure of $6.4 billion for these programs is only $350 million. Our request for the Food and Drug Administration is only $220 million. Taking those amounts away from the $6.4 million, we are asking for $5.8 billion that this subcommittee is charged with appropriation through its process, where as the Ford administration is asking for only approximately $4½ billion for the same programs.

The rescissions that the administration has sent up have been acted upon quickly since the final experience with the OMB proposal to cut $516 million out of the health funds, which was made just 2 days prior to the President's budget proposal was released. We compliment you on your actions in following up those rescissions with as much speed as possible.

In summary, our recommendations we think are reasonable and moderate. They permit a modest 10.8-percent growth. They represent what we consider to be a minimum expenditure.

It's important to note that the expenditure of these funds would create jobs for many people, as well as keep people healthy who are already on the job.

Taste and Smell Clinic

WITNESSES

DAVID AUSTERN, MEMBER OF THE BOARD OF DIRECTORS, TASTE AND SMELL FOUNDATION
MARY SHIPP, MEMBER, BOARD OF DIRECTORS

Mr. Flood. Mr. David Austern of the Taste and Smell Foundation.

Mr. Austern. Good morning, Mr. Chairman and Mr. Roybal.

My name is David Austern. With me is Mary Shipp. We appear on behalf of the Board of Directors of the Taste and Smell Foundation. We wrote a letter to the committee which seems to have gone astray. We very much appreciate this opportunity to appear here. Let me say that our formal statement is not complete and we would, with your permission, like on or before May 20 to submit a formal statement for inclusion in the record.

The budget process, but more importantly the decisions of this subcommittee, establishes national health policy. Without money we can do nothing. We recognize this. We pledge to you our assistance in making that health policy work.

My colleagues and I would be happy to answer any questions.

Mr. Flood. Thank you very much.

Mr. Austern. Let me digress for a moment and say, Mr. Chairman, that I think, although you may not remember, you and Miss Shipp have met on a prior occasion and she wanted to remind you of that.

Miss Shipp. When I was in the Governor's Office in Pennsylvania with Governors Lender and Lawrence.

Mr. Flood. Yes.

Mr. AUSTERN. I should tell you that I appear here on what may seem to be a deminutive matter because the people who appeared before me talked about millions and millions of dollars. I am here on an appropriations matter that is some $200,000, which is obviously not a multibillion dollar package. This concerns the Taste and Smell Clinic at the National Institutes of Health.

I originally was going to appear here and ask you to continue the clinic because the National Institutes of Health had sent out letters to the thousands of patients who are treated at the clinic telling them that the clinic would end. Last week, in conversation with Senator Magnuson's staff on the Senate side, we discovered that the Department had recanted in that position and was willing to continue the clinic at least through July 1, 1976.

Last year when we testified on the Senate side, hopefully and perhaps self-aggrandizingly because of our testimony, the Senate report directed that the clinic should continue at least through this year at the same funding level as it had been funded in fiscal year 1973. I must report to you that this did not happen.

I could give countless examples of how the funding was drastically cut. I would also tell you that myself and others pointed out to the staff at NIH that this was in violation of the Senate report. That did not seem to phase them in the least.

The reason I appear here today is that, while we are satisfied that the clinic is going to continue, we are somewhat distraught at the anticipated funding level at which it may continue. The resources of the clinic are very limited. $200,000 and from the figures you have heard this morning, this is obviously a very small figure. In that regard you should know that, in addition to treating a certain number of patients at NIH, the clinic receives daily letters from patients who cannot be treated all around the country. If you would like to inspect some time at your leisure, Mrs. Shipp has with her a suitcase which contains some 5,000 letters from people who suffer from taste and smell dysfunctions from all over the country who are not treated at the clinic because there are no funds.

In addition, the clinic has 6,000 letters from physicians from all over the country who have said that they have patients for whom they would like to get information or some sort of treatment modalities. Those letters have not been answered because there are no funds available to treat those people.

A clinic is more than just a name. It obviously consists of things and resources. For two minutes I want to speak to that. Among the resources at the clinic and, in fact, the primary resource at the clinic is the one person who founded the clinic and runs the clinic, Dr. Robert Henkin. Not only does he run the clinic now and not only did he found it, but no one else has ever been connected with it who has a medical degree at NIH. He is the one person who runs it. He has published over 150 articles in learned journals in the past years on taste and smell dysfunction. He has patented, on behalf of the U.S. Government for whom he works, a number of devices in this area.

We are now told, and he is now told, that he is to be transferred to a ward at a public health service hospital in Galveston, Tex., with no responsibility to run the taste and smell health clinic. One can only speculate that it is the intention of NIH to let the clinic atrophy with

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somebody else, perhaps not even a medical doctor, who is not qualified to run the clinic.

I mentioned that I appeared here on behalf of the board of directors of the Taste and Smell Foundation. This is a recently incorporated group, tax exempt, which is attempting to raise funds to take over the clinic. Although I am going to ask you to continue it through 1976, the handwriting is on the wall, if you will forgive the "patois," and NIH obviously wants to get rid of it. We are trying to raise funds so that there will be a clinic and they can get rid of it at least in July 1976. We are attempting to raise funds. I may even go to the lion, so to speak, and ask NIH for grants come next year. But let the record reflect that we are actively raising funds to take over the whole operation.

In that regard, you should know that the Georgetown University Medical Center has agreed to act as a locus for the foundation. They have signed a letter of intent. They are providing us with space and they will provide us with the hospital services that are necessary.

In closing I am asking this committee to continue the clinic as HEW has suggested that they are willing to do, but to continue it not at the same funding level as existed last year, but at the same funding level that existed in 1973—which was a mandate of the Senate committee last year which was ignored—and to continue it with those personnel who have demonstrated the qualifications and the commitment to the taste and smell disfunction problem.

Mr. Flood. Thank you.

Mr. Austin. Thank you, Mr. Chairman.

Basic Research

WITNESS

DR. HUGH FUDENBERG, MEDICAL UNIVERSITY OF SOUTH CAROLINA, CHARLESTON, AND PROFESSOR OF MEDICINE AT THE UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Mr. Flood. Dr. H. Hugh Fudenberg of the Medical University of South Carolina, Charleston.

Dr. Fudenberg. Chairman Flood, Congressman Roybal and Mr. Neil, I hold a peculiar position of professor of medicine at the University of California, San Francisco, and am in the process of moving, Mr. Chairman, to the Department of Basic and Clinic Immunology at South Carolina. So I am currently dividing my time between both institutions.

It is indeed a privilege to appear before this distinguished committee. Although I am a member of one of the seven so-called basic science societies that make up the Federation of American Societies of Experimental Biology, my role here today is that of a citizen witness, since it is impossible to obtain 100 percent agreement on any issue amongst any population group, especially scientists.

Since you have already heard testimony from one or another disease-oriented society, including the Coalition for Health Funding, and although I am an M.D. dealing with diagnosis and treatment of patients and clinical research, I am here today to argue in support of "Basic Research" because, without the past advances derived from basic

science laboratories, and their subsequent application to what is called applied laboratories, there would be far fewer clinical tools available for the sophisticated physician for the prophylactics, diagnosis, and treatment of disease.

During the testimony, I also plan to provide some fiscal data on the dollar savings that result from biomedical research—data made possible through the nationwide Committee on Impact of Biomedical Research, representing such diverse areas of biomedicine as photobiology and neurochemistry on the one extreme and allergy and dermatology on the other, see appendix A. My goal, and that of the societies I represent, is to provide information sufficient so that you can reach your own conclusions as to the dollar savings resulting from basic biomedical research. Our own estimate is that taxpayers are currently saving $20 to $30 for each dollar spent 5 to 10 years ago, and that with proper funding and proper division of funds, this trend will continue and perhaps increase. This prepared statement is incomplete. A complete one will be in your hands tomorrow.

[The above-referred to statement follows:]

Mr. Chairman and Members of the Committee:

It is indeed a privilege to appear before this distinguished committee. Although I am a member of the Public Affairs Committee of one of the seven so-called basic science societies that make up the Federation of American Societies of Experimental Biology and a member of the Executive Council of the newly formed Biologic Alliance (representing 40,000 biologists), my role here today is that of a citizen witness. During the testimony, I also plan to provide some fiscal data on the dollar savings that result from biomedical research -- data made possible through the nationwide Committee on the Impact of Biomedical Research, representing such diverse areas of biomedicine as photobiology and neurochemistry on the one extreme and allergy and dermatology on the other (Appendix A). I hope today to provide you with information sufficient so that you can reach your own conclusions as to the net dollar savings resulting from basic biomedical research. (Our own estimate is that taxpayers are currently saving twenty to thirty dollars for each dollar spent five to ten years ago, and that with proper funding and proper division of funds, this trend will continue and perhaps increase.) Since you have already heard testimony for disease-oriented or "clinical" research organizations (i.e., from the Coalition for Health Funding), I shall concentrate on the savings from basic research, even though I am an M.D., dealing with diagnosis and treatment of patients and clinical research. I am arguing in support of basic research funds because without the past advances from basic laboratories, there would be far fewer clinical tools available for eradication, diagnosis, or prophylaxis of disease.

I shall direct most of my testimony to the affairs of the National Institute of Allergy and Infectious Diseases, for two reasons. As I am a clinical immunologist, this is the area which I have analyzed in the greatest detail in my own studies[1,2] of fiscal benefits; also, it is the area which appears to have provided the greatest "bang for the

buck," to use the words of a previous Secretary of Defense.

It is estimated that 15% of all hospitalized patients suffer from one or another immunologic deficiency or aberration. In addition, it is estimated that there are over 30 million Americans with significant allergies, more than 8 million of whom are asthmatics. However, in this era of increasing demands on the federal budget, justification of biomedical research in terms of improvements in quality of life or indeed of lives saved no longer seems sufficient to convince the general public and their elected representatives in Congress that such expenditures deserve high priority. It would appear that expenditures for biomedical research must be shown to be justified in view of taxpayer dollars saved, if such research is to be supported by the general public. Our past data indicating approximately twenty dollars of savings for every dollar spent have been inserted in the Congressional record in past years by various interested Senators [Cranston (California), Bayh (Indiana), and others].

It is quite clear to biomedical scientists, though rarely to laymen, that the achievement of a new therapeutic modality is almost never a "breakthrough." The new advances, when examined in historic perspective, are seen to be dependent on observations that preceded the final triumph by five to twenty years. (Indeed, some clearly date back over the centuries.) Such an understanding is essential if we expect an informed willingness to support studies that appear at a given time to have no relevance to major health problems today, although certain data already accumulated do have immediate relevance. Dr. Louis Thomas of New York has divided biomedical research into two types: one asks "what if" and one asks "how to." "What if" and "how to" are terms which I believe are preferable to the common designations of "basic" versus "applied" (or "targeted") research.

In any event, if dollar benefits are to be a major criterion of expenditures for "what if" research, several guidelines can be used: (1) past performance in terms of dollar savings, (2) probable dollar savings in the near future as a result of recent research advances now ready for clinical application, and (3) the magnitude of the problems still existing in terms of (a) mortality, (b) morbidity, (c) loss of earnings, (d) prolonged or life-long institutionalization, and (e) effect on the quality of life.

I would like to begin by analyzing the current budget and past benefits of the National Institute of Allergy and Infectious Diseases. For this Institute, the FY1975 budgetary expenditures are estimated at $119.37 million. The Institute's own estimate of adequate funding for worthwhile research in 1976 is $142 million, and the proposed allocations of the President's new budget are $108.7 million, roughly a 10% absolute drop compared to FY1975 in addition to the toll taken by inflation (Table I). The total percentage of the NIH budget devoted to this Institute is about 5%. This Institute supports research in virologic diseases, bacteriologic diseases, parasitic diseases, fungal diseases, allergy, and autoimmune diseases, plus almost all of the basic research in immunology, currently the most rapidly exploding of the various biologic disciplines (Appendix B).

TABLE I

Chronology of the 1976 Budget for the National Institutes of Health

Appropriation Per Agency	1975 Estimate	1976 Estimate to Department	1976 Department Estimate to OMB	1976 President's Budget
National Cancer Institute	691,361,000	672,214,000	619,559,000	605,000,000
National Heart and Lung Institute	323,884,000	337,923,000	325,862,000	292,794,000
National Institute of Dental Research	49,833,000	54,966,000	48,744,000	43,536,000
National Institute of Arthritis, Metabolism, and Digestive Diseases	172,980,000	193,008,000	170,477,000	148,409,000
National Institute of Neurological and Communicative Disorders and Stroke	142,034,000	149,082,000	126,764,000	114,955,000
National Institute of Allergy and Infectious Diseases	119,369,000	142,150,000	129,997,000	108,711,000
National Institute of General Medical Sciences	187,290,000	218,764,000	200,653,000	161,630,000
National Institute of Child Health and Human Development	126,067,000	141,566,000	123,239,000	106,062,000
National Institute on Aging	15,722,000	27,207,000	21,168,000	16,190,000
National Eye Institute	44,040,000	47,321,000	45,084,000	39,201,000
National Institute of Environmental Health Sciences	34,937,000	42,726,000	35,676,000	31,113,000
Research Resources	128,250,000	91,156,000	89,111,000	81,058,000
John E. Fogarty International Center for Advanced Study in the Health Sciences	5,406,000	6,093,000	4,949,000	4,540,000
National Library of Medicine	28,448,000	31,315,000	29,753,000	28,815,000
Building and Facilities	3,000,000	43,435,000	4,000,000	3,000,000
Office of the Director	17,986,000	21,042,000	20,759,000	19,986,000
TOTAL	2,090,607,000	2,219,968,000	1,995,795,000	1,805,000,000

I. What have been the fiscal savings in past years?

Research in areas supported by NIAID has resulted in the following: (1) Polio has been eradicated, with a dollar savings of approximately $2 billion yearly (Table II). (2) A measles vaccine has been developed, resulting in prevention of congenital deformations, which occur in children of pregnant mothers who contract the disease, and which often require lifelong institutionalization of such infants. Savings are estimated at about $180 million yearly. (3) Basic immunologic studies designed to learn the mechanism of antibody feedback control have resulted in data which were applied to the eradication of Rh hemolytic diseases in newborns (by the administration of small amounts of anti-Rh antibody to Rh-negative mothers) and thus eliminated this serious illness, which in the past resulted in significant fetal and neonatal mortality and furthermore caused mental impairment of sufficient degree to necessitate lifelong institutionalization for a significant percentage of its victims. Estimated savings from eradication of this disease are about $60 million yearly in the United States, and at least 10-fold that throughout the world. (4) By immunologic means, the antigen associated with transfusion hepatitis has been identified, so that symptom-free donors who are silent carriers of this virus can now be screened and their blood not used for transfusion purposes. Such protection is eliminating sufficient cases of chronic hepatitis so that dollar savings now total approximately $100 million yearly. Furthermore, detection of antibodies to this antigen in certain human sera has led to isolation of the antibodies and production of a vaccine which can now be used to prevent additional cases. Recent evidence suggests that another form of hepatitis due to a different hepatitis agent, so-called infectious hepatitis, has now also been made amenable to eradication by a vaccine due to isolation of the virus by immunologic means from stools of patients with the disease. Production of a vaccine thereto is currently in progress. (5) In the field of transplantation immunology, as a result of research in genetically determined antigens on immunologic cells, and as a result of fundamental research on the effects of anti-tumor drugs on the immune response in mice, scientific developments have delineated the genetic differences responsible for rejection of kidney transplants. Through close matching of donors and recipients, and through administration of these immunosuppressive drugs in correct amounts, transplantation is replacing dialysis. Estimated savings are approximately $100 million yearly.

All these immunologic advances, saving the country hundreds of billions of dollars a year, have been supported by one arm, representing perhaps one-sixth of the total activity, of one Institute of the NIH — that is, the National Institute of Allergy and Infectious Diseases. In summary, the amount of the NIAID budget directed to immunology is about $33 million per year, and cost savings from past research total about $3.3 billion per year, for a dollar benefit-cost ratio of 100 to 1.

II. What are the prospects for fiscal savings in the near future?

In the past ten years, studies of the immunology of the sugar moieties of certain bacteria have led to isolation of the sugar moieties

TABLE II

Estimated losses in the United States avoided through the prevention of paralytic poliomyelitis during the period 1955-1961, and estimated cost of avoidance*

ESTIMATE	MILLIONS OF DOLLARS
Losses avoided	
Medical care costs	326.8
Gross lifetime income lost	6389.7
TOTAL	6716.5
Cost of avoidance	
Vaccine purchase	129.8
Physicians' vaccination fees	468.6
Vaccine administration	13.3
Government-funded research and field trials	41.3
TOTAL	653.0
Net gain	6063.5

*Production of polio vaccine was made possible by the observation that viruses could be grown in cultured monkey cells. This finding was made by Dr. J. F. Enders, who was doing basic research into virus propagation. Subsequently, after the Salk vaccine had been developed and introduced, basic research into the immunology of the gastrointestinal tract produced the finding that an orally administered vaccine was preferable to one administered intramuscularly or subcutaneously, because it led to better protection, even though serum antibody levels were the same. The greater protection conferred by oral vaccine administration occurs because higher levels of "secretory immunoglobulins " (a form of antibody localized to the intestinal tract) are induced, preventing penetration of the gastrointestinal tract by the polio virus. This is the reason why the Sabin oral vaccine is much more effective than the Salk vaccine.

which form the capsule of such bacteria as meningococcus, pneumococcus, and Hemophilus influenzae. Infections with the latter two organisms during the first three years of life account for 90% of deafness in infants. During the first six years of life, the average child has three attacks of ear infection, or otititis media, about 75% of which are due to pneumococcus or Hemophilus. Total cost for routine treatment is about $40 per attack, or $120 — that is, $300 million yearly. Further, 5 to 10% of these infants, if severely affected, develop hearing disability; others, because of the hearing defects, have a learning disability. (In certain population groups the incidence of learning disability is much higher. Among Navajo Indians it appears to be 30 to 35%.) Estimated loss to this country in terms of institutionalization of the mentally deficient and loss of earnings of the slow learners, often not recognized as to cause, is approximately $700 million yearly. Vaccines for the Hemophilus influenzae polysaccharide have been developed and are currently being tested.[3] Preliminary results appear very promising. In the case of pneumococcus, which accounts for 50% of the cases of otitis media in infants, vaccines for thirteen pneumococcal serotypes (specific sugars) have been developed. These have been extremely effective for preventing pneumonia in adults, but funding restrictions will eliminate the studies in infants that were planned for next year.

Meningococcal polysaccharide vaccines have already been applied with great success in preventing epidemics of meningitis in our military. Tests in infants were scheduled to begin within the next few months, and based on what theoretical background we have, these pure polysaccharides, whose isolation entailed great labor by many investigators, should prove successful. They should also prove very useful in preventing meningitis epidemics in this country; as you may know, such epidemics have recently swept countries with economies as diverse as Brazil, Finland, and Denmark.

Thus, the "what if" research for vaccines to pneumococcus, Hemophilus, and meningococcus has been done. But the proposed budget will eliminate the next step, the "how to" research needed to determine the optimum dose, age, method of administration, etc., for these vaccines in children to protect them routinely, much as DTP (diptheria, tetanus, whooping cough) vaccine is used at present.

III. What are the prospects for fiscal savings five to ten years from now?

(1) About ten years ago it was shown that two types of lympocytes are involved in the immune response. One type of cell makes certain serum proteins with specificity for foreign substances (antigens). These proteins are called antibodies and are easily detectable in serum. About five years ago it was shown that the other kind of immune cells -- called T cells because they are derived from or influenced by the thymus — synthesize no such substances in the serum. Nonetheless, T cells (and various subpopulations thereof) are responsible for protection against cancer, against the so-called autoimmune diseases (where immune processes attack the body's own tissues), for kidney graft rejection, for protection against parasites (parasitic diseases such as schistosomiosis

and leishmaniosis are still the world's most prevalent diseases), and for a whole variety of known and probably an even greater number of unknown biologic functions.

During the past five years it has become apparent that the interaction of T cells with antigen results in the liberation of a whole host of factors (about three dozen are known at present) with various biologic activities (these are listed in Table III).[4] None of these factors, collectively termed "mediators of cellular immunity," has thus far been purified, so that their exact in vivo function, that is function within the body, still is unclear. Nonetheless, it appears that these factors, or at least many of them, have definite biologic roles. Some prevent proliferation of cancer cells or of parasites or certain viruses; others kill the tumor cells; still others attract scavenger cells to the area of the foreign antigen, which in turn break the foreign antigen, whether it be a mutant cell, parasite, fungus, etc., into smaller fragments which can be digested and destroyed. Purification of these substances will demand relatively small funds (say $6 to 10 million), but once purified, at least some of them will undoubtedly become very useful adjuncts in the treatment of various infectious and parasitic disorders, autoimmune diseases, malignancies, and so forth.

(2) Another recent development is the discovery of the existence of "immune response genes," certain ones of which appear to be linked to the ability of the body to defend itself against certain diseases. It seems highly likely that research in this field may provide information that will be useful for identifying individuals or groups who have predilections for various diseases before the diseases actually occur, or for early diagnoses when symptoms are vague, so that appropriate treatment can be started when it is most effective, in the early stages of disease.

IV. What will be the effects on the quality of life?

Much attention has focused in the past several years on cancer, heart diseases, and stroke. Although mortality from those diseases far exceeds that from all others, it is of considerable interest that if one considers morbidity, the total number of hospital days due to just one constellation of infectious diseases alone (namely, respiratory infections) is far greater (about threefold) than those for cancer, heart disease, and stroke combined. Furthermore, the population affected in terms of loss of days from usual productive work (or from school), and thus the financial implications of the still unconquered respiratory diseases, is far younger than those of the cancer and heart disease category, where a significant majority are in the retired group. Furthermore, if one considers impact on the quality of life -- for example, the impact of a child with allergic asthma on the entire family -- the adverse impact here is undoubtedly far greater than the adverse impact of the individual with a coronary, whose children are probably grown and who statistically is probably in a group where Medicare covers hospitalization costs.

TABLE III

Mediators of cellular immunity elaborated by sensitized lymphocytes after addition of antigen*

1. Skin permeability factor
2. Chemotactic factors for macrophages
3. Macrophage migration inhibitory factor (MIF)
4. Macrophage activating factor (same as MIF?)
5. Chemotactic factors for other leukocytes (neutrophils, eosinophils, basophils, lymphocytes)
6. Granulocytic migration inhibitory factor (LIF)
7. Growth inhibitory factors (clonal inhibitory factor, proliferation inhibitory factor)
8. Lymphocytotoxin (toxic for all cells other than lymphocytes)
9. Osteoclast activating factor
10. Collagen synthesizing factor
11. Interferon
12. Mitogenic factor(s) for lymphocytes

*Two to three dozen mediators have been tentatively identified in studies of lymphocytes in cell culture. It appears that many of these substances might be isolated and, perhaps, used for therapy in various patients with a number of different diseases. However, further basic research will be required.

A heuristic explanation for the roles of some of the factors listed here is as follows: (1) skin permeability factor dilates the capillaries in the skin, making it easier for cells involved in the immune response to reach for substances (antigens) that have entered the body tissues; (2) chemotactic factors attract macrophages (which engulf and destroy foreign cells or parasites, or break them into small enough pieces for the immune system to handle); (3,4) MIF prevents the macrophages from migrating away from the foreign cells while they are being engulfed; (5) chemotactic factors attract other blood cells which break down and release enzymes that attack viruses, proteins, etc.; (6) LIF prevents those cells from moving away; (7) growth inhibitory factors prevent "transformed" (cancer) cells or foreign organisms from dividing and thus increasing in mass; (8) lymphocytotoxin kills "transformed" cells and foreign organisms; (11) interferon inhibits, at least in animals, the growth of viruses, both those that cause cancer and those that do not; (12) mitogenic factors cause lymphocytes to divide and thus start the process over again; i.e., this is an amplification mechanism.

Recommendations

It is most disturbing that the President's budget request in this area, which has provided such great fiscal benefits, calls for an absolute decrease rather than an increase. [Furthermore, since our total annual health bill this year appears to be right in the neighborhood of $120 billion, total reduction in a proposed budget of $1.8 billion seems fiscally irresponsible. Any corporate manager running a $120-billion-a-year enterprise would, I suggest, devote at least 5% of his total budget to research. I believe this figure (5% of health costs) would be a reasonable one for NIH research, rather than the current figure (less than 2%).]

Further, speaking as a citizen witness, but representing what I believe are the beliefs of the vast majority of American biomedical scientists, some effort must be made to prevent the so-called "rollercoaster" effect of rapid changes in federal funding. Some sort of continuity for long-range funding, so that adequate plans can be made and research teams not disrupted only to be rebuilt again two years later, is obviously highly desirable if not mandatory for continued progress.

Thirdly, the percentage of approved grants funded varies markedly from one NIH Institute to another. For example, it is my impression that the National Cancer Institute has been funding approved grants with priorities of 4.0 (about 85% of the grants approved by NCI, on a scale where 1.0 is the best and 4.5 is the worst), whereas Institutes such as Child Health and Human Development and Allergy and Infectious Diseases are, at least until recently, able to fund only those new grants with priorities of approximately 1.8, or about 18% of the grants approved. Thus, one Institute is funding projects of much lower scientific quality than the vast majority of scientifically better grants that are not being funded because of budget limitations in the other Institutes. I would urge that some consideration be given to reducing the discrepancies between the percentages of approved grants funded by different Institutes -- for example, so that 35 to 50% of all grants with sufficient scientific merit to warrant approval would be funded.

In addition, in the Institute of Child Health and Human Diseases, if the President's proposed budget is approved, it is estimated that funding of new grants will be reduced to at best 6%. Competing renewals (of grants that have reached the end of the period for which they were awarded but for which a continuation is requested) will be reduced to only 12%. And even worse, routine yearly renewals (of grants that have not reached the end of their award periods -- usually three to five years — and for which funds have been promised) will be reduced to 63%, as opposed to the present automatic renewal. This would be an unprecedented breach of faith with the biomedical research community. It would mean that many promising research programs (37%) that have been initiated within the past one to three years would of necessity be dismantled, and that established investigators would suffer a disastrous loss of continuity in their programs. Moreover, funds spent during the first phases of a three- or five-year grant (for initial equipment costs, personnel training, etc.) would be wasted. This "penny-wise pound-foolish" approach strikes me as being both fiscally irresponsible

and morally indefensible. The most likely result would be a loss of faith in the federal funding process for biomedical research, many established investigators would leave biomedicine for other areas (e.g. specialty practice), and the vast majority of promising young students with potential for contributions to biomedical research would undoubtedly choose other professions.

Fourth, we urge that NIH funds allocated for health care delivery, so that newer methods of health care can be made available to a greater percentage of the population, be distinguished as separate from NIH research funding, since the general population apparently regards the NIH budget as totally devoted to biomedical research. I also urge that research in health care delivery, which is indeed necessary for upgrading of health care, be continued or expanded, but that the cost thereof should not be balanced against biomedical research and biomedical research training costs. Indeed, each should perhaps be balanced against other forms of government-sponsored research; for example, what is the research value, or the dollar value for that matter, of sending a man to the moon for yet another time or to Mars, or of research on an SST? I urge that despite the increased funds for "applied" (how to) research, funds for the "what if" research continue at at least the same level. Had funds been awarded according to OMB criteria back in the late 1940s in an attempt to conquer polio, we would now probably have the world's best respirator and polio would still be with us.

Lastly, I would urge that the salaries of directors of various Institutes be raised from their current ceiling of $36,000 yearly. It is obviously very difficult (if not impossible) to attract the highly qualified individuals with the broad scientific and administrative background needed for rigorous analysis and vigorous support of the many diverse, deserving programs within each Institute at salaries on this level, when they can earn twice that in private practice (if M.D.s) or in high executive capacities with one or another pharmaceutical firm (if Ph.D.s).

In conclusion, I believe that the Administration's proposed budget for the NIH does not relect sound fiscal policy, as shown by the benefit-cost analysis I have presented here. I trust that this Committee, after its long and arduous deliberations, will arrive at a budget that will be more realistic in meeting current biomedical research needs and thus reducing the future costs of health care delivery in our country.

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1. H. H. Fudenberg, "The dollar benefits of biomedical research: A cost analysis," J. Lab. Clin. Med. 79, 353 (1972).

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3. J. B. Robbins et al., "Haemophilus influenzae type b: Disease and immunity in humans," Ann. Int. Med. 78, 259 (1973).

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APPENDIX A — SAMPLE LETTER

Committee on the Impact of Biomedical Research
2128 Wyoming Avenue. NW. Washington. D.C. 20008 • 202-332-7700

July 17, 1974

Dear Dr.

An ad hoc "Committee on the Impact of Biomedical Research" composed of 90 biomedical scientists from many diverse "basic" and "clinical" scientific disciplines, has been formed and had its first meeting in Chicago on December 5, 1973.

Its purpose is to generate and analyze information on the dollar benefits derived from biomedical research. (An example is "The Dollar Benefit of Biomedical Research: A Cost Analysis," Journal of Laboratory and Clinical Medicine, 79:353-363, 1972.

The data collected by this organization will be analyzed by a Washington-based economist, and will be disseminated to biomedical scientists, to the public via newspaper science writers and other public media, and to members of the legislative and executive branches of the Government through appropriate administrative assistants in the hope that the information so compiled will have an impact on future funding of biomedical research.

Funds for this effort cannot come directly from established organizations, at least at this time; most of these are tax-exempt and prohibited from efforts of this sort. However, it is possible for individuals to join together as we are asking you to do now, independently, for this purpose.

The initial founding committee, whose names appear below, will seek contributions of $10 per individual for the initial stages of this effort to defray costs of mailing similar letters to members of various biomedical scientific organizations. Other scientists who wish to join on a purely voluntary basis will be notified of this committee and its activities via periodic editorials in Current Contents by the publisher, Dr. Eugene Garfield.

A concentrated effort by all biomedical scientists is necessary to provide funds for what we believe to be a vital project. In these times of fiscal stress we believe that the citizenry must be informed that biomedical research saves not "merely" lives but also dollars, and that the fiscal returns are far greater than the total monies expended for this purpose. If interested, please send your check in the amount of $10.00 (not tax deductible) to:

Committee on Impact of Biomedical Research
2128 Wyoming Avenue, N. W.
Washington, D. C. 20008

The majority of the membership of one society has already indicated its willingness to send contributions, and the Chairman of the Public Affairs Committee of another society has pledged the official support of his organization. Contacts have already been established with sympathetic administrative assistants of Senators and Congressmen who are members of key sub-committees dealing with NIH appropriations and other health and science legislation. Thus we believe that this initial effort will be successful, and there is reason to hope that a continued effort based on annual contributions will help solve the long-term problem of support for basic biomedical research.

The Institute for Scientific Information (publishers of Current Contents) has agreed to aid us, without charge, in the following way:

If any member of our group writes Current Contents citing the published reference of a "clinical breakthrough" which appears to promise large dollar savings by eradication of, or prophylaxis against disease, or by development of new diagnostic or therapeutic methods which will curtail hospital stays, return institutionalized patients to work, etc., the Institute for Scientific Information will do a literature search tracing back the clinical breakthrough to the original papers from which subsequent data making the "breakthrough" possible were derived.

The initial members of the
Committee are the following:

Signers of Founding Letter and Initial Solicitation

COMMITTEE on the IMPACT of BIOMEDICAL RESEARCH

Name	City	Discipline
Robert S. Abernathy, M.D., Ph.D.	Little Rock, Ark.	Infectious Diseases
Herbert L. Abrams, M.D.	Boston, Mass.	Radiology
Charles A. Alford, Jr., M.D.	Birmingham, Ala.	Pediatrics
Curtis P. Artz, M.D.	Charleston, S.C.	Microbiology
J. Claude Bennett, M.D.	Birmingham, Ala.	Microbiology
Robert W. Berliner, M.D.	New Haven, Conn.	Biomedical Administ ti
Alfred Jay Bollet, M.D.	Augusta, Ga.	Arthritis
Barbara H. Bowman, Ph.D.	Galveston, Texas	Human Genetics
Jo Anne Brasel, M.D.	New York, N.Y.	Pediatrics
Eugene Braunwald, M.D.	Boston, Mass.	Cardiovascular Phys
Harris Busch, M.D., Ph.D.	Houston, Texas	Pharmacology
Philip P. Cohen, M.D., Ph.D.	Madison, Wis.	Biochemistry
Julius H. Comroe, Jr., M.D.	San Francisco, Calif.	Physiology
Marcel E. Conrad, M.D.	Chevy Chase, Md.	Hematology
J.E. Darnell, M.D.	New York, N.Y.	Virology
William L. Epstein, M.D.	San Francisco, Calif.	Dermatology
Ronald W. Estabrook, Ph.D.	Dallas, Texas	Biochemical Pharm colog
Frank W. Fitch, M.D., Ph.D.	Chicago, Ill.	Pathology
T.B. Fitzpatrick, M.D., Ph.D.	Boston, Mass.	Dermatology
Daniel X. Freedman, M.D.	Chicago, Ill.	Psychiatry
H. Hugh Fudenberg, M.D.	San Francisco, Calif.	Immunology
Solomon Garb, M.D.	Denver, Colo.	Pharmacology
Eugene Garfield, Ph.D.	Philadelphia, Pa.	Information Science
Lowell A. Glasgow, M.D.	Salt Lake City, Utah	Virology
Frank Glenn, M.D.	New York, N.Y.	Surgery
Robert A. Good, M.D., Ph.D.	New York, N.Y.	Cancer Research
Robert J. Gorlin, D.D.S.	Minneapolis, Minn.	Dentistry
Elizabeth D. Hay, M.D.	Boston, Mass.	Developmental Biol
Paul Heller, M.D.	Chicago, Ill.	Hematology
Ingegerd Hellstrom, M.D., Ph.D.	Seattle, Wash.	Tumor Immunology
Evelyn V. Hess, M.D.	Cincinnati, Ohio	Immunology
Rochelle Hirschhorn, M.D.	New York, N.Y.	Cell Biology
Alan F. Hofmann, M.D.	Rochester, Minn.	Gastroenterology
Robert W. Holley, Ph.D.	San Diego, Calif.	Molecular Biology

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Halsted R. Holman, M. D.	Stanford, Calif.	Rheumatology
B. L. Horecker, Ph. D.	Nutley, N. J.	Biochemistry
Dorothy M. Horstmann, M. D.	New Haven, Conn.	Epidemiology
Kurt J. Isselbacher, M. D.	Boston, Mass.	Gastroenterology
James O. Johnston, M. D.	Oakland, Calif.	Orthopedics
John A. Kenney, M. D.	Washington, D. C.	Dermatology
Seymour S. Kety, M. D., Sc. D.	Boston, Mass.	Biological Psychiat:
Arthur Kornberg, M. D.	Stanford, Calif.	Biochemistry
Marian E. Koshland, Ph. D.	Berkeley, Calif.	Immunology
Samuel L. Kountz, M. D.	Brooklyn, N. Y.	Transplantation Sur
Joshua Lederberg, M. D., Ph. D.	Stanford, Calif.	Genetics
Peter Lengyel, Ph. D.	New Haven, Conn.	Biophysics
Murray L. Levin, M. D.	Chicago, Ill.	Nephrology
John W. Littlefield, M. D.	Baltimore, Md.	Human Genetics
Lawrence D. Longo, M. D.	Loma Linda, Calif.	Fetal Physiology
S. E. Luria, M. D., Sc. D.	Cambridge, Mass.	Microbiology
Charles F. McKhann, M. D.	Minneapolis, Minn.	Tumor Immunology
Alan H. Mehler, Ph. D.	Milwaukee, Wis.	Biochemistry
Myron R. Melamed, M. D.	New York, N. Y.	Cytology
Kenneth L. Melmon, M. D.	San Francisco, Calif.	Clinical Pharmacol
David G. Nathan, M. D.	Boston, Mass.	Hematology
Hans Neurath, Ph. D.	Seattle, Wash.	Biochemistry
Marshall Nirenberg, Ph. D.	Bethesda, Md.	Biochemical Genet
Alfred Nisonoff, Ph. D.	Chicago, Ill.	Immunochemistry
David Novelli, Ph. D.	Oak Ridge, Tenn.	Biochemistry
Michael A. B. Oldstone, M. D.	La Jolla, Calif.	Neuropathology
Ray D. Owne, Ph. D., Sc. D.	Pasadena, Calif.	Genetics
Rose O. Payne, Ph. D.	Stanford, Calif.	Genetics
Bernard Pirofsky, M. D.	Portland, Oregon	Hematology
Joseph E. Rall, M. D., Ph. D.	Bethesda, Md.	Endrocrinology
Helen M. Ranney, M. D.	San Diego, Calif.	Hematology
Joseph Ransohoff, M. D.	New York, N. Y.	Neurosurgery
Howard Rasmussen, M. D., Ph. D.	Philadelphia, Pa.	Biochemistry
William J. Rutter, Ph. D.	San Francisco, Calif.	Biochemistry
Jay P. Sanford, M.D.	Dallas, Texas	Infectious Diseases
Kenneth Ryan, M.D.	Boston, Mass.	Obstetrics
Robert J. Schlegal, M. D., Ph. D.	Watts, Calif.	Pediatrics
Donald W. Seldin, M. D.	Dallas, Texas	Nephrology
Louis M. Sherwood, M. D.	Chicago, Ill.	Endocrinology
Elie A. Shneour, Ph. D., Sc. D.	La Jolla, Calif.	Neurochemistry
Jane I. M. Siegel, M. A.	Portland, Oregon	Pathology

Paul H. Silverman, Ph. D., Sc. D.	Albuquerque, N. M.	Parasitology
S. J. Singer, Ph. D.	La Jolla, Calif.	Molecular Biology
Robert Sinsheimer, Ph. D.	Pasadena, Calif.	Molecular Biology
Kendric C. Smith, Ph. D.	Stanford, Calif.	Radiation Biology
John S. Strauss, M. D.	Boston, Mass.	Dermatology
Lewis Thomas, M. D.	New York, N. Y.	Biomedical Admin.
Max Tishler, Ph. D.	Middletown, Conn.	Chemistry
Elliot S. Vesell, M. D.	Hershey, Pa.	Pharmacology
Richard W. Vilter, M. D.	Cincinnati, Ohio	Hematology
Peter H. Von Hippel, Ph. D.	Portland, Oregon	Biophysics
Donald O. Walter, Ph. D.	Los Angeles, Calif.	Neurophysiology
James D. Watson, Ph. D.	Cambridge, Mass.	Molecular Biology
Willet F. Whitmore, Jr., M. D.	New York, N. Y.	Urology
Ralph C. Williams, Jr., M. D.	Albuquerque, N. M.	Rheumatology
Rosalyn Yalow, Ph. D.	Bronx, N. Y.	Endocrinology
Lawrence E. Young, M. D.	Rochester, N. Y.	Hematology

APPENDIX B
PREFACE FROM IMMUNOLOGY BY H. N. EISEN, M.D.
(Harper & Row, Publishers, Hagerstown, Maryland, 1974)

The special need for such a volume is suggested by the peculiar nature of immunology at this time. When this science took root, almost a century ago, it attracted wide attention among both the general public and the biomedical community because of the promise it offered for relief from epidemic infectious diseases. This promise was fulfilled beyond almost all expectation, and interest in the subject then lagged, although over the ensuing decades a small coterie continued to work in the field, fascinated by the fundamental biological problems raised by the exquisite specificity and diversity of immune responses. In the past 10–15 years, immunology has undergone another flowering, this time based on both its appeal as a fundamental biological science and its changing importance in clinical medicine, where it is contributing a rapidly growing number of diagnostic procedures and reagents, providing tools and concepts for probing mechanisms of diverse diseases, and raising the possibility that its contributions to the control of cancer may approach its earlier successes in controlling diseases of bacterial and viral origin.

These multiple sources of appeal have led to separate courses in immunology in many undergraduate, graduate, and medical school curricula, and I hope that this introductory text may be useful to them. Moreover, for established biologists and medical practitioners this volume may help satisfy a need for the kind of self-instruction that could be helpful in approaching the current flood in immunologic literature—estimated at about 7000 papers in 800 journals this year.

Much of this explosive growth derives from a change in the balance of scientific trade. Until recently, immunology imported more technics and concepts from related disciplines than it exported. This negative balance is being rapidly redressed: there is now hardly a field of biology or medicine in which antibodies are not useful as analytical or diagnostic reagents, and concepts stemming from clonal selection, the immense polymorphism of histocompatibility antigens at cell surfaces, the one cell–one antibody rule, the two genes–one chain hypothesis, and cell–cell cooperation in regulating the activities of antibody secreting cells are just beginning to have broad impact on the study of differentiation and many other areas.

I shall direct most of my testimony to the affairs of the National Institute of Allergy and Infectious Diseases. As a clinical immunologist, this is the area which I have analyzed in the greatest detail in my own studies (1,2) of fiscal benefits, and also the area which appears to have provided the greatest "bang for the buck," to use the words of a previous Secretary of Defense. Since you have already heard testimony for disease-oriented or "clinical research" (i.e., from the Council of Health Funding), I shall concentrate on the savings from basic research. Although I am an M.D., dealing with diagnosis and treatment of patients and clinical research, I am arguing in support of basic research funds because, without the past advances from basic laboratories, there would be far fewer clinical tools available.

I would like to concentrate on the budget and past performance of the National Institute of Allergy and Infectious Diseases which, despite its title, supports research in virologic diseases, bacteriologic diseases, parasitic diseases, fungal diseases, allergy and autoimmune diseases.

I would like to divide my time into several parts. In this era of increasing demands on the Federal budget, justification of biomedical research, in terms of improvements in quality of life or, indeed, of lives saved, no longer seems sufficient to convince the general public and their elected representatives in Congress that such expenditures deserve high priority. Whether wisely or not, it would appear that expenditures for biomedical research must be shown to be justified in view of taxpayer dollars saved, if such research is to be supported by the general public. Our past data, indicating approximately $20 of savings for every dollar spent, have been inserted in the Congressional Record in the past year by Senators Cranston (California), Bayh (Indiana), and Mondale (Minnesota). I would like to concentrate on data obtained, in large part, since then.

Before going further, I would like to ask you to bear with me while I try to define "basic" and "applied" or target research by other means.

Dr. Louis Thomas, of New York, has divided these two types of research into the ones that ask "what if" as compared to the ones that ask "how to" terms, which I believe are preferable to the common designations of "basic" versus "applied."

In any event, if dollar benefits are to be a major criterion of research expenditures, several guidelines, at least in terms of efficacy, can be used: (1) past performance in terms of dollar savings; (2) probable dollar savings in the near future as a result of recent research advances now ready for clinical application; and (3) the magnitude of the problems still existing in terms of (a) mortality, (b), morbidity, (c) loss of earnings, (d) prolonged or lifelong institutionalization, and (e) effect on the quality of life of both the patient and his family.

What are the prospects for fiscal savings in the near future? In the past 10 years, studies of the immunology of the sugar moieties of certain bacteria have led to isolation of the sugar moieties, which form the capsule of such bacteria as meningococcus, pneumococcus, and hemophilus influenza. Infections with the latter two organisms, during the first 3 years of life, account for 90 percent of deafness in infants. During the first 6 years of life, the average child has three attacks of ear infection, or otitis media, about 75 percent of which are due to pneumococcus or hemophilus. Total cost for routine treatment

is about $40 per attack to $120—that is $300 million yearly. Further, 5 to 10 percent of these infants, if severely affected, develop mental disability; others, because of the hearing defects, have a learning disability.

Estimated loss to this country in terms of institutionalization of the mentally deficient, and loss of earnings of the slow learners, often not recognized as to cause, is approximately $700 million yearly. Vaccines for the hemophilus influenza polysaccharide have been developed and are currently being tested. Preliminary results appear very promising. In the case of pneumococcus, which accounts for 50 percent of the cases of otitis media in infants, vaccines for three pneumococcal serotypes—specific polysaccharides—have been developed. These have been extremely effective for preventing pneumonia in adults, but funding restrictions will eliminate the studies in infants that were planned for next year.

Before going further, I would like to indicate to you that our analysis shows that at least for the National Institute of Allergy and Infectious Disease, the immunology component, savings now are $100 yearly for every dollar spent in the past in basic research areas supported. Nonetheless, as you know, fiscal year 1975 budget expenditures are about $1.19 million. The estimate submitted by the Department as necessary for somewhat better than minimal function was $142 million. The proposed allocation in the President's new budget is $187 million, a 10-percent absolute drop, plus the drop in inflation and the cost of supplies has risen far greater than the total inflation costs, at least in that area, about 20 percent.

The total percent of the NIH budget taken by this one Institute is about 5 percent of the total NIH budget. As I said, it supports research in virologic diseases, bacterial diseases, parasitic diseases, fungal diseases, allergy, and autoimmune diseases where the body destroys its own components, autoimmune diseases across all categorical disease lines. Rheumatoid arthritis is one example. Autoimmune endocrine diseases is another example.

Most of the fundamental breakthroughs being used by other institutes, including the Cancer Institute, helps solve these problems which have come from basic research immunology, supported by this one Institute.

Let me give you just a few of the cost savings derived from basic research in the areas supported by this Institute.

Basic research on growing viruses and tissue culture and on the antibiotics of the intestinal bowel, first, the Sabine polio vaccine is saving this country $2 billion yearly; second, a measles vaccine that was developed several years ago resulting in prevention of congenital deformations in women who have had measles in the first trimester of pregnancy which resulted in the newborn infant is in such severe impairment that lifelong institutionalization was required. The eradication of this is saving us about $180 million a year.

Third, basic immunologic studies to learn the mechanism of antibody feedback control led to data which were then applied to eradication of Rh hemolytic diseases in the newborn. As you may notice, this disease has now vanished practically by the administration of the anti-Rh antibody to Rh negative mothers in a significant amount. Infants born of such mothers had such severe breakdown of the red

cells and so much deposition of the pigment of the cells in their brain that they suffered mental retardation and required lifelong institutionalization or lower IQ's. The estimate of savings in this country are conservative. It is estimated at $60 million yearly, worldwide perhaps $600 million yearly.

Fourth, by immunologic means, I had the antigen associated with transfusion hepatitis. We can now pick up the asymptomatic individual who is a silent carrier of that virus. When he goes in to give blood for transfusion purposes—all bloods are screened—this presumably healthy, normal individual is detected and his blood is not used for these purposes.

We are already saving about $100 million yearly due to eradication of most cases of transfusion of hepatitis. Furthermore, recent research has resulted in development of a vaccine. Some people have antibodies to this viral disease in their serum. Vaccine made therefrom should save us another $40 to $50 million a year. In the field of kidney transplantation, immunology, as a result of research in genetically determined antigens on immunologic cells and as a result of fundamental research designed originally to see the effects of antitumor or drugs on immune response have resulted in methods whereby close matching of kidney donors and recipients and administration of appropriate doses of immunodepressant drugs can be used to transplant kidneys rather than putting the patient with chronic renal failure under dialysis. The estimated savings is $100 million a year.

I can go on with this and give you further examples, but if you take the total budget of this one Institute and assume that the immunologic component of that $100 million is one-sixth of the areas—let's say it gets double this money—is $33 million a year. Our savings from just the diseases I have described to you are $3.3 billion. That is a saving ratio of 100 to 1.

Whether this is true in other institutes, I cannot tell you. But I have analyzed some. It appears that the cost-benefit ratios are far greater than five to one.

I will not go on with the prospects for fiscal savings 5 to 10 years from now due to things which have just emanated from the "what if" laboratory. There are many substances that have been isolated from a certain form of immunologic cell just from the past 5 years that have unusual promise for eradication of certain forms of cancer for eradication of certain parasitic diseases.

I might mention the most prevalent diseases in the world today are two parasitic diseases, leischmaniasis and schistosomiasis. Funding difficulties have prevented isolation of these substances so they can be purified in sufficient amounts for clinical trial.

Let me focus on one other area which, in seeing as a citizen witness, I nonetheless believe reflects the beliefs of the vast majority of American biomedical scientists.

An effort must be made to prevent the so-called rollercoaster effect of rapid changes in Federal funding. Stability, long range funding continuity is necessary so adequate plans could be made and research teams not disrupted only to be built again 2 or 3 years later.

Next, as you know, the funding of approved grants varies markedly from one eye institute to another. If you look at the President's budget, the Institute that is to be hit the worst is child health, with a 20 per-

cent absolute reduction. In child health, only the top 15 percent of scientifically approved grants have been fundable until recently, whereas in the past it has been up to 85 percent. I would suggest that perhaps you gentlemen would consider some mechanism for a more adequate disbursal of funds so that grants of greater scientific promise, which cannot be funded by one Institute, can be funded by another.

Mr. FLOOD. Doctor, your time has run out.

Dr. FUDENBERG. Can I give you one more sentence?

This appropriation bill for the first time would take grants which have been impounded for 5 years and 37 percent of those would be cut out of child health. This has never happened before. This will prevent the application of these vaccines to children who get the pertussis diseases now. It would result in disbandonment of research teams because of the disastrous effect on morale. I think this failure to honor these moral commitments for these continuation grants is not only fiscally irresponsible but is morally indefensible.

Gentleman, I thank you for your time.

Mr. FLOOD. Thank you.

[Additional tables follow:]

TABLE I

Chronology of the 1976 Budget for the National Institutes of Health

Appropriation Per Agency	1975 Estimate	1976 Estimate to Department	1976 Department Estimate to OMB	1976 President's Budget
National Cancer Institute	691,361,000	672,214,000	619,559,000	605,000,000
National Heart and Lung Institute	323,884,000	337,923,000	325,862,000	292,794,000
National Institute of Dental Research	49,833,000	54,966,000	48,744,000	43,536,000
National Institute of Arthritis, Metabolism, and Digestive Diseases	172,980,000	193,008,000	170,477,000	148,409,000
National Institute of Neurological and Communicative Disorders and Stroke	142,034,000	149,082,000	126,764,000	114,955,000
National Institute of Allergy and Infectious Diseases	119,369,000	142,150,000	129,997,000	108,711,000
National Institute of General Medical Sciences	187,290,000	218,764,000	200,653,000	161,630,000
National Institute of Child Health and Human Development	126,067,000	141,566,000	123,239,000	106,062,000
National Institute on Aging	15,722,000	27,207,000	21,168,000	16,190,000
National Eye Institute	44,040,000	47,321,000	45,084,000	39,201,000
National Institute of Environmental Health Sciences	34,937,000	42,726,000	35,676,000	31,113,000
Research Resources	128,250,000	91,156,000	89,111,000	81,058,000
John E. Fogarty International Center for Advanced Study in the Health Sciences	5,406,000	6,093,000	4,949,000	4,540,000
National Library of Medicine	28,448,000	31,315,000	29,753,000	28,815,000
Building and Facilities	3,000,000	43,435,000	4,000,000	3,000,000
Office of the Director	17,986,000	21,042,000	20,759,000	19,986,000
TOTAL	2,090,607,000	2,219,968,000	1,995,795,000	1,805,000,000

TABLE II

Estimated losses in the United States avoided through the prevention of paralytic poliomyelitis during the period 1955-1961, and estimated cost of avoidance*

ESTIMATE	MILLIONS OF DOLLARS
Losses avoided	
Medical care costs	326.8
Gross lifetime income lost	6389.7
TOTAL	6716.5
Cost of avoidance	
Vaccine purchase	129.8
Physicians' vaccination fees	468.6
Vaccine administration	13.3
Government-funded research and field trials	41.3
TOTAL	653.0
Net gain	6063.5

*Production of polio vaccine was made possible by the observation that viruses could be grown in cultured monkey cells. This finding was made by Dr. J. F. Enders, who was doing basic research into virus propagation. Subsequently, after the Salk and Sabin vaccines had been developed and introduced, basic research into the immunology of the gastrointestinal tract produced the finding that oral administration of vaccine was preferable to intramuscular or subcutaneous administration, because higher levels of antibodies specific for the gastrointestinal tract were induced, preventing the polio virus from entering the system and thus conferring greater protection.

TABLE III

Mediators of cellular immunity elaborated by sensitized lymphocytes after addition of antigen*

1. Skin permeability factor
2. Chemotactic factors for macrophages
3. Macrophage migration inhibitory factor (MIF)
4. Macrophage activating factor (same as MIF?)
5. Chemotactic factors for other leukocytes (neutrophils, eosinophils, basophils, lymphocytes)
6. Granulocytic migration inhibitory factor (LIF)
7. Growth inhibitory factors (clonal inhibitory factor, proliferation inhibitory factor)
8. Lymphocytotoxin (toxic for all cells other than lymphocytes)
9. Osteoclast activating factor
10. Collagen synthesizing factor
11. Interferon
12. Mitogenic factor(s) for lymphocytes

*Two to three dozen mediators have been tentatively identified in studies of lymphocytes in cell culture. It appears that many of these substances might be isolated and, perhaps, used for therapy in various patients with a number of different diseases. However, further basic research will be required.

A heuristic explanation for the roles of some of the factors listed here is as follows: (1) skin permeability factor dilates the capillaries in the skin, making it easier for cells involved in the immune response to reach for substances (antigens) that have entered the body tissues; (2) chemotactic factors attract macrophages (which engulf and destroy foreign cells or parasites, or break them into small enough pieces for the immune system to handle); (3,4) MIF prevents the macrophages from migrating away from the foreign cells while they are being engulfed; (5) chemotactic factors attract other blood cells which break down and release enzymes that attack viruses, proteins, etc.; (6) LIF prevents those cells from moving away; (7) growth inhibitory factors prevent "transformed" (cancer) cells or foreign organisms from dividing and thus increasing in mass; (8) lymphocytotoxin kills "transformed" cells and foreign organisms; (11) interferon inhibits, at least in animals, the growth of viruses, both those that cause cancer and those that do not; (12) mitogenic factors cause lymphocytes to divide and thus start the process over again; i.e., this is an amplification mechanism.

APPENDIX A

An ad hoc "Committee on Impact of Biomedical Research" composed of 100 biomedical scientists from many diverse "basic" and "clinical" scientific disciplines has been formed and had its first meeting in Chicago on December 5, 1973. Its purpose is to generate and analyze information on the dollar benefits derived from biomedical research. (An example is The dollar benefits of biomedical research: A cost analysis, *J. Lab. Clin. Med.*, 1972, *79*, 353.) The data collected by this organization will be analyzed by a Washington-based economist and will be disseminated to biomedical scientists, to the public via newspaper science writers and other public media, and to members of the legislative and executive branches of the government through appropriate administrative assistants[1] in the hope that the information so compiled will have an impact on future funding of biomedical research. Funds for this effort cannot come directly from established organizations, at least at this time: most of these are tax-exempt and prohibited from efforts of this sort. However, it is possible for individuals to join together as we are asking you to do now, independently, for this purpose. The initial founding committee is seeking contributions of $10 per individual for the initial stages of this effort to defray costs of mailing similar letters to members of various biomedical scientific organizations. Other scientists who wish to join on a purely voluntary basis will be notified of this Committee and its activities via periodic editorials in *Current Contents* by Dr. Eugene Garfield, its publisher. A concentrated effort by all biomedical scientists is necessary to provide funds for what we believe to be a vital project, because in these times of fiscal stress we believe that the citizenry must be informed that biomedical research saves not "merely" lives but also dollars, and that the fiscal returns are far greater than the total monies expended for this purpose. If interested, please send your check in the amount of $10 (not tax deductible) to Committee on Impact of Biomedical Research, 2128 Wyoming Avenue, N.W., Washington, D.C. 20008.[2]

The majority of the membership of one society has already indicated its willingness to send contributions, and the chairman of the public affairs committee of another society has pledged the official support of his organization. Contacts have already been established with sympathetic administrative assistants of Senators and Congressmen who are members of key subcommittees dealing with NIH appropriations and other health and science legislation, as well as with some legislative analysts of these committees. Thus we believe that this initial effort will be successful; if so, we hope that a continued effort based on annual contributions will provide a long-term approach to helping solve the problems of support of basic biomedical research.

The Institute for Scientific Information (publishers of *Current Contents*) has agreed to aid us, without charge, in the following way:

If any member of our group writes *Current Contents* citing the published reference of a "clinical breakthrough" which appears to promise large dollar savings by eradication of or prophylaxis against disease, or by development of new diagnostic or therapeutic methods which will curtail hospital stays, return institutionalized patients to work, etc., the Institute for Scientific Information will do a literature search tracing back the clinical breakthrough to the original papers from which subsequent data making the breakthrough possible were derived.[3]

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[1] A former patient of Dr. Fudenberg's with a background in newspaper and radio, and current director of communications for a well-known public utility based in Washington, D.C., has agreed to aid us (without charge) by translating any analysis we derive into a style both interesting and understandable to laymen and, if an elected subcommittee of our parent committee approves, to place these in all Washington media.

[2] This is the temporary office of the Committee (that of Nathaniel Polster, a trained economist and former Editor of the Blue Sheet, which provides data on biomedical funding). This office will serve (without charge) as a mailing address for the Committee until sufficient funds are generated to maintain our own secretarial staff in Washington. He has been able in the past to get economic information with biomedical impact to us within hours of decision making at the highest levels.

[3] The initial signatories have all agreed to define useful scientific areas for fiscal analysis.

APPENDIX B

PREFACE

The immunology section of MICROBIOLOGY by Davis, Dulbecco, Eisen, Ginsberg, and Wood is reprinted here to make it available to those interested in just this part of the book. The numbering of pages and chapters has been left intact, but a new separate index has been prepared.

The special need for such a volume is suggested by the peculiar nature of immunology at this time. When this science took root, almost a century ago, it attracted wide attention among both the general public and the biomedical community because of the promise it offered for relief from epidemic infectious diseases. This promise was fulfilled beyond almost all expectation, and interest in the subject then lagged, although over the ensuing decades a small coterie continued to work in the field, fascinated by the fundamental biological problems raised by the exquisite specificity and diversity of immune responses. In the past 10–15 years, immunology has undergone another flowering, this time based on both its appeal as a fundamental biological science and its changing importance in clinical medicine, where it is contributing a rapidly growing number of diagnostic procedures and reagents, providing tools and concepts for probing mechanisms of diverse diseases, and raising the possibility that its contributions to the control of cancer may approach its earlier successes in controlling diseases of bacterial and viral origin.

These multiple sources of appeal have led to separate courses in immunology in many undergraduate, graduate, and medical school curricula, and I hope that this introductory text may be useful to them. Moreover, for established biologists and medical practitioners this volume may help satisfy a need for the kind of self-instruction that could be helpful in approaching the current flood in immunologic literature—estimated at about 7000 papers in 800 journals this year.

Much of this explosive growth derives from a change in the balance of scientific trade. Until recently, immunology imported more technics and concepts from related disciplines than it exported. This negative balance is being rapidly redressed: there is now hardly a field of biology or medicine in which antibodies are not useful as analytical or diagnostic reagents, and concepts stemming from clonal selection, the immense polymorphism of histocompatibility antigens at cell surfaces, the one cell–one antibody rule, the two genes–one chain hypothesis, and cell–cell cooperation in regulating the activities of antibody secreting cells are just beginning to have broad impact on the study of differentiation and many other areas.

CURRICULUM VITAE

H. HUGH FUDENBERG, M. D.

Birthdate:	October 24, 1928 Birthplace: New York, N. Y.	
Education:	Elementary and High School, Minneapolis, Minn.	
A.B.	University of California, Los Angeles, Calif.	1949
M.D.	University of Chicago, Chicago, Ill	1953
M.A.	Boston University (Immunochemistry)	1956
Training:		
Intern	University of Utah Hospital (Straight Medicine)	1953-54
Resident	Mt. Sinai Hospital, New York, N. Y.	1956-57
Resident	Peter Bent Brigham Hospital (Harvard) Boston	1957-58
Hematology Traineeship	Dr. William Dameshek, Director of Hematology, New England Center Hospital, Tufts Medical School, Boston	1954-56
	Dr. R. E. Rosenfield, Director, Rh Laboratory, New York City Board of Health, Bureau of Laboratories, and Director, Immuno-Hematology Laboratory and Blood Bank, Mt. Sinai Hospital, New York, N. Y.	
	Dr. Fred H. Allen, Jr., Harvard Blood Grouping Laboratory, Boston, Mass.	
	Dr. William Boyd, Professor of Immunochemistry, Boston University	
Positions:		
	Research Associate, Rockefeller Institute, New York, N. Y.	1958-60
	Assistant Professor of Medicine, University of California School of Medicine, San Francisco, Calif.	1960-62
	Associate Professor of Medicine, University of California School of Medicine, San Francisco, Calif.	1962-66
	Associate Professor of Immunology University of California, Berkeley	1965-66
	Professor of Medicine, University of California School of Medicine, San Francisco and	1966-Oct.75
	Professor of Bacteriology and Immunology, University of California, Berkeley	1966-Oct. 75
	Professor and Chairman, Department of Basic and Clinical Immunology and Microbiology, Medical University of South Carolina	1974-

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Society Memberships: (Past and Present)

American Association for the Advance of Science (Fellow)

American Association of Immunologists:

a) Committee for Congressional Liaison for HEW Appropriations
b) Long-Range Planning Committee

American Association of Physicians

American Federation for Clinical REsearch

American Rheumatism Association

American Society for Clinical Investigation
Chairman, Committee on Public Information, 1971 -

American Society of Hematology:

a) President, Subdivision of Immunohematology and Immunogenetics, 1970 and 1974
b) Subcommittee on Research in Teaching, 1961 -

American Society for Human Genetics
Member, Executive Council, 1969 -

Biologic Alliance (Member, Executive Committee)

Genetics Society of America

International Society of Blood Transfusion (Executive Councillor) 1965 - 1971

International Society of Hematology

Midwinter Conference of Immunologists (Founder and Past President)

Netherlands Society for Immunology (Honorary Member)

American Society of Microbiology (Fellow)

Royal Society of Medicine (Associate Member)

Swiss Society of Science, Member, USA Advisory Committee

Transplantation Society

Western Association of Physicians

Western Society for Clinical Research

Public Service: (Past and Present)

Member, Advisory Committee on Personnel for Research - American Cancer Society

Consultant, American Red Cross (National Blood and Plasma Program)

Chairman, Advisory Committee on Research in Methods of Health Care Delivery, Health Systems, Inc.

Member, Expert Advisory Panel on Immunology, World Health Organization (WHO) 1962-1967, 1968-1973, 1973-1978

Member, Expert Committee on Genes, Genotypes, and Phenotypes, World Health Organization, 1966 -

Member, Expert Committee on Genetics of the Immune Response, World Health Organization, 1967 -

Member, Expert Committee on Immunologic Deficiency States, World Health Organization 1970, 1973.

Member, Expert International Committee for Standardization in Hematology of the International Society of Blood Transfusion, 1970 -

International Union of Immunological Societies: 1971 -

a) Member, International Committee for Biological Standardization
b) Member, Nomenclature Committee

Member, Medical Advisory Board, Ataxia Telangiectasis Research Foundation -

Member, Committee on Immunologic Standardization, National Institutes of Health -

Member, National Task Force Multiple Myeloma and Chronic Leukemia, National Institutes of Health, 1966-1971

Member, Public Affairs Committee, Federation of America Societies for Experimental Biology, 1971 -

Various Study Sections: NIH, National Foundation, NSF, Cystic Fibrosis etc.

Clubs:

1. International Platform Association
2. Commonwealth Club of America

Editorial Boards: (Past and Present)

American Journal of Human Genetics (1968 - 1971)

Annals of Allergy

Biochemical Genetics

Blood (term expired 1971)

Clinical Genetics

Clinical Immunology and Immunopathology, (Chief Editor), Academic Press Inc., October, 1972.

Excerpta Medica (Immunology, Serology and Transplantation) 1973 -

Immunochemistry (1965 - 1971, 1973 -

Infection and Immunity (American Society for Microbiology) 1970 - December, 1972

Journal of Immunogenetics (1973 -

Journal of Immunology (1963 - 1971)

Journal of Irreproducible Results

Review Francaise de Transfusion

Transfusion

Vox Sanguinis

Hospital Practice

Honors:

Pasteur Medal, Institute Pasteur, Paris, France, 1962

First Decennial Lecturer, British Society of Immunology, 1966

Robert A. Cooke Memorial Medal, American Academy of Allergy, 1967

Invited Participant, III Nobel Symposium, Stockholm Sweden, 1967

Distinguished Service Award, University of Chicago Medical Alumni, June, 1973

13th Herman Beerman Lecturer, Society for Investigative Dermatology, Inc., June, 1973

Invited Speaker at Various Symposia:

Cold Spring Harbor Symposium
Gordon Conference
New York Academy of Sciences
Nobel Symposium, Stockholm, Sweden
Ph.D. Theses Opponent (Amsterdam, Sweden and Australia)

Host of post-graduate courses throughout the country and many visiting professorships in medicine, microbiology, genetics, etc., both in this country and abroad.

H. Hugh Fudenberg, M.D.

B O O K S

1. BASIC IMMUNOGENETICS. H. Hugh Fudenberg, J.R.L. Pink, D. P. Stites and An-Chuan Wang. Oxford University Press, New York, New York, February 1972 (2nd Edition in preparation (1975)

2. THE SCIENCE AND PRACTICE OF CLINICAL MEDICINE. (Editors: J. M. Dietschy, L. E. Earley, H. H. Fudenberg, A. Renold, C. A. Sanders and J. P. Sanford) Grune & Stratton, New York, New York, 1975.

3. PHAGOCYTIC MECHANISMS IN HEALTH AND DISEASE. (Editors: R. C. Williams and H. Hugh Fudenberg) Intercontinental Medical Book Corporation, New York, New York, 1972.

4. BASIC AND CLINICAL IMMUNOLOGY. H. Hugh Fudenberg, D. P. Stites, J. Vivian Wells and Joseph Caldwell. Lange Medical Publications, Los Altos, California, in preparation.

P A P E R S

Author of 425 scientific papers (original articles, requested reviews, requested editorials, etc.).

Mr. FLOOD. The committee will be in order.

Now we have Dr. John Sherman, vice president of the Association of American Medical Colleges.

You may proceed.

DEPARTMENT OF LABOR, HEALTH, EDUCATION, AND WELFARE BUDGET

WITNESS

DR. JOHN SHERMAN, VICE PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. SHERMAN. Mr. Chairman, we have a full statement we would like to submit for the record but we have an abbreviated one to read.

Mr. FLOOD. We will put the full statement in the record.

[The complete statement follows:]

STATEMENT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON CERTAIN APPROPRIATIONS FOR THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE.—FISCAL YEAR 1976[1]

Mr. Chairman and members of the subcommittee, the Association of American Medical Colleges welcomes this opportunity to appear before the subcommittee during its consideration of the President's fiscal 1976 budget for the health programs of the Department of Health, Education, and Welfare.

Now in its 98th year, the association represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 115 operational U.S. medical schools and their students, 400 of the major teaching hospitals, and 52 learned academic societies whose members are engaged in medical education and research. The association and its membership thus have a deep and direct involvement in the many programs whose appropriations requests this subcommittee is now reviewing.

The association's comments today are limited to those programs funded in the Labor-HEW appropriations bill for which there are authorizations for fiscal 1976. These include the research activities of the National Institutes of Health. Authorities for other major Federal health activities—such as health manpower training—expired at the end of fiscal 1974. Since these authorities have not yet been extended, the association will not offer its fiscal year 1976 recommendations at this time, but would like to request an opportunity to appear before this subcommittee when those authorities are extended.

THE FEDERAL HEALTH BUDGET IN CONTEXT

Before presenting its recommendations the association would like to place the specific health figures in the context of overall health activities. The programs and activities of the National Institutes of Health (NIH), the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), the Health Services Administration (HSA), the Health Resources Administration (HRA), and the Center for Disease Control (CDC)—agencies of the Department of Health, Education, and Welfare—are critical components of Federal funding for health. Even so, the budgets of these agencies are small in relation to the total Federal budget for health.

When one examines the administration's budget request for Federal health activities, it becomes tragically clear how comparatively little of it is directed toward improving the health education and care systems of the Nation, and how much is directed toward sustaining or even diminishing the status quo. Of the requested $37.7 billion in spending for Federal health programs in fiscal 1976, $27.4 billion is for the DHEW. Within the $27.4 billion in DHEW health spending, $15 billion is for medicare and $7.4 billion is for medicaid. Only $1.8 billion

[1] Presented by John F. Sherman, Ph. D., vice president, Association of American Medical Colleges, before the Labor-HEW Subcommittee of the House Appropriations Committee, May 14, 1975.

is for medical research sponsored by the National Institutes of Health; $1.1 billion is for the Health Services Administration; $841 million is for the Health Resources Administration; and $745 million is for the Alcohol, Drug Abuse and Mental Health Administration.

If the contributions to the advancement of health knowledge, health manpower, and health care which accrue from the activities of the Nation's health centers are to mean anything to the people who helped to support it through their tax dollars, the pattern of Federal health spending must change. Increasing—rather than decreasing—amounts of the Federal effort in health must be channeled into activities which have as their prime objective, improving the health system of the country. Those include biomedical research, health training and education, improvements in the organization and delivery of health services, and prevention and control of health problems. The association would now like to examine ways in which the administration's budget for fiscal year 1976 provides for these programs which are the agents of change in health.

The administration is requesting $4.5 billion in fiscal 1976 budget authority for the health agencies of the DHEW. This budget authority includes the following: NIH, $1.8 billion; HRA, $611 million; HSA, $697 million; ADAMHA, $654 million; and CDC, $133 million. The net change for these programs from the level of funds provided by the Congress for fiscal 1975 is a decrease of $786 million.

The figures for these agencies conceal a great deal. They conceal, for example, a $288 million drop from funds appropriated in fiscal 1975 for NIH research and research education (including the elimination of the vital general research support program); a $259 million decrease in the education and training of health personnel (including abolishing Federal educational assistance to allied and public health personnel); the termination of nearly $200 million in medical facilities construction funds; a $46 million reduction in community health services; and drastic reductions in research, training, and community programs in mental health, drug abuse, and alcoholism.

The Coalition for Health Funding, of which the association is a member, has made a detailed analysis of budget requests for all of the health programs of the Department of Health, Education, and Welfare and has compared the requests against authorized levels of appropriations or estimates of appropriations levels more consistent with the needs. For those activities not specifically addressed in this statement, the assosciation supports the recommendations of the coalition.

ASSOCIATION PRIORITIES

In making its recommendations, the association has identified six areas of priority. In descending order these priorities are:

1. Maintenance of effort in research programs sponsored by the National Institutes of Health.
2. Continuation of the general research support program.
3. Continued efforts in biomedical research training.
4. Maintenance of general clinical research centers.
5. Implementation of health planning legislation.
6. Construction of the Lister Hill Center and modernization of the Clinical Center at the NIH.

Based on these priorities, the association has formulated specific recommendations for the subcommittee's consideration. These recommendations, which will be discussed in greater detail below, may be summarized as follows:

ASSOCIATION RECOMMENDATIONS

For the Federal health research and planning programs funded in the Labor-HEW appropriations bill, the association recommends:

1. Increased appropriations of $465 million over the administration's request for the research institutes and divisions of the National Institutes of Health to respond to public expectations raised by enactment of major research and research training legislation, to maintain current programs of lifesaving biomedical investigations, and to initiate new research and education programs;
2. Restoration and continuation of the general research support program. The 93d Congress appropriated $43 million for this program in fiscal 1975 in response to the administration's attempts to terminate it. The association calls upon the Congress to reiterate its support for and recognition of the important role of the GRS program in providing an essential degree of flexibility in the institutions'

research environments by again rejecting the administration's termination plan and by providing $50.5 million for a modified GRS program in fiscal 1976. This program is more important than ever in times of financial uncertainty or stringency if the institutional environments essential for large-scale research efforts are to be maintained;

3. Continued congressional emphasis on programs of research education which produce the Nation's most skilled and sophisticated research personnel, and appropriation of $200 million for training programs. The association suggests that the Congress strictly scrutinize future administration proposals which might restrict this educational opportunity only to postdoctoral students;

4. Continuation of existing general clinical research centers, at a level $47.6 million, and maintenance of the current level of effort;

5. Appropriation of $106.9 million to implement national and local health planning, and to phase out existing planning mechanisms;

6. Provision of $27.7 million in construction funds for the Lister Hill Center for biomedical communications, to complete the final, crucial link in the rapid transmission of biomedical knowledge; and for the initiation of the increasingly necessary ambulatory care research facility of the Clinical Center at the National Institutes of Health.

NIH RESEARCH

	Budget authority (thousands)		
	1974 appropriation	1975 estimate	1976 request
Conduct of research, total	$1,612,567	$1,885,772	$1,629,553
Regular research grants, total	701,896	802,189	676,448
Noncompeting	447,531	508,175	537,482
Competing	254,365	294,014	138,966
Other research grants, total	298,370	340,593	272,132
General research support[1]	52,197	50,221	7,165
Multidisciplinary centers	127,530	167,921	154,651
Other special programs	118,643	122,451	10,316
Direct operations, total	612,301	742,990	680,973
Intramural collaborative research	40,410	54,060	57,073
R. & D. contracts	289,178	348,448	296,572
Other direct operations	220,753	252,384	259,770
Cancer control	34,216	50,098	45,558
Cancer construction	27,744	38,000	22,000

[1] Includes minority biomedical support.

The purpose of biomedical research is to find the scientific basis for the subsequent development of improved methods for the treatment of disease. The leading edge in biomedicine is comprised of the new ideas which can be pursued through research grants and by the new investigators who can be developed through training programs. The scientific advances generated by NIH-supported and conducted research continue to enhance the quality of human life, by alleviating pain and suffering and by eradicating dread disease. The success generated by the atmosphere of scientific inquiry associated with the NIH and its programs is evidenced by the fact that, by 1973, 54 Novel laureates had been either employed or supported by NIH research programs. The Congress has rceently had an opportunity to meet with several distinguished alumni of the NIH and the association endorses their comments offered at that time.

The regular research grant mechanism is a key component of NIH research activities. The administration's plans do not provide adequate funds to maintain this meritorious program at a reasonable level. Awards for competing research grants, for example, are decreased by 25 percent from 1975 levels. All NIH institutes except cancer, neurology, and allergy will decrease the number of these grants awarded and the dollars available to fund them. The association urges the Congress to halt this regression and restore funding for regular research grants to the level of $950.9 million.

In addition to its regular research grants, the NIH sponsors a variety of other essential research activities which would be hampered by the administration's budget request. The association's recommendations for these programs are detailed in the following table:

PRESIDENT'S FISCAL 1976 BUDGET (in thousands)

Research Institutes and Divisions	Regular Research Grants	Research Training Programs	General Research Support Grants	General Clinical Research Centers	Other Activities	Total
Cancer	$114,599	$18,163	$ --	$ --	$472,238	$605,000
Heart	160,871	20,954	--	--	110,969	292,794
Dental	12,669	5,497	--	--	25,370	43,536
Arthritis	100,761	4,344	--	--	43,304	148,409
Neurology	61,500	7,900	--	--	45,555	114,955
Allergy	55,699	7,934	--	--	45,078	108,711
Gen. med. sci.	78,247	40,851	--	--	42,532	161,630
Child health	50,356	9,515	--	--	46,191	106,062
Aging	7,937	1,762	--	--	6,491	16,190
Eye	24,124	4,647	--	--	10,430	39,201
Envir. health	9,685	1,745	--	--	19,683	31,113
Research resources[1]	--	334	7,165	41,601	31,958	81,058
Fogarty Intern'l. Ctr.	--	--	--	--	4,540	4,540
TOTAL	$676,448	$123,646	$7,165	$41,601	$904,339	$1,753,199

ASSOCIATION OF AMERICAN MEDICAL COLLEGES FISCAL 1976 RECOMMENDATIONS (in thousands)

Research Institutes and Divisions	Regular Research Grants	Research Training Programs	General Research Support Grants	General Clinical Research Centers	Other Activities	Total
Cancer	$210,000	$ 38,000	$ --	$ --	$479,000	$727,000
Heart	194,000	21,000	--	--	145,000	360,000
Dental	20,000	6,500	--	--	28,500	55,000
Arthritis	128,500	19,000	--	--	42,900	190,400
Neurology	86,700	18,000	--	--	52,000	156,700
Allergy	72,300	10,000	--	--	49,000	131,300
Gen. med. sci.	108,000	63,000	--	--	35,100	206,100
Child health	75,000	13,000	--	--	52,510	140,510
Aging	8,000	2,000	--	--	6,190	16,190
Eye	33,000	4,500	--	--	11,000	48,500
Envir. health	15,400	4,500	--	--	18,500	38,400
Research resources[1]	--	500	58,400	47,600	35,700[2]	142,200
Fogarty Intern'l. Ctr.	--	--	--	--	6,100	6,100
TOTAL	$950,900	$200,000	$58,400	$47,600	$961,500	$2,218,400

[1]Includes Minority Biomedical Support

[2]Includes $13.1 million for primate centers, and $2.75 million for primate breeding.

GENERAL RESEARCH SUPPORT/BIOMEDICAL RESEARCH SUPPORT

	Budget authority (thousands)		
	1974 appropriation	1975 estimate	1976 request
General research support and minority biomedical support	$52,197	$50,221	$7,165

The value of Federal funds directed to the support of specific research projects is greatly multiplied by some additional funds providing general research support. These funds can be used at the discretion of an institution in the development of new research programs, providing initial support for young investigators, undertaking pilot projects and feasibility studies, and supporting centralized facilities and services needed by multiple investigators. General research support funds enable an institution to balance its various research programs in a manner complementary to the research conducted with project grant funds.

The administration's fiscal 1976 budget for the National Institutes of Health proposes a reduction of approximately $47 million in the Division of Research Resources. This includes $43 million for the general research support program, which the administration proposes to terminate. Last year, the Congress specifically rejected a similar proposal and appropriated $43 million for fiscal 1975. At that time, the Congress also directed the NIH to propose future modifications in the GRS program.

The proposed modifications, which were recently submitted to the Congress, would combine the current general research support grant and biomedical science support grant programs, and would help maintain the financial flexibility which is essential to institutions conducting large-scale research programs. It is these institutions which carry the primary responsibility for the Nation's biomedical research endeavor.

The legislative history of the GRS program acknowledges the need for such flexible funding to provide institutional discretion "to meet emerging opportunities in research, to explore new and unorthodox ideas, and to use research funds in ways and for purposes which they, in their judgment, feel would contribute effectively to the furtherance of their research program." (H. Rept. 2174, 86th Cong., 2d sess., Aug. 26, 1960.)

The rapidly accelerating pace and complexity of biomedical research renders these words even more compelling today than they were when the GRS program was established in 1960. The association believes that it is imperative that the proposed merged program, the "biomedical research support grant" program, be accepted and adopted by the Congress as an essential, integral part of the Nation's biomedical research program.

In addition, this program must be supported by adequate appropriations. The association recommends that this program be funded at a minimum level of $50.5 million in fiscal 1976. The additional funds over the fiscal 1975 level are necessary to carry out the expanded scope of the merged program.

RESEARCH TRAINING

	Budget authority (thousands)		
	1974 appropriation	1975 estimate	1976 request
Conduct of research training, total	$186,195	$155,401	$123,646
Fellowships	29,035	58,055	51,858
Training grants	97,160	97,346	71,788

Predoctoral and postdoctoral research training programs are key elements in the overall NIH research activities. These programs have assured a constant flow of individuals with advanced training in the latest, most sophisticated research methods to replenish and enlarge the Nation's pool of bioscientists. In addition, these training programs provide their sponsoring institutions or agencies an opportunity for great diversity in the types of research training programs conducted, and allow this training to be conducted as a minimum expense.

The value of these programs was recognized and acknowledged by the Congress when it enacted the National Research Service Awards Act (Public Law 93–348). This legislation will expire on June 30, and preparations for its extension have already begun in the Senate. It should be pointed out that the National Research Service Awards program provides strict control over the numbers and types of traineeships and fellowships awarded each year. It therefore has built-in accountability to the Congress and to the Nation's taxpayers.

The association recommends that $200 million be appropriated for research training programs in fiscal 1976. It also recommends that the Congress subject to intense scrutiny any attempts by the administration to modify this program or to exclude certain classes of candidates from participation in its benefits.

GENERAL CLINICAL RESEARCH CENTERS

	Budget authority (thousands)		
	1974 appropriation	1975 estimate	1976 request
General clinical research centers	$41,513	$42,326	$41,601

The administration's fiscal 1976 budget calls for funding of 74 GCRC's. At present, however, there are 84 such centers. The administration has given no explanation for the phase out or termination of 10 of these important facilities. These centers provide hospital beds, highly sophisticated technical equipment, and specially trained health personnel for patients involved in research in areas such as cancer, diabetes, and organ transplantation. The administration must not be allowed to arbitrarily terminate any of these centers. The association believes that funding at a level of $47.6 million for all 84 general clinical research centers in fiscal 1976 is essential if clinical research in congressionally targeted areas is to continue.

The association further recommends that any attempts by the administration to decrease the number of general clinical research centers be carefully examined by the Congess. Any proposed termination of these centers should be justified on the basis of scientific merit, rather than upon arbitrary economic convenience or other less appropriate criteria.

HEALTH PLANNING AND RESOURCES DEVELOPMENT

The administration has requested $175 million for fiscal 1976 to implement the National Health Planning and Resources Development Act (Public Law 93–641). Of this amount, $75 million is designated for health planning activities. The Congress stipulated that the Federal Government's share of health systems agencies (HSA's) funding under this act should be a minimum of $0.50 per capita, suggesting a need for total operational funding of $110 million. The fiscal 1976 authorization in the legislation includes $90 million for health systems agencies planning grants.

Recognizing that a phase-in period will be required and that not all HSA's will be operational during fiscal 1976, the association recommends that the Congress appropriate funds at a level which will assure that the HSA's have the resources to carry out their broad responsibilities under the law. To accomplish this, the association urges that $65 million be appropriated for support of the HSA planning grants.

The administration has also requested $9.5 million for State health planning and development agency grants. Considerable planning functions are vested in the State agencies, such as review of certificates of need and development of State health plans. Responsibilities of the State agency and the statewide health coordinating council include that of consolidating the local health systems plans. Adequate funding for these entities is no less important than that designated for the HSA's. For State agency activities, the Congress authorized $30 million for fiscal 1976. Since not all of the State agencies will be fully operational during fiscal 1976, however, the association recommends appropriations for State agencies at a minimum of $15 million.

Finally, the association would like to point out that the previous planning agencies—regional medical programs, comprehensive health planning, and experimental health service delivery systems—were to be funded until December 31, 1975. Because phase-out activities may require additional support beyond

the period that the HSA's become operational, the association recommends that an additional $10 million be appropriated over the $16.9 million "transitional funding," so that essential functions may be continued until the HSA's can assume their full responsibilities.

BUILDINGS AND FACILITIES

The association urges the Congress to provide funds for the construction of two facilities which are of vital importance to the activities of the National Institutes of Health and the biomedical research community and therefore to the Nation. These are the Lister Center for Biomedical Communications, and the ambulatory care research facility at the NIH Clinical Center.

The Administration has again failed to request funds for the construction of the Lister Hill Center for Biomedical Communications. This facility was authorized by a joint resolution of the Congress in 1968, and final plans have been completed. Construction of the Center would permit the consolidation of activities of the Lister Hill Center, Specialized International Services, the National Medical Audiovisual Center, and the extramural programs of the National Library of Medicine. The Association recommends that funds be appropriated this year to start construction of this Center, which will serve as a fitting monument to Senator Hill's efforts on behalf of the health of the American people.

The association also recommends that the Congress provide funds to begin construction of the ambulatory care research facility, a component of the NIH Clinical Center. The addition of this facility to the Clinical Center would update current systems and structures and would expand the Center's resources for outpatient care.

The association recommends that $27.7 million be appropriated to initiate these two construction projects.

Other Association Recommendations

In addition to the specific recommendations above, the association would like to comment briefly on two other aspects of funding of Federal health programs.

PROGRAM BALANCE AT NIH

First, the association would like to renew its request of past years that the Congress continue to focus particular attention on the program balance at the NIH. The NIH is divided administratively into 12 institutes and research divisions. Taken individually, each of these entities has responsibility for a specialized area of scientific research activity—such as cancer, arthritis, child health, or general medical science. Taken collectively, they have a far greater responsibility—the conduct and support of research which will improve the health of the American people.

One very important indicator of program balance is that of staffing. In fiscal 1975, approximately 10,700 positions were budgeted for the NIH. The Administration's fiscal 1976 request would reduce that level to approximately 10,550—or a decrease of 540 positions since 1968. The association believes that in order to carry out its mandate to administer the Nation's biomedical research programs, the NIH must be staffed at a level of approximately 11,500 positions. This increase over the 1975 level is necessary to carry out expanded Congressional initiatives in such areas as cancer, heart, arthritis, and diabetes research.

If additional positions are not provided, program balance and effective as well as efficient management will be impaired. It is impossible for these programs to expand productively while essential staffing is reduced. If the Administration's staffing request is not increased, the perinatal wing of the Clinical Center cannot be opened; the intramural research mandated by the National Arthritis Act cannot be implemented; the national diabetes program will receive no new personnel to augment its already inadequate staffing; kidney research services cannot be expanded. These are just a few examples of the national research efforts which will be seriously compromised if sufficient staffing is not provided by the Congress.

Unfortunately, providing authority for additional positions at the NIH is not the total solution to the growing program imbalance at the NIH. Inadequate salaries play a major role. The inability of the NIH to attract and retain the highest quality of researchers and administrators over the past few years has

been all too apparent. The comparatively low salaries of NIH professionals combined with inadequate numbers of personnel to carry out the NIH missions and objectives threatens to seriously compromise the future efficiency and effectiveness of federally conducted and supported biomedical research programs.

The association urges this subcommittee to address the need for more full-time positions at the NIH, and the necessity of providing more competitive salaries for NIH employees. The association realizes that it is beyond the purview of this subcommittee to designate specific salaries for Federal employees. However, recognition by this subcommittee of the inadequacies of the present salary structure at the NIH may encourage the appropriate legislative committees of the Congress to deal with this very serious and destructive situation. Attached to this statement is a brief comparison of salaries of medical school faculty to those of NIH career bioscientists. The association believes that this comparison speaks for itself.

The association recommends that the employment ceiling for the NIH be raised to 11,500 positions in fiscal 1975, and that these positions be distributed as follows:

Institute/division:	*Recommended*
NCI	1,975
NHLI	730
NIDR	290
NIAMDD	615
NINCDS	575
NIAID	650
NIGMS	175
NICHD	375
NIA	190
NEI	150
NIEHS	290
DRR	85
FIC	55
NLM	490
DCRT	305
DRS	600
OD	1,950
CC	1,600
DRG	400
Total	11,500

The association also requests that this subcommittee make reference in its report to the inadequacy of the current salary structure at the NIH.

BUDGET RESCISSIONS, DEFERRALS

Before concluding this statement, the association wishes to emphasize its concern about past and future impoundments of health funds. Federal health programs have been a favorite target of the recent Administrations' unlawful impoundment activity. The association urges that the Congress reject future health rescission requests, and that it scrutinize all Administration deferrals of health funds. The Administration must not be allowed to accomplish by deferral what it has been forbidden to accomplish by rescission.

Mr. Chairman, this concludes the association's statement. If you or other members of the subcommittee have any questions, I would be pleased to respond to them.

ATTACHMENT

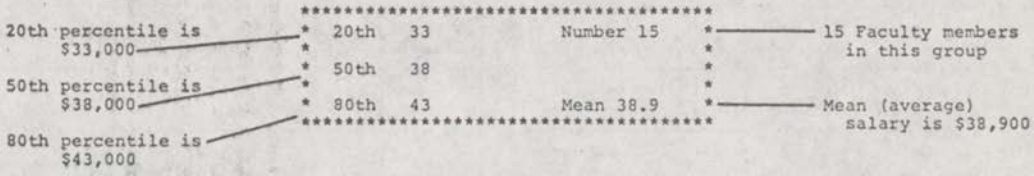
COMPARISON OF SALARIES AT THE NATIONAL INSTITUTES OF HEALTH WITH THOSE AT AMERICAN MEDICAL COLLEGES

The U.S. Government has placed a ceiling on its salaries for career personnel at $36,000 per annum. Scientists at the National Institutes of Health (NIH) are subject to this ceiling. Because of the very select labor market from which it draws its personnel, the salaries offered by the NIH are becoming less competitive.

A comparison of this $36,000 ceiling with current salaries of medical school faculty reveals the discrepancy which is attracting top Government scientists to the private sector. The 1974–75 Report on Medical School Salaries by the Association of American Medical Colleges contains data on faculty salaries for those individuals who receive their entire professional income from funds controlled by the medical school. This data reveals that compared with the $36,000 maximum at the NIH: Department chairmen in medicine are paid salaries that average $53,200; professors are paid salaries that average $42,200. Chairmen of anesthesiology, pathology, and radiology departments receive average salaries ranging from $51,600 to $60,200; professors in these departments average between $40,400 to $47,700. These figures are averages only, and many faculty earn in excess of these base numbers. Furthermore, the fringe benefits in non-Federal institutions are more attractive than in Federal service.

Following are tables indicating average salaries in the clinical sciences departments of medical schools.

KEY TO SALARY TABLES



Note on Computation of Percentile Statistics - The percentile statistics were calculated in the following manner: To obtain the value for the nth percentile statistic, reported salaries were counted in ascending order until the inclusion of a particular reported salary accounted for n percent or more of the reported salaries. No interpolation was performed. As a consequence of this procedure, cells with N=2 show identical values for the 20th and 50th percentile.

Strict full-time medical school faculty are those who receive their entire professional income as a fixed annual amount from funds controlled by the medical school or its parent institution, who devote their full time to the programs of the medical school, and whose professional activities are under the direct auspices of the medical school.

Source: Report on Medical School Faculty Salaries 1974-1975;(March, 1975) Division of Operational Studies Association of American Medical Colleges

ALL REGIONS — STRICT FULL-TIME — ALL SCHOOLS — BUDGETED POSITIONS

BASIC SCIENCE DEPTS.	INSTRUCTOR	ASSIST. PROFESSOR	ASSOC. PROFESSOR	PROFESSOR	CHAIRMAN
ANATOMY	20TH 12 NUMBER 92 50TH 15 80TH 18 MEAN 15.3	20TH 16 NUMBER 486 50TH 18 80TH 20 MEAN 18.1	20TH 20 NUMBER 317 50TH 22 80TH 25 MEAN 22.4	20TH 25 NUMBER 264 50TH 28 80TH 32 MEAN 28.7	20TH 32 NUMBER 89 50TH 37 80TH 41 MEAN 36.6
BIOCHEMISTRY	20TH 10 NUMBER 73 50TH 13 80TH 15 MEAN 12.9	20TH 16 NUMBER 368 50TH 18 80TH 21 MEAN 18.6	20TH 20 NUMBER 326 50TH 23 80TH 26 MEAN 23.0	20TH 25 NUMBER 304 50TH 30 80TH 34 MEAN 29.3	20TH 33 NUMBER 88 50TH 38 80TH 42 MEAN 37.6
MICROBIOLOGY	20TH 11 NUMBER 62 50TH 13 80TH 15 MEAN 13.3	20TH 16 NUMBER 348 50TH 18 80TH 20 MEAN 18.5	20TH 20 NUMBER 264 50TH 22 80TH 24 MEAN 23.1	20TH 25 NUMBER 253 50TH 30 80TH 33 MEAN 29.2	20TH 33 NUMBER 92 50TH 37 80TH 42 MEAN 37.8
PHARMACOLOGY	20TH 10 NUMBER 68 50TH 14 80TH 16 MEAN 14.4	20TH 17 NUMBER 324 50TH 19 80TH 21 MEAN 19.0	20TH 21 NUMBER 254 50TH 24 80TH 26 MEAN 23.9	20TH 25 NUMBER 241 50TH 30 80TH 35 MEAN 30.4	20TH 34 NUMBER 86 50TH 38 80TH 43 MEAN 38.6
PHYSIOLOGY	20TH 11 NUMBER 73 50TH 13 80TH 16 MEAN 13.5	20TH 16 NUMBER 424 50TH 18 80TH 20 MEAN 18.5	20TH 20 NUMBER 330 50TH 23 80TH 24 MEAN 23.2	20TH 25 NUMBER 265 50TH 30 80TH 34 MEAN 29.6	20TH 35 NUMBER 96 50TH 38 80TH 43 MEAN 38.7
OTHER BASIC SCIENCES	20TH 12 NUMBER 89 50TH 14 80TH 17 MEAN 14.8	20TH 16 NUMBER 341 50TH 18 80TH 22 MEAN 19.0	20TH 20 NUMBER 210 50TH 23 80TH 27 MEAN 24.1	20TH 27 NUMBER 227 50TH 32 80TH 37 MEAN 32.2	20TH 30 NUMBER 82 50TH 38 80TH 45 MEAN 38.2
TOTAL BASIC SCIENCES	20TH 11 NUMBER 457 50TH 14 80TH 17 MEAN 14.1	20TH 16 NUMBER 2201 50TH 18 80TH 20 MEAN 18.6	20TH 20 NUMBER 1701 50TH 23 80TH 26 MEAN 23.2	20TH 25 NUMBER 1584 50TH 29 80TH 34 MEAN 29.0	20TH 33 NUMBER 533 50TH 38 80TH 43 MEAN 37.9

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ANNUAL SALARY SURVEY FOR FISCAL YEAR 1974-75

ALL REGIONS — STRICT FULL-TIME — ALL SCHOOLS — BUDGETED POSITIONS

CLINICAL SCI. DEPTS.	INSTRUCTION	ASSIST. PROFESSOR	ASSOC. PROFESSOR	PROFESSOR	CHAIRMAN
ANESTHESIOLOGY	20TH 22 NUMBER 101 50TH 28 80TH 37 MEAN 29.0	20TH 30 NUMBER 203 50TH 37 80TH 43 MEAN 36.8	20TH 39 NUMBER 111 50TH 44 80TH 49 MEAN 43.7	20TH 40 NUMBER 78 50TH 47 80TH 54 MEAN 46.8	20TH 51 NUMBER 37 50TH 57 80TH 65 MEAN 57.9
COMMUNITY HEALTH	20TH 14 NUMBER 76 50TH 17 80TH 24 MEAN 18.7	20TH 18 NUMBER 117 50TH 24 80TH 30 MEAN 24.4	20TH 23 NUMBER 78 50TH 28 80TH 37 MEAN 30.9	20TH 29 NUMBER 42 50TH 35 80TH 40 MEAN 35.2	20TH 34 NUMBER 27 50TH 45 80TH 48 MEAN 43.5
DERMATOLOGY	20TH 12 NUMBER 6 50TH 15 80TH 17 MEAN 15.3	20TH 24 NUMBER 26 50TH 27 80TH 35 MEAN 29.3	20TH 25 NUMBER 27 50TH 34 80TH 34 MEAN 29.4	20TH 33 NUMBER 26 50TH 39 80TH 47 MEAN 39.7	20TH 42 NUMBER 14 50TH 46 80TH 53 MEAN 46.0
FAMILY PRACTICE	20TH 13 NUMBER 28 50TH 19 80TH 24 MEAN 19.1	20TH 23 NUMBER 99 50TH 31 80TH 37 MEAN 30.1	20TH 30 NUMBER 46 50TH 34 80TH 38 MEAN 33.9	20TH 36 NUMBER 21 50TH 40 80TH 45 MEAN 40.6	20TH 42 NUMBER 18 50TH 45 80TH 50 MEAN 46.1
MEDICINE	20TH 13 NUMBER 278 50TH 18 80TH 24 MEAN 18.6	20TH 24 NUMBER 985 50TH 28 80TH 33 MEAN 29.4	20TH 30 NUMBER 643 50TH 36 80TH 40 MEAN 35.7	20TH 35 NUMBER 680 50TH 41 80TH 49 MEAN 42.2	20TH 48 NUMBER 53 50TH 53 80TH 59 MEAN 53.2
NEUROLOGY	20TH 15 NUMBER 57 50TH 18 80TH 25 MEAN 19.2	20TH 22 NUMBER 152 50TH 28 80TH 33 MEAN 28.9	20TH 24 NUMBER 85 50TH 32 80TH 38 MEAN 32.3	20TH 33 NUMBER 81 50TH 41 80TH 49 MEAN 41.4	20TH 44 NUMBER 32 50TH 48 80TH 53 MEAN 49.2
OBS-GYNECOLOGY	20TH 14 NUMBER 86 50TH 16 80TH 22 MEAN 19.2	20TH 21 NUMBER 206 50TH 30 80TH 35 MEAN 28.5	20TH 28 NUMBER 133 50TH 34 80TH 43 MEAN 36.9	20TH 34 NUMBER 105 50TH 43 80TH 49 MEAN 42.4	20TH 48 NUMBER 41 50TH 52 80TH 70 MEAN 54.0
OPHTHALMOLOGY	20TH 13 NUMBER 32 50TH 18 80TH 20 MEAN 17.6	20TH 19 NUMBER 79 50TH 27 80TH 37 MEAN 28.8	20TH 22 NUMBER 52 50TH 29 80TH 39 MEAN 31.4	20TH 30 NUMBER 34 50TH 45 80TH 54 MEAN 43.1	20TH 44 NUMBER 21 50TH 53 80TH 70 MEAN 53.8
OTOLARYNGOLOGY	20TH 10 NUMBER 39 50TH 13 80TH 19 MEAN 14.8	20TH 17 NUMBER 60 50TH 21 80TH 35 MEAN 26.7	20TH 23 NUMBER 46 50TH 27 80TH 40 MEAN 32.3	20TH 25 NUMBER 27 50TH 30 80TH 50 MEAN 36.0	20TH 53 NUMBER 14 50TH 58 80TH 70 MEAN 59.3
PATHOLOGY	20TH 13 NUMBER 111 50TH 18 80TH 24 MEAN 18.5	20TH 21 NUMBER 447 50TH 27 80TH 32 MEAN 27.1	20TH 27 NUMBER 313 50TH 34 80TH 40 MEAN 34.7	20TH 34 NUMBER 294 50TH 39 80TH 47 MEAN 40.4	20TH 46 NUMBER 59 50TH 50 80TH 59 MEAN 51.6
PEDIATRICS	20TH 13 NUMBER 190 50TH 17 80TH 21 MEAN 17.3	20TH 22 NUMBER 556 50TH 26 80TH 30 MEAN 26.1	20TH 27 NUMBER 294 50TH 31 80TH 35 MEAN 31.7	20TH 33 NUMBER 246 50TH 39 80TH 45 MEAN 39.1	20TH 45 NUMBER 51 50TH 50 80TH 53 MEAN 49.5

ALL REGIONS ALL SCHOOLS

STRICT FULL-TIME BUDGETED POSITIONS

CLINICAL SCI. DEPTS.	INSTRUCTOR	ASSIST. PROFESSOR	ASSOC. PROFESSOR	PROFESSOR	CHAIRMAN
PHYSICAL MED & REHAB.	20TH 13 NUMBER 60 50TH 17 80TH 25 MEAN 19.3	20TH 18 NUMBER 114 50TH 27 80TH 34 MEAN 26.7	20TH 21 NUMBER 42 50TH 33 80TH 42 MEAN 31.7	20TH 28 NUMBER 41 50TH 37 80TH 50 MEAN 37.6	20TH 29 NUMBER 23 50TH 44 80TH 58 MEAN 44.8
PREVENTIVE MEDICINE	20TH 13 NUMBER 30 50TH 16 80TH 18 MEAN 16.5	20TH 18 NUMBER 78 50TH 21 80TH 30 MEAN 23.6	20TH 21 NUMBER 42 50TH 24 80TH 32 MEAN 26.9	20TH 25 NUMBER 47 50TH 32 80TH 41 MEAN 33.2	20TH 35 NUMBER 16 50TH 40 80TH 47 MEAN 40.7
PSYCHIATRY	20TH 12 NUMBER 238 50TH 15 80TH 24 MEAN 17.8	20TH 18 NUMBER 589 50TH 25 80TH 33 MEAN 25.9	20TH 24 NUMBER 327 50TH 32 80TH 39 MEAN 32.5	20TH 30 NUMBER 305 50TH 40 80TH 47 MEAN 39.2	20TH 45 NUMBER 46 50TH 51 80TH 57 MEAN 51.9
RADIOLOGY	20TH 16 NUMBER 167 50TH 22 80TH 30 MEAN 23.3	20TH 22 NUMBER 449 50TH 34 80TH 48 MEAN 32.7	20TH 27 NUMBER 220 50TH 43 80TH 58 MEAN 40.6	20TH 37 NUMBER 188 50TH 49 80TH 57 MEAN 47.7	20TH 52 NUMBER 47 50TH 60 80TH 70 MEAN 60.2
GENERAL SURGERY	20TH 15 NUMBER 99 50TH 19 80TH 28 MEAN 20.9	20TH 22 NUMBER 295 50TH 33 80TH 38 MEAN 31.7	20TH 29 NUMBER 195 50TH 40 80TH 45 MEAN 38.8	20TH 40 NUMBER 222 50TH 47 80TH 56 MEAN 47.7	20TH 51 NUMBER 39 50TH 59 80TH 68 MEAN 58.5
NEUROSURGERY	20TH 16 NUMBER 10 50TH 20 80TH 25 MEAN 21.3	20TH 19 NUMBER 38 50TH 28 80TH 39 MEAN 30.8	20TH 25 NUMBER 30 50TH 35 80TH 50 MEAN 39.1	20TH 34 NUMBER 19 50TH 49 80TH 51 MEAN 44.1	20TH 48 NUMBER 14 50TH 55 80TH 72 MEAN 58.0
ORTHOPEDIC SURGERY	20TH 17 NUMBER 14 50TH 19 80TH 35 MEAN 26.5	20TH 29 NUMBER 53 50TH 38 80TH 42 MEAN 36.2	20TH 37 NUMBER 32 50TH 42 80TH 55 MEAN 46.1	20TH 46 NUMBER 31 50TH 50 80TH 61 MEAN 51.3	20TH 51 NUMBER 18 50TH 58 80TH 73 MEAN 59.5
PLASTIC SURGERY	20TH 14 NUMBER 6 50TH 15 80TH 16 MEAN 16.3	20TH 30 NUMBER 11 50TH 34 80TH 43 MEAN 34.5	20TH 34 NUMBER 7 50TH 38 80TH 44 MEAN 41.3	20TH 47 NUMBER 4 50TH 53 80TH 64 MEAN 55.3	20TH 55 NUMBER 3 50TH 57 80TH 60 MEAN 57.3
THORACIC & CARDIO-VASCULAR SURGERY	20TH 15 NUMBER 3 50TH 17 80TH 18 MEAN 15.7	20TH 31 NUMBER 13 50TH 39 80TH 41 MEAN 38.1	20TH 40 NUMBER 8 50TH 45 80TH 55 MEAN 47.8	20TH 47 NUMBER 12 50TH 54 80TH 69 MEAN 54.6	20TH NUMBER 1 50TH 80TH MEAN
UROLOGY	20TH 17 NUMBER 4 50TH 19 80TH 32 MEAN 23.8	20TH 26 NUMBER 32 50TH 35 80TH 45 MEAN 37.1	20TH 32 NUMBER 15 50TH 40 80TH 47 MEAN 41.7	20TH 42 NUMBER 19 50TH 47 80TH 63 MEAN 51.2	20TH 27 NUMBER 9 50TH 53 80TH 55 MEAN 49.3
OTHER CLINICAL SCI	20TH 12 NUMBER 75 50TH 17 80TH 27 MEAN 19.2	20TH 17 NUMBER 202 50TH 24 80TH 33 MEAN 25.7	20TH 22 NUMBER 102 50TH 29 80TH 39 MEAN 31.0	20TH 27 NUMBER 76 50TH 35 80TH 45 MEAN 36.2	20TH 35 NUMBER 40 50TH 45 80TH 55 MEAN 45.7
TOTAL CLINICAL SCI	20TH 13 NUMBER 1712 50TH 18 80TH 28 MEAN 19.6	20TH 21 NUMBER 4874 50TH 28 80TH 35 MEAN 28.9	20TH 26 NUMBER 2850 50TH 34 80TH 42 MEAN 35.0	20TH 34 NUMBER 2506 50TH 41 80TH 50 MEAN 42.0	20TH 44 NUMBER 625 50TH 52 80TH 60 MEAN 52.1

Dr. SHERMAN. Mr. Chairman and members of the subcommittee, the Association of American Medical Colleges welcomes this opportunity to appear before the subcommitee during its consideration of the President's fiscal 1976 budget for the health programs of the Department of Health, Education, and Welfare.

Now in its 98th year, the association represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 115 operational U.S. medical schools and their students, 400 of the major teaching hospitals, and 52 learned academic societies whose members are engaged in medical education and research. The association and its membership thus have a deep and direct involvement in the many programs whose appropriations requests this subcommitee is now reviewing.

The association's comments today are limited to those programs funded in the Labor-HEW apropriations bill for which there are authorizations for fiscal 1976. These include the research activities of the National Institutes of Health. Authorities for other major Federal health activities—such as health manpower training—expired at the end of fiscal 1974. Since these authorities have not yet been extended, the association will not offer its fiscal year 1976 recommendations at this time, but would like to request an opportunity to appear before this subcommittee when those authorities are extended.

The budget figures proposed by the President for the PHS agencies this year conceal a great deal. They conceal, for example, a $288 million drop from funds appropriated in fiscal year 1975 for NIH research and research education (including the elimination of the vital general research support program); a $259 million decrease in the education and training of health personnel (including abolishing Federal educational assistance to allied and public health personnel); the termination of nearly $200 million in medical facilities construction funds; a $46 million reduction in community health services; and drastic reductions in research, training, and community programs in mental health, drug abuse, and alcoholism.

The Coalition for Health Funding, of which the association is a member, has made a detailed analysis of budget requests for all of the health programs of the Department of Health, Education, and Welfare and has compared the requests against authorized levels of appropriations or estimates of appropriations levels more consistent with the needs. For those activities not specifically addressed in this statement, the association supports the recommendations of the coalition.

ASSOCIATION PRIORITIES

In making its recommendations, the association has identified six areas of priority. In descending order these priorities are:

1. Maintenance of effort in research programs sponsored by the National Institutes of Health.
2. Continuation of the general research support program.
3. Continued efforts in biomedical research training.
4. Maintenance of general clinical research centers.
5. Implementation of health planning legislation.
6. Construction of the Lister Hill Center and modernization of the Clinical Center at the NIH.

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Based on these priorities, the association has formulated specific recommendations for the subcommittee's consideration.

ASSOCIATION RECOMMENDATIONS

For the Federal health research and planning programs funded in the Labor-HEW appropriations bill, the association recommends:

1. Increased appropriations of $465 million over the administration's request, or $176 million over fiscal year 1975 appropriations, for the research institutes and divisions of the National Institutes of Health to respond to public expectations raised by enactment of major research and research training legislation and to maintain current programs of life-saving biomedical investigations.

The administration's plans do not provide adequate funds to maintain meritorious research programs at reasonable levels. Awards for competing research grants, for example, are decreased by 25 percent from 1975 levels. All NIH institutes except Cancer, Neurology, and Allergy will decrease the number of these grants awarded and the dollars available to fund them. The association urges the Congress to halt this regression.

2. Restoration and continuation of the general research support program. The 93d Congress appropriated $43 million for this program in fiscal 1975 in response to the administration's attempts to terminate it. The association calls upon the Congress to reiterate its support this year for and recognition of the important role of the GRS program in providing an essential degree of flexibility in the institutions' research environments by again rejecting the administration's termination plan and by providing $50.5 million for a modified GRS program in fiscal 1976. This program is more important than ever in times of financial uncertainty or stringency if the institutional environments essential for large-scale research efforts are to be maintained. I might add that numerous observers describe these funds as among the most useful and efficient for biomedical research.

3. Continued congressional emphasis on programs of research education which produce the Nation's most skilled and sophisticated research personnel, and appropriation of $200 million for training programs including both training grants and scholarships.

The association believes that these training programs provide their sponsoring institutions or agencies an opportunity for great diversity in the types of research training programs conducted, and allow this training to be conducted at a minimum expense.

The value of these programs was recognized and acknowledged by the Congress when it enacted the National Research Service Awards Act (Public Law 93–348). This legislation will expire on June 30, and preparations for its extension have already begun in the Senate. It should be pointed out that the national research service awards program provides strict control over the numbers and types of traineeships and fellowships awarded each year. The association suggests that the Congress strictly scrutinize future administration proposals which might restrict this educational opportunity only to post-doctoral students. That is possibly excluding predoctoral students.

4. Continuation of existing general clinical research centers, at a level $47.6 million, and maintenance of the current level of effort.

The administration's fiscal 1976 budget calls for funding of 74 GCRC's. At present, however, there are 84 such centers. The administration has given no explanation for the phaseout or termination of 10 of these important facilities. These centers provide hospital beds, highly sophisticated technical equipment, and specially trained health personnel for patients involved in research in areas such as cancer, diabetes, and organ transplantation.

The association further recommends that any attempts by the administration to decrease the number of general clinical research centers be carefully examined by the Congress. Any proposed termination of these centers should be justified on the basis of scientific merit, rather than upon arbitrary economic convenience or other less appropriate criteria.

5. Appropriation of $106.9 million for health planning activities. The National Health Planning and Resources Development Act authorizes Federal participation in health planning activities. The funding recommended by the association would contribute to health systems agency planning grants, State health planning grants, and to the orderly phaseout of regional medical programs, comprehensive health planning, and experimental health service delivery systems.

6. Provision of $27.7 million in construction funds for the Lister Hill Center for Biomedical Communications, to complete the final, crucial link in the rapid transmission of biomedical knowledge; and for the initiation of the increasingly necessary ambulatory care research facility of the Clinical Center at the National Institutes of Health. The Lister Hill Center for Biomedical Communications was authorized by a joint resolution of the Congress in 1968, and final plans have been completed. Construction of the Center would permit the consolidation of activities of the Lister Hill Center, Specialized International Services, the National Medical Audiovisual Center, and the extramural programs of the National Library of Medicine.

The association also recommends that the Congress provide funds to begin construction of the ambulatory care research facility, a component of the NIH Clinical Center. The addition of this facility to the Clincal Center would update current systems and structures and would expand the Center's resources for research on outpatients. This construction is vital if the Center is to remain among the Nation's leading research environments, in both the type of research conducted and for recruitment and retention of the foremost scientists for which it has been famous.

OTHER ASSOCIATION RECOMMENDATIONS

In addition to the specific recommendations above, the association would like to comment briefly on two other aspects of funding of Federal health programs.

First, the association would like to renew its request of past years that the Congress continue to focus particular attention on the issue of program balance at the NIH.

One very important indicator of program balance is that of staffing. You know well, I think, from my previous experience, this was a matter of considerable concern to me while at NIH.

In fiscal 1975, approximately 10,700 positions were budgeted for the NIH. The administration's fiscal 1976 request would reduce that level to approxi-

mately 10,550—or a decrease of 540 positions since 1968. The association believes that in order to carry out its mandate to administer the Nation's biomedical research programs, the NIH must be staffed at a level of approximately 11,500 positions. Our recommendations are detailed in a table in the full statement. This increase over the 1975 level is necessary to carry out expanded congressional initiatives in such areas as cancer, heart, arthritis, and diabetes research.

Unfortunately, providing authority for additional positions at the NIH is not the total solution to the growing program imbalance at the NIH. Inadequate salaries play a major role. The inability of the NIH to attract and retain the highest quality of researchers and administrators over the past few years has been all too apparent. The comparatively low salaries of NIH professionals combined with inadequate numbers of personnel to carry out the NIH missions and objectives threatens to seriously compromise the future efficiency and effectiveness of federally conducted and supported biomedical research programs.

The association urges this subcommittee to address the need for more full-time positions at the NIH, and the necessity of providing more competitive salaries for NIH employees. The association realizes that it is beyond the purview of this subcommittee to designate specific salaries for Federal employees. However, recognition by this subcommittee of the inadequacies of the present salary structure at the NIH may encourage the appropriate legislative committees of the Congress to deal with this very serious and destructive situation.

BUDGET RESCISSIONS, DEFERRALS

Before concluding this statement, the association wishes to emphasize its concern about past and future impoundments of health funds. Federal health programs have been a favorite target of the recent administrations' unlawful impoundment activity. The association urges that the Congress reject future health rescission requests, and that it scrutinize all administration deferrals of health funds. The administration must not be allowed to accomplish by deferral what it has been forbidden to accomplish by rescission.

Mr. Chairman, this concludes my statement. If you or other members of the subcommittee have any questions, I would be pleased to respond to them.

Mr. FLOOD. Thank you very much.

Dr. SHERMAN. Thank you very much.

NATIONAL INSTITUTE ON AGING

WITNESS

DR. F. MAROTT SINEX, GERONTOLOGICAL SOCIETY

Mr. FLOOD. Dr. F. Marott Sinex, Gerontological Society.

Dr. SINEX. Representative Flood and members of the committee, I am F. Marott Sinex, chairman of the Department of Biochemistry at Boston University School of Medicine and Co-Director of the Gerontology Center at Boston University. From 1969 to 1970 I was president of the Gerontological Society as whose representative I appear. I have served on the Training Grant and Program Project Study Section of the Institute of Child Health and Human Development and three years on the Board of Scientific Counselors of that Institute which advises on the intramural program.

The development of the fiscal 1976 budget is an extremely critical matter for the proposed National Institute on Aging at the National Institutes of Health. Legislation alone does not create an institute, it requires staff and funding. Only if this is done can the new institute get on with the job of learning the causes of aging, the ways of manipulating the aging process, and studying the role of aging in the development of disease.

To review briefly the state of the Institute, there is a Council and there is a study section; dealing with program projects and training grants. Dr. Kretchmer, Director of the Institute of Child Health and Human Development, is serving as Acting Director and two or three members of Dr. Kretchmer's staff are assigned to the new Institute, servicing Council and assisting Dr. Kretchmer with a few absolutely essential matters. However, the major responsibility for development and management of the extramural program remains within child health and human development. The reason is that there are no new slots and very little new money. Let us discuss the money first.

The budget proposed by the administration of $16.2 million for fiscal 1976 represents a million dollar reduction in the funds available to the aging program in fiscal 1975. Fiscal 1975 expenditures came from two sources, $15.7 million of fiscal 1975 funds and $1.5 million of impounded funds, a total of $17.2. This $17.2 million was distributed as follows: $9.2 million in extramural research grants, $0.8 million into contracts, $1.8 million into training, $4.6 million into the intramural program and $0.8 million for management.

If you approve the 1976 budget, appropriations for extramural research grants will have to be decreased from $9.2 to $8 million. Training will hold relatively stable at $1.8 million as will the intramural program and contracts. The charges for research management will increase 123,000, almost all of which is for intramural. The 1975 and 1976 budgets are compared in the following table:

	1975	1976
Extramural	9.2	8.0
Training	1.8	1.8
Intramural	4.6	4.8
Contracts	.8	.7
Research management	.8	.9
Total	17.2	16.2

At the last meeting of Council it was only possible to fund 23 out of 300 research grants. To have funded down to a priority score of 250 would have required an additional $1.4 million for regular research grants and another $0.5 million for program projects. To fund all approved grants would have required $9 million. There is thus a rather remarkable backlog of approved and unfunded grants. The scientific community is clearly willing to do research on aging. It will not be able to do this without funds.

Now let us discuss slots. The 154 slots in Baltimore in the Gerontology Research Center are not as critical an issue as the extramural slots; nevertheless, they are important. Innovation within the intramural program may be best carried out through the creation of new branches and the full utilization of the building in Baltimore for aging research.

In the extramural program, however, there is a serious problem that I would like to bring to your attention. Regardless of the future relationships between the National Institute of Aging and the National Institute of Child Health and Human Development it will be best if these are arrived at through the voluntary association of equals and not through an aborted birth. The extramural program is

currently being serviced entirely by Child Health personnel. This is unfair to both the new Institute and to Child Health. The minimum staff required to operate the Director's office and associated functions of the extramural programs of an institute of any stature at all is 50. Currently the transfer of the 12 slots in the existing aging program in Child Health and four slots from Child Health itself still leaves the new Institute very short. This could impose some severe problems in respect to program development.

Now let me say just a few words about the program.

If I were to identify three program areas for more intensive study I would pick the following: Research on senile dementia in order to learn its causes, how to prevent it and reduce the population of our nursing homes; the testing of drugs which may slow the rate of aging, and basic studies on chromatin and its repair because I think that will lead to real understanding of how to intervene in the aging process.

As examples of these program areas I would mention the following. In regard to senile dementia we have found at Boston University that the number of connections between brain cells decreases with age in rats and the layer of cells with which rats and men think becomes thinner with age.

The next illustration shows the effect of adding dimethylaminoethanol to the drinking water of mice It makes mice live longer.

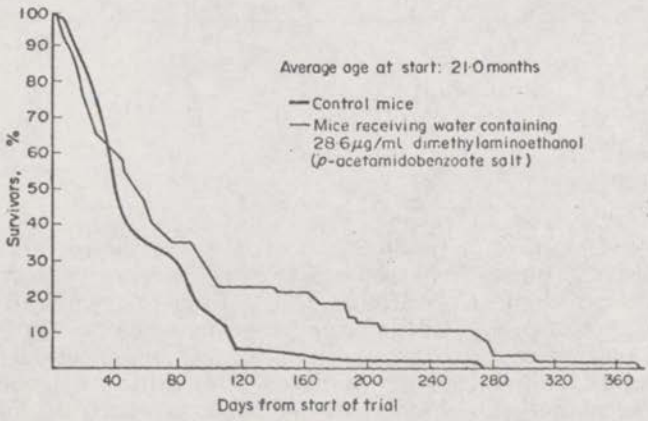
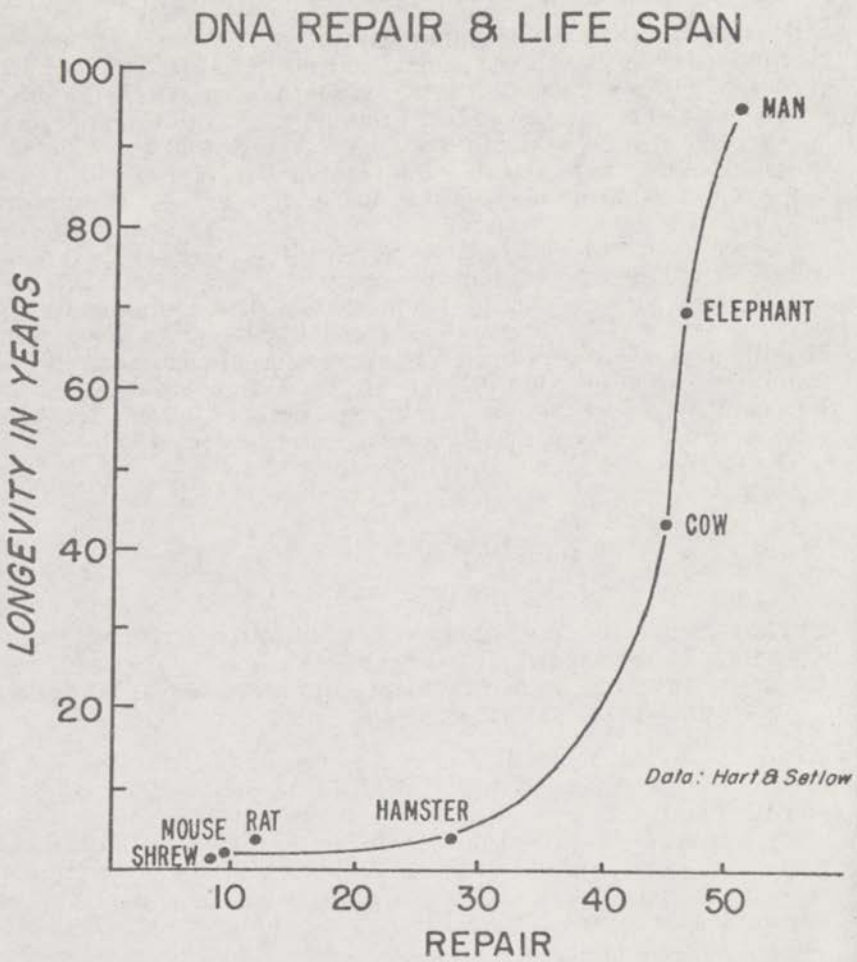


FIGURE 1.—Senile male A/J mice

The second illustration shows the differences between repair enzyme in short-lived species such as mice and long-lived species such as humans.



It should be possible, through biological technology, to give men and women more vigorous life in their middle years and to retard the onset of aging. The speed at which this is accomplished is to a considerable extent, dependent on the investment in research on aging. If without a director and with no increase in budget a small program within the Institute of Child Health was able to achieve a $9 million backlog in approved grants, effective leadership should be able to double the program within a year. I suggest, therefore, that you appropriate for fiscal 1976 $32 million for research on aging.

Last year you recall that we detailed a $28 million budget, and it would probably be more appropriate if the new Director, when he was appointed, would detail budgets. However, you will recall that when Dr. Kretchmer appeared before you a few weeks ago in a fairly informal way he made a similar estimate.

That is the main part of what I want to say about NIA. NIA is concerned with what causes aging and what to do about it in a biomedical sense. They are involved with behavioral science.

Behavioral science, for example, is involved with learning how to overcome some of these psychological detriments in a way that can be done right now, and done effectively. But for the most part, in the terms of the here and now, much of that programing is with Congress, and it is dependent on the Administration on Aging. And the Administration on Aging has a research and training program in which they talk about how to develop service delivery programs and support services.

The society for which I testify, and myself, strongly support these research and training programs because that is how we train leadership to work with the elderly. I note that in the training and manpower program of AOA there is a possibility it would be cut from $8 million to zero. Certainly I would recommend that research and training program for AOA go up to 10. The Congress has created the NIA and AOA and there is certain expectations, and effective programing in these agencies will require some appropriation.

Thank you.

Mr. FLOOD. Thank you.

BLOOD RESEARCH

WITNESSES

LOUIS FRIEDLAND, CHAIRMAN OF THE BOARD, NATIONAL HEMOPHILIA FOUNDATION

DR. LOUIS ALEDORT, VICE CHAIRMAN, DEPARTMENT OF MEDICINE AT MOUNT SINAI HOSPITAL, NEW YORK

Mr. FLOOD. The National Hemophilia Foundation, Dr. Louis Aledort, vice chairman, Department of Medicine, Mount Sinai Hospital and Mr. Friedland.

Mr. FRIEDLAND. I am chairman of the National Hemophilia Foundation and I am also president of MCA–TV which is a company that operates with Universal Studios in California. Dr. Louis Aledort, medical adviser of the National Hemophilia Foundation will present the formal portion of our report. May I ask permission to submit the statement of the foundation?

Mr. FLOOD. Without objection it will be done.

[The statement follows:]

TESTIMONY OF THE NATIONAL HEMOPHILIA FOUNDATION REGARDING APPROPRIATIONS FOR BLOOD RESEARCH

Mr. Chairman, the National Hemophilia Foundation [1] is grateful for the opportunity to testify before you regarding the appropriations of the Department of Health, Eduction, and Welfare in relation to blood research. This is the first time we are testifying before your committee although we have, for many years, heard of your excellent work in support of biomedical research in this field.

We know that if it had not been for your support and that of your committee, as well as the support of your colleagues in the Appropriations Subcommittee in the Senate, all of the remarkable advances in blood research that have occurred

[1] The National Hemophilia Foundation, located at 25 West 39th Street, New York, New York 10018, is a voluntary, nonprofit health agency, and the only national organization concerned with the disease of hemophilia. The foundation is an active member of the National Health Council and furnishes reports to the National Information Bureau. It maintains an active liaison with the American National Red Cross and other organizations that are concerned with assuring an adequate, safe, and reasonably priced supply of blood and blood products to those who require it. The foundation is also a member of the American Blood Commission. For further information, contact Mr. George Theobald, executive director.

in the years since such research has been supported at NIH would not have been possible.

So that you and the members of your committee can better understand the nature of he disease and the work of our foundation, I have attached to this testimony copies of literature for your study, which will explain the problems we confront, and how we hope to solve them.

We are very pleased to be able to testify immediately after the American Society for Hermatology. We have their testimony, and agree with it completely, just as we agree with their proposed amendments to the Heart, Blood Vessel, Lung and Blood Act of 1972, which is up for renewal at this time in the health authorizing subcommittee.

We particularly wish to stress the necessity of continuing appropriations at a high level for blood research. We know the remarkaole advances that have occurred regarding the disease we are concerned with, and know also the remarkable opportunities which exist, as well as how far we have to go.

The cutbacks proposed by the President's budget are simply unreasonable, in the literal sense of the word. The cutbacks in training grants and research grants which are proposed have already lowered the morale of those who work in blood research, and we know that many of our most promising young scientists are seriously considering leaving the field (and many who might enter are turning away from it) because of the instability of funding for the programs in which they are vitally interested and in which they have so much to offer.

Because this is the first time that we have testified, I would like to spell out for you in some detail the advances we have made in recent years, as well as the most promising research opportunities which exist, and some of the serious problems we are faced with in research on hemophilia.

Mr. Chairman, there are almost 100,000 hemophiliacs in this country, 25,000 of whom are severely or moderately affected. (A recent study, funded by the National Heart and Lung Institute, verifies that number.) They all suffer a genetic disorder of the blood, in which the clotting factor is either partially or completely missing—this disorder is commonly known as bleeders' disease. It is important that this committee understand that hemophiliacs are unique among chronic disease victims because they are not born crippled and can be spared the physical pain usually associated with the disease if financial conditions allow them continuous access to the missing clotting factor, which must be derived from human blood for both emergency and prophylactic use. Without this ongoing treatment, the hemophiliac unnecessarily becomes a burden to himself, his family, and to society. Without the treatment the hemophiliac is literally, during bleeding episodes, and after, crippled by his own blood, due to the bleeding which takes place in the joints and tissues, destroying them.

Now, however, a medical miracle can take place whenever we desire it and can pay for it—a medical miracle which has taken place because of the research supported by the legislative activities of this very committee. Scientific advances have provided us with materials capable of correcting this disorder by replacing the missing clotting factor. Bleeding usually can be checked with transfusions of the clotting factor concentrates, or with transfusions of part or whole blood, or plasma. Due to the very nature of the disease, while the patient is fully dependent upon the availability of the product, this availability and use is not alone enough to insure that the hemophiliac can remain in the mainstream of a productive society. Adequate treatment of the disease mandates a comprehensive care approach, to heal the ravages of the past lack of care, as well as social and psychological injuries to the family and loved one. This comprehensive approach must utilize the services of hematologists, orthopedic specialists, dentists, psychiatrists, social service and vocations specialists. For it is only by utilizing adequate diagnostic and treatment facilities that the hemophiliac can be assured of receiving the vitally necessary care that he requires in order to play his full role in society.

RESEARCH INTO BLOOD DISEASES AND BLOOD RESOURCES

There are two areas of research that should be funded at a high level: blood diseases and blood resources. The first is concerned with the nature of blood and its diseases, and the second is concerned with the supply and distribution, as well as the separation into components for efficient use, of the collected blood for medical use.

A. *Accomplishments.*—In recent years there have been a number of accomplishments in hemophilia research. Technological advances have made possible separation of a single unit of blood into its many components. For example, the white blood cells and platelets can be removed to treat patients with aplastic anemia and leukemia, and the red blood cells for bleeding, and the plasma for hemophiliacs.

These latter fractions are being utilized for the acute treatment, prophylatic therapy and now home care (self infusion) for suffers of these bleeding syndromes. This aspect of blood disease and blood resource research is a perfect example of clinically applied basic science. Currently, however, the cost of these infusions is extremely high, and there is now, working its way through Congress, a bill which would provide aid to blood separation centers to improve the separation process so that the cost of components can be lowered. The bill would also provide support to demonstration centers so that optimum delivery of care methods can be developed. This legislation has not yet passed the Congress, so that we will not comment on the appropriations requirements for it in this testimony, but we are very hopeful that by next year at this time we will be able to appear before you to speak in support of that authorizing legislation.

Your past support in the fight against this disease has brought about considerable:

1. Information:
   - (*a*) development of a program to determine state of the art of a synthetic factor VIII,
   - (*b*) a national workshop to improve the safety of factor IX (another component of the blood, missing in some hemophiliacs), and
   - (*c*) considerable data about the current status of our knowledge of the natural course and treatment of patients with inhibitors against clotting.
2. Basic science and technologic advances:
   - (*a*) application of the molecular biology of factor VIII to carrier detection for appropriate genetic counselling,
   - (*b*) increasing the yield of clotting factors during processing thereby more effectively using our blood resources, and
   - (*c*) development of animal models with coagulation disorders.

These accomplishments have resulted from your support, Mr. Chairman, and have expanded the base of research from which we will be able to make considerable advances in the near future.

B. *Activities in Progress.*—I would like to turn now to the activities currently in progress in hemophilia research, which are taking place under the current fiscal year's research funding of $3 million. First, researchers are working on the purification of animal factor VIII and testing in bleeding patients with antibodies. Also, researchers are working on the pilot evaluation of treatment facilities. Additionally, many of the leading figures in the blood research and resource community have been meeting to develop a viable structure for the delivery of care and effective research, and efficient blood utilization for future implementation (a so-called "gaming of the hemophilia management complex" program).

C. *New Actions Planned for the Near Future.*—There are a number of new actions planned for the near future, which can take place if funding becomes available. They are the laboratory study of patients in a systematic way to chart the natural course and clinical impact of factor VIII inhibitors, including the standardized assay method and reference materials to allow comparability of data, intensive study of certain inhibitors to clotting, and the development of a reference laboratory and coordination center for information about hemophilia.

D. *Further Needs and Opportunities.*—Administrators working in the field of blood research have identified a number of needs and opportunities for future work, which can only be accomplished if adequate, and stable, funding is available.

There is a need for a hemophilia therapy data center; a determination of the status of counseling in the field of carrier detection as well as genetic counseling itself; the evaluation of national use of therapeutic products; the development of improved methods of factor VIII and factor IX concentrate production to decrease loss of materials from fractionation for optimal plasma utilization;

the review of the status of synthetic factor VIII; and the necessity to improve the data base of hemophilia epidemiology and treatment facilities.

There is need to superimpose additional studies on the factor VIII inhibitor trial, including the evaluation of various modes of therapy once the clinical study methods are established, and the demonstration of the validity of the testing methods involved.

There are other studies which are vital, and which will affect not only hemophiliacs, but all those who have blood diseases. These include the extension of the SCOR program of the National Heart and Lung Institute to include thrombosis and hemostasis, the evaluation of opportunities for improvement and standardization in clinical coagulation laboratory techniques, the study of thromboembolic disorders in patients with various hemorrhagic diseases, the development of immunologic assays for all clotting factors, the clarification of the heterogeneity of genetic clotting disorders, the relationship between coagulation and inflammation of the blood, the classification of qualitative platelet disorders, the development of simple screening techniques for platelet defects, and the investigation of the possibility of synthetic factor VIII activity. Solution of these vital questions will have broad impact on major public health issues.

Mr. Chairman, we recognized that many of these activities, new actions, and future needs and opportunities have been stated here in complex scientific language, and in almost "laundry list" form. However, we believe, because it is our first time before you, that we must lay out as comprehensively as possible what has been done, what is being done now, and what must be done in the future.

After reading these paragraphs, there can be no doubt in your mind that the assertions of the American Society for Hematology are correct, that there has been an explosion in knowledge and opportunities in blood research. There must be no doubt in anyone's mind that the last thing we would want is to stifle the present research, or to dismantle any ongoing research program put together at great cost and effort, which has been productive.

BLOOD RESOURCES RESEARCH

It is becoming increasingly clear that the blood system of the nation has serious problems, including:

Inadequate and poorly distributed supply of blood,
Lack of an all-volunteer blood donor system,
Insufficient and inadequately trained personnel,
Inefficient administration of the national blood supply,
No reliable data on demand and supply of blood and blood products,
Inadequate cost accounting of blood and its products,
Poor utilization of blood and its components.

Blood therapy itself has problems of safety, including the transmission of hepatitis viruses, rapid outdating and human error in blood transfusion, the possible leaching of toxic materials from blood bags and containers. Blood component therapy at best has unresolved problems, some of which are platelet preservation and typing, and loss of material by plasma fractionation. In addition, the serious problems of tissue compatability for transplantation biology must be addressed quickly.

But in a more general view, it is clear that the National Heart and Lung Institute must be given more funding support regarding research into the management of the nationwide blood system. Parenthetically, it should be noted here that in the last year, when the Department of Health, Education, and Welfare began its initial support of the American Blood Commission which is beginning to develop the national blood policy, the National Health and Lung Institute was required by the Office of the Secretary to set aside $250,000 to assist in the developmental programs of the Commission, which sum came out of the blood research funds. If the Department desires to support the Commission further, which support we ourselves would back because of the necessity of the Commission to grow, it should not take the funding out of blood research dollars currently within the NHLI. We are hopeful that this committee can make clear in bill report language that this should be the case.

We believe that NHLI should have the opportunity to support research to solve the above problem regarding our national blood resource, so much so that we support proposed amendments before the authorizing committees in the Congress which would spell out precisely that such research is authorized. The support that we give before those committees for the amendment, we also give here.

We also support their suggestion of an appropriation level for the Heart and Lung Institute of at least the level of fiscal year 1975 appropriations plus 10 percent to match the inflation rate. Indeed, we are hopeful that you will be agreeable to the addition of even higher appropriations, so that we can begin on the new opportunities for blood research which are opening before us. Thank you.

Mr. FRIEDLAND. First, I want to thank you personally, and I have come here for that purpose, for all of the work you have done in the advocacies of biomedical research. I know of it and thank you for it.

I would like to show you something to give you a graphic indication of what your support has meant to some of us.

I have four braces here I can barely carry, and for the first 17 years of his life my son, now 24, wore these things and could barely move in them. He wore them to sleep and wherever he went; he could not attend school. He bled profusely. Most people are not aware of the fact hemophilia destroys the joints and brings pain of an excruciating nature.

The research done in blood resources and ability to extract contents from the blood resources is useful to hemophiliacs. My son has injected a blood extract into his blood each and every day for 7 years. I am happy to tell you he is not home right now. He attends Harvard as a regular student and lives an effective life. Our foundation works hard to assist in providing care to other kids whose fathers can't afford the cost of care (my medical payments are $20,000 a year). We work to make these materials available for treatment on a protective basis. The infusion daily, when necessary, has prevented the crippling of untold numbers of children.

I cannot tell you how thankful I am this development has occurred and what it has meant to me and all of these kids and my son in particular.

I also want to tell you that the work that is being done in the blood resources has only just begun. What it has done for hemophiliacs is just a portion of it. What it will mean to the population at large when blood components are used I can only guess.

I am particularly delighted that my young friend, Dr. Lou Aledort here, who has been on many Government commissions, has become the vice president of the American Blood Commission recently and will be helpful, I hope, in extending this concept of blood component therapy.

I have come here to thank you and can't tell you how deeply I feel about your excellent support.

Dr. ALEDORT. I am Dr. Louis Aledort, medical director of the National Hemophilia Foundation, vice president of the Department of Medicine of Mount Sinai and vice president of the American Blood Commission.

I represent approximately 100,000 hemophiliacs, 25,000 of whom require constant treatment for this disease.

Cutbacks at this time in blood disease and blood resource research education for the development of personnel in the field will markedly deaccelerate, and be counterproductive to, the present explosion of scientific and social advances in our field. Therefore, we will support the position taken by the American Society of Hematology whose testimony we read this morning and which will be presented here a little while from now.

I would like to address myself to the disease of hemophelia, and mention a few of the very gratifying research advances that have occurred in the field which could not have occurred without research support.

The first one has been the successful use of blood parts rather than whole blood. This advance really affects every American. Advanced technology resulting from basic science has made available the possibility that a unit of blood can be broken up now into multiple components so that a leukemia patient can receive platelets, or a patient with aplastic anemia and receive white blood cells, so bleeding patients with ulcers can receive red blood cells, and hemophiliacs can receive plasma components.

This advance is really a brilliant example of the clinical application of basic science and has broad impact in American society today.

The second advance I would like to describe has been carrier detection. What I mean by that is to be able to tell a woman who has delivered a hemophiliac child or someone in the family of hemophiliacs whether or not she has the gene to pass on this dieases to her children.

Mr. FLOOD. At what point in here does the Mendelian theory apply, if at all?

Dr. ALEDORT. It applies very much in the case of the mother because it has passed from the carrier, the female, to the male child. However, a third of the patients do not have a family history of hemophilia, and it is important to know whether the mother is a new carrier. And therefore whether none of the rest of her children will be abnormal, or whether she is truly a carrier and sons will have the disease. Because of utilization of a new test based on the biology of the molecule, we can now go about the community at large and say yes, you are or are not a carrier. This test is now being utilized in other fields for carrier detection.

Lastly I would like to tell you about the ongoing inquiries and the promising areas of research in the field of hemophilia today. One is the potential syntheses of these missing clotting factors so we don't need to use large quantities of blood.

The second is improved fractionization so that we don't lose a lot of the clotting material while we are making it in an injection form. This has great implication in terms of conservation or our blood resources.

Another is better preservation of red blood cells, platelets, and white cells so they can be utilized over a longer period of time and therefore can be stored for future use.

The last, which is very important, is to be able to answer the research questions posed by the mandated national blood policy to deliver safe available blood to the American population when it needs it. And because of these things we ask you not to accept the 1976 proposed budget but support the 1975 level with an additional 10 percent for inflation and hopefully a small increment for money for new start-up programs that we think are so important.

Thank you.

Mr. FLOOD. Thank you.

WITNESSES

DR. HELEN RANNEY, CHAIRMAN, ADVISORY COMMITTEE, AMERICAN SOCIETY OF HEMATOLOGY
PAUL JOHN BIANCHI, COOLEY'S ANEMIA FOUNDATION
DR. CHARLES F. WHITTEN, PRESIDENT, NATIONAL ASSOCIATION FOR SICKLE CELL DISEASE

Mr. Flood. Now the American Society of Hematology, Dr. Helen Ranney, chairman, advisory committee.

Dr. Ranney. Mr. Chairman, I am Helen Ranney. I am professor of medicine and chairman of the Department of Medicine at San Diego and the immediate past president of the American Society of Hematology. I have been chosen to testify here by the American Society of Hematology regarding the fiscal 1976 appropriations for blood research.

We would like to begin by pointing out we are indeed grateful for the opportunity to testify on the matter of research on blood. Particularly we are indebted to you for your leadership on those issues related to the importance of basic research which have been so important to research on blood and to the establishment of the general priorities in the programs of National Institutes of Health.

Your recognition of the necessity and value of basic research has been shared by all researchers in blood, and you know how important it is that this concept be protected and that the advances in basic research really provide for the future applications in clinical medicine.

At this time we would like to point out that we recognize not only the difficulties that will be imposed by the proposed budget for the current status of research on blood, but we would like to emphasize also the unexcelled opportunities for advances in blood research that lie before us.

Some of these advances have been outlined in a document that was prepared by Dr. Maxwell Wintrobe regarding development in the field of hematology, and he is going to present that to the Rogers' committee next week in the hearings on the National Heart and Lung Institute. It is attached to my formal testimony and I ask that it become part of the record.

Because this is the first time that our society has made a statement about blood research we would like to give some indication of the basis on which we request the levels of funding that we do.

The disorders of the blood and blood performing organs are numerous. Not only are sickle cell anemia and Cooley's anemia included but thrombosis, the clotting of blood within vessels, or bleeding disorders such as hemophilia which you have just heard about and leukemia itself are included in blood disorders.

Blood forms a system which consists of the red blood cells, the bone marrow, the liver, the spleen, the white blood cells, platelets, and the plasma of the blood. Studies of the blood in blood forming organs have had a major impact not only upon our understanding of these disorders but upon medicine as a whole.

For example, it becomes hard to define what the limits of blood research are when we say that thrombosis is a field of blood research for coronary thrombosis in the case of most heart attacks, the closing off of a vessel by a clot.

Similarly, stroke is in general the result of the closing off of a vessel of the brain by a clot.

In addition to the hereditary anemia, sickle cell anemia, and Cooley's anemia, there are anemias which are the result of nutritional deficiencies and there are anemias which are the result of other disorders such as chronic kidney disease.

In addition, many studies of blood have had very important ramifications for allied areas of medical knowledge.

Safe blood transfusions were developed by matching the blood types of given individuals and by studies of blood and from these studies of blood types some of the preliminary work necessary for organ transplantation arose.

Many of the facts that we now have available about human genetics and about molecular biology in humans have originated in research on human blood disorders. Whole blood banking, the development of blood resources and blood products used for transfusion for the treatment of all kind of blood disease is also very important in many kinds of major surgery, particularly cardiac surgery, and in the treatment of other medical illnesses.

With that rather large background we would call attention to the following broad key areas for research:

1. Research at all levels ranging from fundamental research on normal and abnormal molecular structure and function and pathophysiology at the cellular level;
2. Applied research concerning new medications;
3. Study of the use and complications of blood and blood products;
4. Training of individuals for research in blood diseases and resources;
5. Education of physicians and the public with regard to blood diseases and resources; and
6. The establishment of models to enhance the effectiveness of the other approaches in the research in blood disorders.

On pages 7 to 9 of the submitted document from the American Society of Hematology we have listed the impact of the proposed budget on research in blood disorders. This really encompasses a number of different institutes, indeed, and concerning the research in one area, leukemia, I counted six different institutes which were involved in research.

Overall the 1976 budget results in a significant decrease, some 12 to 15 or even 17 percent in nearly every institute in which there is research in blood disorders, and also carries a remarkable decrease in the provisions for training for individuals so that we will continue to have gifted young researchers available to carry on research in blood.

I would like to speak about two specific examples of the broad areas of blood research which we have made significant advances. In blood transfusion we have made very significant progress in the last few years in the elimination of the transmission of hepatitis. More remains to be done. A few of the viruses have been identified. Further, at least one and perhaps another virus capable of transmitting hepatitis to the recipient could be identified and thus remove one of the significant hazards of blood transfusion.

In the treatment of childhood leukemia, we now have made very significant advances. Many of the children with leukemia now live 7 to 10 years, we even speak possibly of cure. But these cures which are induced by drugs are possible only because we have the support element from blood, that is that we can give red blood cells when they are needed to the children, we can give white cells when they are needed to fight infection in the children, and we can give platelets when they need them as a result of the bleeding tendency which may accompany either the disease or the drug treatment for the disease.

These studies in transfusion and for blood disorders and transfusions for a variety of other reasons, major surgery or for trauma, suggest that future studies are necessary concerning the preservation of blood and further studies on the blood typing and whether chemical treatment of blood or substitutes for blood could be developed which would make safer blood available more immediately in all areas of the country.

Again I would like to emphasize that we view with significant distress the cut in training funds since research in blood requires sophisticated biochemical training, and we see a shortage of trained personnel to make possible the advances which we have had in the past to make sure that kind of progress is insured in the future.

We would strongly recommend that the cutbacks in the proposed budget not be agreed to. We suggest that the present level of funding plus a 10-percent increase for inflation and some small amount of money for new starts would permit us to maintain the rate of progress in research in blood disease which we feel has been very productive when one looks at the advance of the last few decades.

I have with me here Mr. Bianchi on my immediate left of the Cooley's Anemia Foundation and Dr. Whitten, president of the National Association for sickle cell disease. I would like to submit a statement by Mr. Bianchi from the Cooley's Anemia Foundation and one which will be submitted within a few days by Dr. Whitten. We all want to thank you again for the help and interest you have shown in blood research in the past. If the American Society or any of the other societies in hematologic research can be of any help in your task, we hope you will call upon us.

Mr. FLOOD. Thank you.

[The statement follows:]

STATEMENT OF THE AMERICAN SOCIETY OF HEMATOLOGY

(By Helen M. Ranney, M.D.)

Mr. Chairman, I am Dr. Helen Ranney. I have been chosen to testify before you by the American Society of Hematology regarding fiscal 1976 appropriations regarding blood research.

We are grateful for the opportunity to testify before you on the matter of research on blood. All of us who have been concerned about the scope and direction of biomedical research in this Nation are grateful for your leadership on the issues, not only in matters of funding, but also in the establishment of general priorities in programs of the National Institutes of Health. We are particularly grateful for your recognition of the necessity and value of basic research. We know from the record of your leadership that you are deeply committed to the need for basic research, the seeking of knowledge and understanding in the field of biomedical research, without any certainty of how such knowledge will be helpful and practical in the future. You know very well, having observed the biomedical scientific community over the many years of your work in the legislative field, that it is important that this concept be protected.

and indeed that many of the advances that have been made over the years have originated in basic research.

This is the first time this society has formally made a statement regarding blood before this committee on public policy and appropriations. We find it necessary now to make this statement because of the serious difficulties facing research on blood, as well as because of the unexcelled opportunities that lie before us.

You are well aware that hearings are taking place before the authorizing committees regarding the renewal of the Heart, Blood Vessel, Lung, and Blood Act of 1972. That legislation, which is concerned with the Institute which funds more research on blood than any other, is up for renewal at a particularly opportune time for the blood research enterprise. The field is quite literally exploding in terms of opportunities. For that reason, we are suggesting before the authorizing committees that a series of amendments be adopted which will permit the change of the name of the Institute now called the Heart and Lung Institute to the Heart, Lung, and Blood Institute, in recognition of the advances recently made and the opportunities that exist now, and which will put proper emphasis on blood research and blood resources within that Institute. I recognize that it is not proper at this time to go into detail on our legislative proposals, but one piece of testimony given at that time is particularly valuable in conjunction with my comments on blood research. That is the statement given by Dr. Maxwell Wintrobe, who has been for many years a leader in blood research and in our society, regarding the development of the field of hematology, and the opportunities which now exist for future discoveries. I request that his statement be made a part of this hearing record, because of its value is assessing the request for increased funding above the President's budget that I will make.

BACKGROUND

Because this is the first time our society has made a statement regarding research on blood, I believe it might be useful for the committee to understand some of the background on blood research, so that you may understand the basis of the levels of funding requested.

Disorders of the blood and blood-forming organs are numerous, including anemia, leukemia, bleeding problems, thrombosis, and many other diseases of blood and blood cells.

The blood forms a system, very much like the cardiovascular and nervous systems. Its organs are the bloodstream, bone marrow, liver, and spleen.

Studies of the blood and blood-forming organs have had a major impact not only upon our understanding of disorders of these organs, but upon medicine as a whole. For example, thrombosis—disordered coagulation within blood vessels—must be understood not only as a disease of blood clotting, but as a process responsible for diseases in many organs, including the heart (principally coronary thrombosis), brain (a commonplace cause of stroke) and lungs (as the source of pulmonary embolism). Similarly, anemia may be due to disorders of the red blood cells themselves, as in sickle cell disease or Cooley's anemia. But it more often reflects the presence of other diseases, for example, blood loss due to a variety of causes, nutritional deficiencies, or impaired development of blood cells resulting from malignancy.

Additionally, studies of the blood have had important ramifications for many allied areas of medical knowledge. Information needed to insure safe blood transfusions has served as the basis for the developing field of transplantation of organs such as the kidney. Unexpectedly, the ability to test blood groups appropriate for such transplantations has led to new understanding of the relationship between blood types and disease. Modern human genetics and molecular biology—keys to the prevention of disease—are based in no small measure upon insights gained from research on human blood disorders. The science of blood banking, encompassing both the development of blood resources and the use of blood products for transfusion therapy, is vital to the treatment of all blood diseases but is also essential for the support of many kinds of surgery and the treatment of many other medical illnesses.

The American Society of Hematology feels that blood diseases and blood resources together deserve attention in the following key areas:

(1) Research at all levels ranging from fundamental research on normal and abnormal molecular structure and function and pathophysiology at the cellular level;

(2) Applied research concerning new medications;

(3) Study of the use (and complications) of blood and blood products;
(4) Training of individuals for research in blood diseases and blood resources;
(5) Education of physicians and the public with regard to blood diseases and resources; and
(6) The establishmeent of models to enhance the effectiveness of the other approaches.

THE SUPPORT OF RESEARCH IN THE INSTITUTES

The broad implications of research relevant to blood disease and blood resources has, not surprisingly, led to fragmentation of support throughout the National Institutes of Health, although approximately 65 percent of the total NIH support for blood research currently comes from the National Heart and Lung Institute. The tables below, drawn from an analysis presented at the first meeting of the Blood Disease and Resources Committee of NHLI on January 6, 1975, which summarizes the diverse support for blood research within the various Institutes of the National Institutes of Health, illustrate the fact that blood research has come to be viewed as an important par of the activities supported by institutes whose title reflects a primary interest in a multitude of other specialty areas.

PROFILE OF HEMATOLOGY SUPPORTED AT NIH

TABLE 1.—*Total extramural blood research at NIH, fiscal year 1974*

Institute:	*Millions*
Allergy (NIAID)	[1] $6.4
Arthritis (NIAMDD)	9.5
Cancer (NCI)	[1] 14.04
Child health (NICHD)	0.97
Dental (NIDR)	0.36
Environmental health (NIEHS)	[1] 0.6
Eye (NEI)	0.07
General medicine (NIGMS)	1.41
Heart (NHLI)	51.0
Neurology (NINDS)	0.0
Research resources (DRR)	[1] 5.0
Total	[1] 89.35

[1] Figures are approximate.

TABLE 2.—EXTRAMURAL SUPPORT OF HEMATOLOGY PROGRAM AREAS AT THE NIH (FISCAL YEAR 1974)[1]

	NIAID	NIAMDD	NCI	NIGMS	NICHD	NHLI
1. Blood cell formation, function, and kinetics		2.0	1			2
2. Hemoglobins: Synthesis, structure, function		2.0		1.0		2
3. Red blood cell transport and metabolism		1.0	1			2
4. Hypoplastic anemias		2.0			3	1
5. Iron transport and metabolism		4.0				
6. Deficiency anemias		4.0				1
7. Hemolytic anemias		1.0				4
8. Blood coagulation						4
9. Leukemia and erythroleukemia			4			
10. Tumors of the hematopoietic system			4			
11. Plasma cell disorders and dysproteinemias	?	1.0	4			
12. Blood grouping, transfusion, safety of blood therapy (including hepatitis), blood comp. therapy, bone marrow transplantation	2.0					3
13. Other						4
Total (millions)	[1] 6.4	9.5	[1] 14	1.4	1	51

[1] Figures are approximate.

Note: Percent support of program area: 1 equals 10–25 percent; 2 equals 25–50 percent; 3 equals 50–75 percent; 4 equals 75–100 percent.

COST OF BLOOD DISEASE

Having given you a general overview of the widespread support for blood research, I would like to indicate to you what the costs of blood disease are for the Nation. The best estimate we have found on the matter of annual costs of diseases of the blood and blood-forming organs, including hemotologic malignancies, is estimated at $4 billion. This includes $2 billion in direct costs for treatment alone during that period of time, and $2 billion estimated for productivity losses due to death and morbidity. Of course, not included in the monetary costs are the terrible costs of pain and emotional distress which accompanies diseases of the blood.[1]

THE EFFECTS OF THE PRESIDENT'S BUDGET

Many witnesses have appeared before you to discuss the impact upon biomedical research generally by the President's proposed budget. The impact on the areas of blood research would be very damaging.

In the Heart and Lung Institute, we find that in the area of research on blood diseases and resources, the cutbacks in research and research training will be severe. Expenditures in NHLI for blood in fiscal year 1975 were $51.8 million and the President's budget proposes $49.98 million for 1976, a drop of $5.63 million in 1 year.

We have already indicated to you the existence of an enormous growth in research opportunities in blood, and these cutbacks will have the effect of stifling the opportunities to exploit those opportunities, especially in the areas of new starts for research projects.

I would also comment on the cutbacks in research training in the NHLI. During fiscal year 1974 there were 112 trainees at a cost of $2,205,000. In fiscal year 1975 there will have been 97 trainees for a total of $2,073,000, a drop of 15 trainees, at a time when the Institute has projected a need for an additional 300 additional researchers in the field.

It is very clear that this research training cutback will have very serious implications for all of blood research in the future. These cutbacks, and uncertainty of training funds, simply cannot be allowed to continue if we are to make progress in our field.

The impact of blood research programs in other institutes will also be severe. Below is a listing of the institutes, the funds received in the last 2 fiscal years, what funds are anticipated in the upcoming fiscal year, and the impact of each cutback.

NATIONAL HEART AND LUNG INSTITUTE

Fiscal year 1974—$51.18 million was spent on grants and contract support for blood diseases and blood resources.

Fiscal year 1975—$49.98 million is projected.

Fiscal year 1976—The administration has requested $44.35 million, a decrease of approximately 12 percent.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

Fiscal year 1974—Approximately $1 million was spent on hematologic research, including erythropoiesis in chickens, blood diseases such as iron deficiency and secondary to oral contraceptives, hemaglobin synthesis and hemolytic anemias (erythroblastosis).

Fiscal year 1975—Projected expenditures in this area are approximately $1 million.

Fiscal year 1976—Administration-request decreases NICHD total for fiscal year 1976 of $106,062,000 from $126,067,000, a $20 million or 15 percent decrease from fiscal year 1975, implying a comparable cutback in support for hematologic research and no support for new starts in fiscal year 1976.

NATIONAL EYE INSTITUTE

Fiscal year 1974—Approximately $420,000 was spent on research and training related to microcirculation of the blood and transplantation.

Fiscal year 1975—Estimate is similar.

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[1] This figure is from a study completed in 1972 by Dorothy Rice of the Social Security Administration.

Fiscal year 1976—The Administration has requested a reduction of total budget of $44.1 million for fiscal year 1975 to $39 million for fiscal year 1976. It may even be difficult to maintain present commitments.

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

Fiscal year 1974—Approximately $5 million was spent on research and research training related to hematology.

Fiscal year 1975—Approximately the same amount is projected.

Fiscal year 1976—The administration has requested $161 mlilion for NIGMS, a significant reduction from the $187 million appropriated for fiscal year 1975. This cut obviously would also preclude new starts.

NATIONAL DENTAL INSTITUTE

Fiscal year 1974—$3.36 million was spent on research in hematology.

Fiscal year 1975—$3.12 million was spent in the same way.

Fiscal year 1976—If the administration-recommended fiscal year 1976 budget for the Dental Institute is reduced from $50 million for fiscal year 1975 to a request of $42 million, no competing research awards can be made in the area of hematology.

DIVISION OF RESEARCH RESOURCES

Fiscal year 1974—$5.1 million was spent on hematologic work in clinical research centers and GRSG money $0.3 million on biotechnology and $0.3 million on primate research.

Fiscal year 1975—The projection is for a similar expenditure.

Fiscal year 1976—The administration has requested a cut from a total of $88 million, a cut from $128 million in fiscal year 1975. This would eliminate the general research support programs, decrease activities of the clinical research centers, the primate research centers and biotechnical research in hematology.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASE

Fiscal year 1974—$11.8 million, including all programs both intramural and extramural, expended for support of hematologic research and training.

Fiscal year 1975—$12.5 million is projected—this also includes all programs, both in intramural and extramural.

Fiscal year 1976—$10.9 million (administration budget)—all programs, both intramural and extramural. While the overall reduction for the institute in the 1976 administration budget is approximately 15 percent, research grants will absorb about 5 percent. This reduction will be an across-the-board reduction for all program areas, including hematology.

NATIONAL CANCER INSTITUTE

Fiscal year 1974—$45 million was spent for studies that related to blood diseases and resources. The total NCI budget was $580 million.

Fiscal year 1975—It is projected that $48.5 million will be spent on studies related to blood diseases and blood resources. The total NCI budget is $669 million.

Fiscal year 1976—The administration is asking for $605 million, which is a decrease from fiscal year 1975 and it is anticipated that $40 million will be for blood related studies. This will represent a decrease of approximately 17 percent.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

Fiscal year 1974—$7.5 million was spent for studies on transplantation and hepatitis B. This is probably an underestimate if one could identify research support for studies of complement and of autoimmune hemolytic disease.

Fiscal year 1975—$8.5 million is projected for transplantation and hepatitis B studies.

Fiscal year 1976—The administration has requested $7.3 million total for transplantation and hepatitis B. This represents a decrease of approximately 14 percent.

The cumulative effect of these total reductions in the President's budget will have serious implications for all of blood research. Not only will there not be funds for significant new starts on research, but all researchers will feel that the instability begun in the impoundment and rescission period will last at least

another year, and that the future is not bright. Young researchers, especially, are certain to turn away from the field of biomedical research, and of course they will turn away from hematology as well.

NEW OPPORTUNITIES

I have related to you how exciting investigation is open to the general field of blood research. I would like to comment, if I may, on three examples of new research opportunities, which, if properly exploited could in the short range have widespread positive implications for certain present medical problems. The three examples are: hepatitis, leukemia, and transfusion, blood storage, and artificial blood substitution.

HEPATITIS

In the past several years we have increased our knowledge greatly about the serious inflammation of the liver known as hepatitis. As you know, blood transfusions were responsible for transmitting this disease from the donor to the recipient, especially when blood from paid donors was used.

NIH research funds, again, were largely responsible for the opportunity to isolate two hepatitis viruses, tagged hepatitis A, and hepatitis B, and greatly reduce them in our blood supply system, which has made it immeasurably safer.

However, we now know that there is at least one more virus, hepatitis C, and maybe more, and we believe that given more research funding in this area, we will be able to isolate and control this virus as we have the others, because of the knowledge we received in our attack on the viruses previously mentioned.

Of course, we have at the same time learned a great deal about the public health aspects of this disease, and such knowledge is creating a basic change in our national blood collection system. The benefits of the original research dollars are almost incalculable regarding the lessening of illness, death, suffering, and economic impact concerning medical care required.

LEUKEMIA

Leukemia is an excellent example of a blood disease that illustrates accomplishments attributable to research advances in recent years. Advances in drug therapy have produced very significant prolongation of life in childhood leukemia, prolongations reaching to 7–10 years that now permit one to legitimately start to use the word "cure." Other significant advances include the work that has led to the ready transfusion of blood platelets (essential to permit the blood to clot) and the increased transfusion of white blood cells (granulocytes) to enable the body to fight infection while chemotherapeutic drugs are being given to the patient in order to kill the leukemia cells. Significant advances have also been made in the important new field of bone marrow transplantation after radiation to kill the leukemia cells.

It is clear that much remains to be done in terms of arriving at a satisfactory solution to the management or cure of leukemia. Much more research is needed into the fundamental mechanisms of control of blood cell production. The precise mechanisms of drug sensitivity and resistance for different leukemias require much work. An important future in this field of work lies in the further characterization of the immunologic properties of leukemic cells and the possible use of immunotherapy. Studies of the viral origins of leukemia in animals and in man must be pursued vigorously.

Leukemia, as a disease upon which many areas of research bear, illustrates in an important fashion how interest in (and support for) blood diseases and blood resources are scattered throughout many Institutes of the NIH. As examples, the National Cancer Institute is concerned with programs of chemotherapy, studies of the viral origins of the diseases, and platelet support to prevent bleeding. The National Heart and Lung Institute has active programs of research into life support of leukemic and other needy patients with blood and blood products. The transplantation approach is a matter of interest to the NHLI, the NCI, the Institute of Allergy and Infectious Disease and the National Eye Institute. Many of the relevant studies are being carried out in medical centers with support from the Division of Research Resources (GRSG funds and clinical research centers). Support for research into the mechanisms that control blood cell production comes from the NHLI, NCI, NIAMDD, NIDR, NIGMS, and NICHD.

TRANSFUSION, BLOOD STORAGE, AND ARTIFICIAL BLOOD SUBSTITUTION

While there are many opportunities for advances in blood resources immediately available to us, I would like to stress these, which would have profound implications for the national health delivery system.

First, as to opportunities in transfusion of blood (transfusions are necessary for a wide range of medical and surgical procedures—from treatment of leukemia to open heart surgery) : major advances seem likely soon in the way transfusions could be managed in the future. As you know, not every person can be a donor for any patient, because of differences in blood types. Transfusion with an incompatible blood type can be fatal. As a practical matter, every blood bank should have available many separate blood types. Obviously, this leads to major problems of supply and demand across the country, particularly in rural areas. Such a practice is also very expensive because currently blood becomes outdated rapidly (a condition I will comment on shortly).

It now seems possible that we could change the red blood cell types in the blood to be transfused, by chemical or other means, so that any blood, regrdless of type, could be used for any patient.

Second, there are excellent research opportunities immediately available in blood storage. As you know, refrigerated, unfrozen blood can be stored for only 3 or 4 weeks, and we unavoidably lose significant amounts of blood by outdating. The storage of forzen blood, which can be kept indefinitely, is expensive and difficult.

It is entirely possible that with the new knowledge about red cells we have acquired as the result of our research, largely supported by NIH, much better, simpler, and cheaper storage methods can be developed by which we might be able to keep blood alive unfrozen for two or three times as long as we are now able to do.

The impact of improved blood storage and transfusions will have an enormous impact upon our health care delivery system as to costs, improved availability and more effective use of blood as a national resource.

There is also a somewhat more speculative, but entirely possible, research opportunity, that is the development of artificial blood, composed of fluids containing chemicals which carry oxygen, and which can be kept for long periods of time, at normal temperatures, and which could even be carried in emergency vehicles, ready for instant use at the scene of a disaster.

Our recommendations for appropriations are that the President's cutbacks not be agreed to in this committee in the area of blood research, and that additionally not only should the appropriations equal last years' level, but that there be built in an increase sufficient to take care of the inflationary trends, which will certainly be a 100 percent or more increase this year, and beyond that to add several percent increase for the new starts that are so vitally needed this year.

SUMMARY

Mr. Chairman, we want to thank you for your interest in blood research. If at any time the American Society of Hematology can be helpful to you in your work, please call on us.

TESTIMONY BY MAXWELL M. WINTROBE, M.D., PH. D., PAST PRESIDENT, AMERICAN SOCIETY OF HEMATOLOGY, VICE PRESIDENT, INTERNATIONAL SOCIETY OF HEMATOLOGY, MEMBER, NATIONAL ACADEMY OF SCIENCES

CURRICULUM VITAE

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B.A., 1921; M.D., 1926; B.Sc. (Med.), 1927; all at the University of Manitoba.

Ph.D., Tulane University, New Orleans, La., 1929.

D.Sc. (Hon.), University of Manitoba, 1958; University of Utah, 1967; Medical College of Wisconsin, 1974.

Fellow, American College of Physicians, 1945; Master, 1973.

Instructor in medicine, Tulane University, and assistant visiting physician, Charity Hospital, New Orleans, La., 1927–30.

Instructor in Medicine, then associate in medicine, Johns Hopkins University Medical School, 1930–43, and associate physician, Johns Hopkins Hospital, 1930–43.

Professor of medicine and head, Department of Medicine, University of Utah College of Medicine, 1943–67; Distinguished Professor of Internal Medicine, 1970–.

Director, Laboratory for the study of hereditary and metabolic disorders, University of Utah, 1945–73.

Chief consultant in medicine, Veterans' Administration Hospital, Salt Lake City, Utah, 1946–67.

Director, Cardiovascular Research and Training Institute, University of Utah, Salt Lake City, Utah, 1969–73.

Editor-in-Chief, Harrison's Principles of Internal Medicine, McGraw Hill Book Co., New York, 6th edition, 1970; 7th edition, 1974.

Author, Clinical Hematology, Lea & Febiger, Philadelphia, Pa., 1st edition, 1942; 7th edition, 1974.

Author, 350 journal articles, chiefly on hematologic subjects.

Past president: Association of Professors of Medicine, 1965–66; Robert H. Williams Award, 1973; American Society of Hematology, 1971–72; Association of American Physicians, 1964–65; and Kober Medalist, 1974.

Vice-President, International Society of Hematology, 1974.

President-elect, International Society of Hematology, 1978–80.

Member: National Advisory Arthritis and Metabolic Diseases Council, 1950–54; Cancer Chemotherapy Advisory Committee, National Cancer Institute, 1953–55; Chairman, hermatology study section, National Institutes of Health, 1955–59; General Clinical Research Centers Committee, 1961–63; Advisory Committee, Office of International Research, NIH, 1963–67; National Advisory Allergy and Infectious Diseases Council, NIH, 1967–71; Visiting Committee, Medical Department, Brookhaven National Laboratory, Associated Universities, Upton, L.I., N.Y., 1959–63; and Advisory Committee for Biology, Oak Ridge National Laboratory, Oak Ridge, Tenn., 1961–64.

World Health Organization: special consultant, Nutritional Anemias, 1959; and chairman, Investigators on Nutritional Anemias, 1971.

U.S. Army: Committee on Metabolism, 1960–63; and Committee on Hematology and Tropical Medicine, 1963–69.

American Medical Association: Council on Drugs, 1961–66.

National Academy of Sciences, Committee on Biomedical Research in the Veterans' Administration, National Research Council, 1974.

Mr. Chairman: Because this is the first time that representatives of the American Society of Hematology have appeared before Congress, I would like to make a brief statement regarding the scope of the term hematology; the nature and results of research in this field; how such research has enlarged our understanding of life processes; to what extent we have been successful in relieving or easing the ills of mankind; and what tasks lie before us.

Hematology includes fundamental studies of the blood itself and of the diseases thereof. It encompasses the fluid or plasma in which the blood cells are carried as well as the red and white blood cells and the platelets; the bone marrow where the blood cells are made; and the spleen and lymph glands. The term blood resources refers to products derived from blood that are used in treatment.

Mankind has always been interested in the blood. The blood nourishes all the tissues of the body. Without it, life is impossible. Because it is so readily available, blood has been the subject of study longer, perhaps, than any other tissue of the body and this has brought untold benefit for mankind. Since the early twenties, research in hematology has been very productive; particularly is this true of the past 25 years. We are now in the midst of a veritable explosion of understanding of the disease processes which are classified as blood disorders. Regrettably, there is real danger that these promising advances will be brought to a halt as a result of reduction in the financial support which has made these discoveries possible.

In the chart I have placed before you, I have indicated a few of the areas in which research conducted within the past 50 years or so has progressed most gratifyingly and I have indicated what the fruits thereof have been. You will note that the advances that have been made are of a widely varied character. I shall try to point out also how the pursuit of knowledge brings unforseen rewards. Research, if done carefully and imaginatively, yields benefits which often are unforeseen at the time it is being initiated.

Let me cite a few examples. In 1926 the successful treatment of pernicious anemia with liver was announced. This was the result of a search for the food substances which are needed for the manufacture of red blood cells. For the victims of pernicious anemia the discovery of the effectiveness of liver therapy meant long, happy life instead of certain death, usually within a year or two. But this was only a small part of the dividend. Research into the ways in which certain food factors affect blood formation also led to the discovery of folic acid. This was followed by the observation that children with acute leukemia became worse if they were treated with folic acid. This in turn led to the production of compounds antagonistic in their action to folic acid, substances which interfere with the growth of cells. With the development of such folic acid antagonists, and also as an outgrowth of the study of the effects of mustard gas during World War II, modern chemotherapy was born. Chemotherapy means the treatment of disease, particularly various forms of cancer, with drugs which interfere with the growth of cells. And it is not only blood cell cancers which are attacked by these agents. Chemotherapy now is being employed in the treatment of so-called solid tumors—breast, bone, bowel, etc.

Another outgrowth of the original studies directed toward the understanding and treatment of pernicious anemia was appreciation of the fact that the growth of cells depends not only on their being supplied with protein, vitamins, and minerals. We came to realize that there are mechanisms within the body which control cell growth. The study of such controlling mechanisms has led to a better understanding of genetics, including human genetics—that is, how the implantation of a sperm within an egg results in the development of a human being—how this is controlled and how the mechanism can go wrong. Thus, we have learned how one of the polypeptide chains which make up the hemoglobin that carries oxygen to our tissues, when not correctly constructed, results in such diseases as sickle cell anemia and Cooley's anemia. From such an understanding investigators now are seeking ways whereby a disordered mechanism may be set straight. We are not quite there yet, but we are close!

Let us take another area—blood transfusion. The four blood groups, A, B, AB, and O, were discovered by Landsteiner in 1901. This made blood transfusion possible. But reactions occurred. Women who had previously been transfused or had received injections of certain blood products began to give birth to dead babies—or, if the babies were born alive, there might be severe brain injury. Then came the discovery of the Rh factors—then exchange transfusion as a form of treatment—and now methods have been developed whereby Rh disease can be prevented, thereby eliminating what was once a serious hazard for couples whose bloods were incompatible.

There have been many other dividends resulting from the original research related to blood groups and blood transfusion. Cardiac surgery would be impossible today if methods for the collection and storage of blood had not been greatly improved, blood banks developed and all the factors that are involved in reactions to transfusion investigated. And I should add that all that you have heard about transplantation of organs would still be impossible if we had not learned about the ways in which the body reacts to foreign tissues and how these may be controlled. Such information had its roots in the search for a way to transfuse blood without causing adverse reactions.

I can only mention the process of coagulation, the clotting of blood. We are beginning to understand the detailed steps involved in this very intricate mechanism. This has made possible an increasingly successful attack on bleeding disorders such as hemophilia. What was once a dread disease which brought both physical and financial crippling to male members of certain families, by methods of treatment arising out of identification of factors involved in the clotting of blood, the victims of hemophilia can now look forward to an essentially normal future. On the other hand, in regard to the clotting disorders, thrombosis—the process which leads to obstruction of the circulation of the heart and of the brain, resulting in heart attacks and stroke—we have yet a long way to go.

When one reviews the long list of accomplishments to date, of which I mention only a few, when one takes the time to understand how research has resulted in so enormous a growth in our knowledge and understanding, when one sees the resulting benefits in the welfare and happiness of mankind, it is difficult to believe that anyone responsible for the welfare of the people of this country can consider cutting back on the funding of research and research training. You are well aware, I am sure, that in spite of all the extraordinary gains made to date, there is much left to learn before we achieve our objective of conquering

and preventing the diseases which plague mankind. I can only explain the desire to cut back on funding to a lack of understanding of the issues involved.

Excellent opportunities lie before us if we fund our research programs properly, and if we improve the organization and authorities of the major Institute supporing that research, the National Heart and Lung Institute. Dr. Helen Ranney will give the reasons why we have proposed amendments concerning the organization and authorities of that Institute. I will close my remarks by commenting on the levels of funding that will be authorized by this bill. We are all aware that the administration proposes to cut back on the authorized levels for this legislation and in another action, are cutting back substantially on appropriations for the field.

In relation to the total amount of money which our Government spends, that provided for medical research is a very small proportion. I would stress that the return on every dollar supplied has proportionately been far greater than the dividends which come from expenditures in any other area. In closing I wish to emphasize three points:

(1) Hematological research, because of its inherent breadth, has not only led to greater understanding and treatment of blood diseases; it has also contributed and continues to contribute to cancer therapy, surgery of all kinds, cardiovascular and pulmonary disease, nutrition and other areas.

(2) Funds used for the support of fundamental research—research which leads to understanding of the nature and causes of diseases—in the end yield greater dividends than funds used in the treatment and care of the victims of disease. Admittedly the latter are needed but a proper balance in the distribution of funds for these respective purposes is essential.

(3) Research requires people—investigators who have ability as well as imagination; people who have been trained, men and women who will carry on in the future. During the golden days of the National Institutes of Health research support program an atmosphere was created which attracted to medical research a small but sufficient fraction of promising medical students. They were attracted because they were led to believe that if they worked hard, secured good training and were imaginative, the future lay before them. This is what led to the great advances we have seen in the past 25 years.

Unfortunately, the atmosphere has been changed. Already we are seeing the ill effects of the cuts in the support of research and research training which have been made in the last few years. No longer are there many promising young people coming into the field. They have been discouraged and they are being forced to seek other occupations. This is an extremely serious matter which is not easily nor quickly corrected. We cannot start too soon to turn the tide. Our future and that of our children is being compromised by the short-sightedness which has marked the last few years.

A Narrative of the Cooley's Anemia Control Act—1972

In 1972, the 92d Congress passed into law a bill providing $11 million to be spent for research, screening, and education on Cooley's Anemia, a disease of the blood, which is fatal to young Americans. As of May 1975, a few months before the expiration of this "law of the land," not a dime has been directly assigned and spent specifically for Cooley's Anemia by the Federal Government.

The direct responsibility for implementing this act was as follows: (a), screening, treatment, and counseling programs—$3 million—to the Health Services Administration; (b) research—$5.1 million—to the National Institute of Health; and (c), education—$3 million—to the Health Services Administration.

However, the conversion of authorized funds into working projects never took place. The administration did not request, nor did the Congress demand, that these funds be spent. Instead, funds for Cooley's Anemia were to come from general appropriations to the NIH, as this agency saw fit.

This fact dramatizes the apparent minimization of concern for blood diseases and blood research in this country. And for this very reason we consider the bill to assign more blood related funding and responsibility to the Heart and Lung Institute extremely important to those of us who are affected by diseases such as Cooley's Anemia. It is surprising that a fatal disease such as Cooley's Anemia, which the World Health Organization recognizes as the largest quantitative hemoglobinopathy in the world, and which affects hundreds of thousands of Americans receives so little attention within our massive Federal programs.

The entire blood community has recognized a need for more effective research into blood disorders. The extension of the Cooley's Anemia Control Act is com-

patible with their desires. But an extension must include assurance that the money will be spent specifically for Cooley's Anemia research and development programs, so as to avoid a repeat of the neglect within the 1972 act.

We of the Cooley's[1] Anemia National Foundation ask: (a), that the Cooley's Control Act be extended and monitored so that research programs are fruitful; and (b), that inclusion of Cooley's Anemia in any higher order blood program; for example, Heart Lung and Blood Institute, birth defects or genetic defects, specifically recognize the needs of our children with adequate funding levels for research, screening and education, and treatment.

The following facts should explain our concern with specifics and followup:

Fact: The National Institute of Health has claimed that $4 million has been spent, from its general funding, on 39 projects for Cooley's Anemia. The National Cooley's Anemia Foundation's medical staff examined these projects and found relatively few that are considered applicable.

Fact: No screening programs have ever been started due to the lack of an inexpensive test. The control act never stipulated that an inexpensive test was a prerequisite. No inexpensive test was ever attempted to be developed.

Fact: The Health Services Administration never received or asked for any moneys for Cooley's Anemia. This agency had the head responsibility for implementing screening and education portions of the act.

Fact: An Interagency Committee on Cooley's Anemia was to oversee the work of the various agency projects. This committee never functioned, as there was nothing to oversee.

Fact: There have been essentially no counseling programs, no educational materials or information, and no treatment centers established for the benefit of Cooley's Anemia victims.

In summation, the control act, though well intended, has not been fruitful. A WHO report, published in 1966, well before the passage of the act, describes the status, knowledge, and treatment of Cooley's Anemia as it exists today. In fact, with the FDA's ruling to increase the iron content in flour products, American children with Cooley's Anemia are worse off today than in 1972.

Clearly, it is time to pay attention to these young Americans—children who may reach adulthood if we act now.

National Institute of Arthritis, Metabolism, and Digestive Diseases

WITNESS

THOMAS KUGEL, PRESIDENT, WASHINGTON CHAPTER OF THE JUVENILE DIABETES FOUNDATION

Mr. Flood. Mr. Erwin Lurie, Chairman of the Board, Juvenile Diabetes Foundation.

Mr. Kugel. My name is Thomas Kugel. I am president of the Washington Chapter of the Juvenile Diabetes Foundation, appearing on behalf of Dr. Lurie, chairman of national foundation board of directors. He is unable to be here and I want to speak in favor of increased funding for diabetes and its complications.

As I am sure you are aware, it has been 50 years since the discovery of insulin. During the greater part of that 50 years, medical science rested on its laurels, secure in the knowledge that this early wonder drug, which literally meant life to the juvenile or insulin-dependent diabetic, was the answer to this age-old disease. But with the passage of time, many of those kept alive with this wonder drug developed a

[1] The Cooley's Anemia Blood and Research Foundation for Children, Inc., is the only national, voluntary, nonprofit organization concerned solely with the disease called Cooley's anemia. The foundation is an active member of the American Association of Blood Banks, the ad hoc committee to establish an American Blood Commission, and the hemolytic anemia study group sponsored by the National Heart and Lung Institute. Also, the foundation maintains contact with other organizations concerned with the problems affecting Cooley's anemia victims.

wide variety of severe complications—blindness, kidney disease, neurological diseases, heart and other vascular diseases—and it became quite apparent that just taking insulin was no magic cure-all.

Research into the reasons for these complications ran into the basic problem that while one highly important method of treating the disease was known—insulin—very little was known about the disease itself. The research community has delved into this subject with the result that while much more has been learned, every discovery seems to lead to more questions.

We have learned some disturbing things, however. We do know diabetes is supposed to be the third leading cause of blindness and the leading cause of new blindness. We know that diabetes itself is the seventh leading cause of death from disease and that it frequently leads to at least three kinds of complications, which include the leading cause and two others among the first six leading causes of death by disease.

This means that diabetes is, or can be, a primary or secondary cause of four of the seven leading causes of death from disease. It would be impossible to prove, but this probably means that overall, diabetes, directly or indirectly, may be the fourth or fifth leading cause of death. We take no pride in such a figure, I assure you. I make the argument solely to support the often heard statement that diabetes is the most neglected of the major diseases. There is much that we do not know about diabetes, but we do know that it is one of the three or four major health problems in the United States today.

What else don't we know about diabetes? We don't know its incidence. Estimates by responsible and knowledgeable persons in the field range from a low of 1 in 40, 2½ percent or 5.3 million people, to an incredible high, including those with no current manifestation but who have an inherited predisposition to diabetes, of 1 in 5, 20 percent or 42 million people. Recent experience seems to suggest that 2½ percent is too low and that there is no real evidence to support the 20 percent figure. The more generally used number is 1 in 10, which is 10 percent or roughly 21 million Americans who have or potentially might have the disease, and that is a large number indeed.

Further, we know, but we don't know why, that the incidence is increasing and it is increasing more rapidly among younger children. These children, and their brothers and sisters who may have the inherited predisposition, are growing up and will be having children, potentially making the problem far worse. I do not know what the formal definition of an epidemic is, but I would submit to you that a large part of our population which is growing larger, faster than our total population is growing, with, or having the predisposition to, a major health hazard has at least some of the characteristics of a real or potential epidemic. And I submit to you that with our current knowledge we are not now in a position to do one single thing to reverse this trend.

To reverse the trend will take knowledge we don't have. To get that knowledge will take research. And to do that research will take money. The Congress recognized the necessity to get this effort started by enacting the "Diabetes Mellitus Research and Education Act," which required the establishment of a Commission to investigate and report on the needs for research in diabetes and its complications. This Com-

mission was to have made recommendations for fiscal year 1976 funding for diabetes programs, but because its establishment was delayed, it is only now holding its first hearings. It may not be able to make any recommendations to the Congress or to this committee in time for action for fiscal year 1976.

We hope that it will be able to do so, for their recommendations, we are sure, will be reasoned, informed, and judicious. However, the Juvenile Diabetes Foundation feels that the case is so clear and compelling and the need so obvious, that we must make some recommendations regardless of whatever the Commission may or may not recommend.

Specifically the Juvenile Diabetes Foundation recommends an increase over the pending request for the National Institute of Arthritis, Metabolism, and Digestive Diseases of $14,500,000, comprised of the following: $8 million earmarked for diabetes research, with the recommendation that out of the total amount available for diabetes, not more than one additional multidisciplinary center be funded beyond those funded and operating in fiscal year 1975, pending the Commission's final report evaluating the effectiveness of the center concept; $5 million for diabetes-related research in endocrinology; $1 million for research in diabetes-related kidney disease; and $500,000 to establish a strong diabetes program office to manage and coordinate the overall NIH diabetes research program.

We recommend an increase over the pending request for the National Eye Institute of $2 million intended for additional research in the area of diabetic retinopathy. We urge that each of the other Institutes be encouraged to identify and stimulate research activities within their particular spheres of competence—activities aimed at initiating or expanding upon the cooperative and coordinated approach to research into diabetes and its complications that the National Diabetes Mellitus Research and Education Act requires and that all seem to agree is needed. We urge that each of these Institutes, particularly those dealing with heart and vascular research and the promising new research in the fields of viruses have their diabetes-related program activities increased above the requested amount by a minimum of 5 percent. Further, we urge that the National Center for Health Statistics undertake an accelerated program aimed at improving the quality and quantity of data on the incidence of diabetes and its complications, and that the Center for Disease Control undertake at least preliminary studies of the potential innovative epidemiological approaches to the problems of diabetes.

One last comment. In 1964 the annual loss to the Nation from diabetes was estimated to be well in excess of $2 billion. Allowing for the inflation in medical care costs, and the growth in the population including diabetics, in just 10 years the annual loss to the Nation from diabetes has increased to the point where, conservatively estimated, it would be between $4 and $5 billion. Surely the Nation cannot afford such a cost in economic terms alone, much less in terms of human suffering. As my diabetic son's doctor said to me recently, "It's cheaper to prevent diabetes than it is to cure it." As one who hopes one day for my son to be cured, I cannot wholly accept that. But surely the economic argument is sound, and we all hope that when we understand how to prevent the disease, we'll also learn how to cure it. But to do so, we have got to start to make the investment that's necessary. The Juvenile Dia-

betes Foundation believes that time—long overdue—is now. Thank you for letting us have this opportunity to offer our views on this subject so crucial to us.

Mr. FLOOD. Thank you.

ALCOHOL AND DRUG ABUSE

WITNESS

H. LEONARD BOCHE, PRESIDENT, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

Mr. FLOOD. Mr. Boche, president of the Alcohol and Drug Problems Association of North America.

Mr. BOCHE. Mr. Chairman, my name is H. Leonard Boche, president of the Alcohol and Drug Problems Association of North America and I make my living as the director of the alcohol and drug program in Hennepin County, city of Minneapolis.

I submit in behalf of our association the prepared testimony for your consideration and consideration of the committee. In doing so I would like to make one or two other comments and be available for any questioning.

[The statement follows:]

STATEMENT OF H. LEONARD BOCHE

Mr. Chairman and members of the subcommittee, it is a pleasure to appear before you for the Alcohol and Drug Problems Association of North America (ADPA), and to have this opportunity to share our views and suggestions on fiscal year 1976 appropriations for the programs administered through the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse of the Department of Health, Education, and Welfare. Our comments also address the importance of support for the alcohol and drug education program administered through the Department's Office of Education.

Federal support of these programs has helped to stimulate a growing number of national, State, and local groups to commit and focus their resources and priorities in this area. A total of 62 organizations joined together last year to sponsor the North American Congress on Alcohol and Drug Problems.[1] The

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[1] The following organizations joined to examine their mutual interests and concerns in alcohol and drug problems, at the North American Congress on Alcohol and Drug Problems, held in San Francisco, December 1974. Efforts are underway to continue this Congress as a permanent forum:

Alcohol and Drug Problems Association of North America
American Association Against Addiction
American Bar Association
American Business Men's Research Foundation
American Federation of Labor and Congress of Industrial Organizations
American Hospital Association
American Medical Association
American Medical Society on Alcoholism
American Nurses Association
American Psychiatric Association
American Public Health Association
Association of Canadian Distillers
Association of Halfway House Alcoholism Programs
Association of Labor-Management Administrators and Consultants on Alcoholism
B'nai B'rith
Brewers Association of Canada
Canadian Foundation on Alcohol and Drug Dependencies
Canadian Medical Association
Canadian Psychiatric Association
Centro Mexicano de Estudios en Farmacodependencia
Christopher D. Smithers Foundation
Council of State and Territorial Alcoholism Authorities
Distilled Spirits Council of the United States
Drug Abuse Council, Inc.
Education Commission of the States
Health and Welfare Canada Health Protection Branch—Non-medical Use of Drugs Directorate
Institute for the Study of Drug Misuse, Inc.
International Brotherhood of Teamsters
International Council on Alcohol and Addictions
The Kemper Companies and the James S. Kemper Foundation
National Association of Alcoholism Counselors and Trainers
National Association of Anti-poverty Alcoholism Programs

(Footnote continued on p. 202.)

organizations ranged from the National Council on Alcoholism, the Drug Abuse Council, and our organization to the American Bar Association, American Medical Association, and other professional associations to groups concerned with the full range of community priorities like the National League of Cities, U.S. Conference of Mayors, National Association of Counties, National Congress of Parents and Teachers, and United Automobile Workers. Alcohol and drug problems have become a part of the mainstream of community concern and hopefully, increasingly, services will become a part of the mainstream of community health and social services. Much remains to be done in this area, however, and citizens with alcohol or other drug-taking problems are excluded from receiving help in many settings, health insurance coverage is lacking, title XVI of the Social Security Act which federalized the adult welfare groups distinguishes citizens with alcohol and drug addiction problems for special discriminatory actions, and, in many communities and States, citizens with these problems are locked up in jail or a mental hospital instead of helped. Many services are still unresponsive except to the chronic stage alcoholic or to the long-term heroin user. Many myths reinforce the reluctance to commit and provide services earlier. There is an attitude among many care givers that people with these problems cannot be helped or they do not want to be helped. We have learned quite the contrary. Both alcoholics and drug addicts can and are being successfully rehabilitated. They seek help but often have to go to considerable extremes for a particular service. We are learning how to appropriately intervene while the suffering person still has a high potential for recovery.

Drs. Dupont and Chafetz recently appeared before your subcommittee to tell of some of the promising new knewledge and results. I believe Dr. Chafetz reported an overall 70-percent recovery rate for people receiving services in alcohol treatment centers. Increased earnings of recovering clients, he reported, totaled more than the Federal Government was spending on the programs. The employee assistance programs established by industries in cooperation with organized labor are reporting even higher rates. Baltimore City has a program for employees with any problem that interferes with job performance. Fellow employees act as referring personnel to get such employees to alcohol, drug or other health, legal and social services. The investment made by the Federal Government in stimulating employee assistance programs has provided the success models which have permitted private and public employers to establish programs. My own State of Minnesota, under Governor Wendell Anderson, is asserting leadership by requesting $5 million for the biennium to implement employee assistance programs in the State. This is happening as a direct result of the investment of $150,000 over 3 years by NIAAA. It is happening because of the foresight of this subcommittee, you as its chairman, and the actions of Congress. Much can be done and it is not a time to cut back on Federal dollars or the Federal presence in these efforts.

Members of organizations such as the ADPA and voluntary groups and those directly affected, especially by alcohol drinking problems, have done the core work to stimulate a national concern. But it is significant to keep in perspective that it has taken congressional determination to spur a reluctant administration to support the Federal program initiatives to approach alcohol and drug problems from a community care standpoint. And we have witnessed what happens when

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National Association for the Prevention of Addiction to Narcotics
National Association of Black Social Workers
National Association of Counties
National Association of Social Workers, Inc.
National Association of State Drug Abuse Program Coordinators
National Association of State Mental Health Program Directors
National Clergy Council on Alcoholism (and Related Drug Problems)
National Congress of Parents and Teachers
National Coordinating Council on Drug Education
National Council on Alcoholism
National Council of Churches of Christ
National Council of Community Mental Health Centers
National Federation of Concerned Drug Abuse Workers
National Institute of Alcohol Abuse and Alcoholism
National Institute on Drug Abuse
National League of Cities
National Spanish Speaking Commission on Alcoholism
Native Council of Canada
North Conway Institute
Occupational Programs Consultants Association
President's Special Action Office for Drug Abuse Prevention
Provide Addict Care Today, Inc.
Rutgers Center of Alcohol Studies
Southern Region American Public Health Association
United Automobile Workers
United Methodist Church Board of Church and Society
U.S. Brewers Association, Inc.
U.S. Conference of Mayors
United States Jaycees
Veterans Administration
Wine Institute

there is any let up. Funds are impounded or administrative delays and maneuvers cause uncertainties and undermine commitments at State and local levels.

The history of these first years of initial support has been a constant cranking up and cranking down as funds were impounded, or released for a short period for a war on drugs or other crisis-oriented basis. We need to find ways to develop a more stable Federal, State and local partnership. You cannot sustain and integrate services or obtain commitments from personnel with the short fuse approach that has been characteristic of Federal efforts to date.

We want to also emphasize that the assumption by the administration and often by Congress that local units of government can assume responsibility for the continuation of programs initiated through Federal funding is unrealistic. Mechanisms for ongoing support need to be developed. Local government and community agencies have been expected to take on additional responsibility with no change or expansion of their sources of revenue. Substantial local funds have been generated, but, unless and until the Federal partnership can be sustained through such means as title XX of the social security amendments and other similar permanent Federal sources, such as expanded medicaid and medicare coverage, these programs will need your commitment and support.

Communities have responded. A great variety of interest groups express the concern of their constituents that there is a great catchup need in this area. Frankly, States and local governmental bodies and other groups are in over their heads. There is a need for more determination by Congress to stay in there. These are problems with which we are all familiar and we are becoming increasingly aware of the profound extent of drug use and misuse in America.

Your appropriations are for 1 year, but, once initiated, the continued involvement of the Federal partner is exceedingly important. We at the local and State levels cannot treat your year-to-year approach as an isolated event.

Our specific recommendations for appropriations are based on the view that formula grants should be increased and serve as the principal mechanism for assuring a more stable and dependable funding and program approach to alcohol and drug abuse programs at Federal, State, and local levels.

The Federal Government should honor its commitment for project grants and contracts to assure that the initiatives taken by States and communities will not be undercut by the premature exit of Federal funds. By being responsible, the Federal Government can provide for the orderly transition of program support to the more stable funding base of formula grants and noncategorical sources. With greater dependence on formula grants the interrelationship between the Federal efforts and those of the States and local government, cooperation can be fostered. The anticipated result will be a delivery system which effectively utilizes the contribution of Federal, State, and local efforts.

The specific recommendations for changes in the proposed administration budget for NIDA and NIAAA are reflected in the table below. In contrast, the OMB figures are projections based on the fiscal year 1975 rescission budget which was rejected by this Congress. A great deal has been said about our record annual rate of inflation; the administration does not appear to have recognized this factor in presuming that a maintenance of effort can be sustained by continuing or decreased levels of funding based on an inoperative budget base. Neither do the figures reflect the fiscal year 1973 restored appropriations expended in fiscal year 1975. What we are faced with, particularly in NIAAA, is a massive and crippling cutback by the administration at a time when, despite or perhaps even because of our current domestic situation, the Federal thrust needs to remain effective and undiminished.

BUDGET RECOMMENDATIONS, FISCAL YEAR 1976

[In thousands of dollars]

	NIAAA	NIDA	OE
Research	14,000	31,600	
Training	18,000	8,000	
Community programs:			
Project grants and contracts	90,000	158,000	
Staffing grants	10,400		
Grants to States	80,000	45,000	
Special incentive grants to States	13,000		
Management and information	11,500	14,300	
Total	236,900	256,900	20,000

In fiscal year 1974 the moneys available to the Division of Drug Education/health and nutrition programs of the Office of Education totaled $6.7 million. With these funds five regional training centers were operating in Miami, Long Island, Chicago, San Antonio, and Oakland. Six hundred school and community teams were trained. There were six demonstration projects for the training of school personnel in colleges of education. Approximately 2,000 future teachers participated.

Last year Congress wisely added alcohol abuse problems to be officially addressed by the Division of Drug Education. Major emphasis on prevention is now recognized to be essential by national, State, and community education leaders and workers in the field of alcohol and drug problems. The Office of Education's program on alcohol and drug abuse is uniquely capable of reaching the Nation's teachers because of its long-standing communications link with the 16,000 school systems throughout the Nation.

Congress has included $4 million for fiscal year 1975 in a still pending supplemental appropriation. For fiscal year 1976 we propose that $20 million be appropriated for this effort. With these funds the existing activity of the regional training centers and demonstration projects could be maintained for drug abuse activity. Additional activity could be generated for alcohol abuse in keeping with the congressional intent of last year and new programs could be developed to aid State departments of education in mounting better programs at the State and local levels.

In conclusion, we would like to express our appreciation in having an opportunity to appear before you to share our views on these matters.

This concludes the formal part of our testimony. We will be happy to answer any questions that the members may have.

Mr. Boche. The concern that we have as deliverers of services is that the Federal partnership we feel needs to be vital and needs to be a continuing partnership we can depend on. We find one of the most disconcerting things for us in trying to relate to our client is to find that we are on a roller coaster in which the interests of the Federal agency, the complications associated with rescission, with impoundment, constantly puts us into a situation in which we are gearing up, gearing down, attempting to adjust and spending a disproportionate amount of our energy in the whole matter of survival rather than relating to our clients.

Our remarks and testimony here today are basically a plea for stability in the relationship between the Federal initiative and those commitments that are being made on a State and local level.

We feel that there have been substantial commitments made on the State and local levels which are directly related to the initiative which the Federal Government has taken.

Just a very simple example of this. The National Institute on Alcohol Abuse and Alcoholism initiated a troubled employee program and over 3 years put about $150,000 in the State of Minnesota. As a result, the Governor has seized the initiative and has requested that the State appropriate $5 million of State funds over the next 2 years to stimulate and implement an expanded troubled employee program in the State of Minnesota. This is a clear payoff from the initiative which the Federal Government through the National Institute on Alcohol Abuse and Alcoholism has taken.

We can bring up other examples of the effect of the Federal initiative upon the whole delivery system. We believe it has a tremendous multiplying effect.

We are also concerned that if we are to move in an orderly process to stabilize the field, to make it a delivery system where clients can depend on it, that we will need to move in the direction of a greater dependency upon formula grants rather than on project grants.

The third area where we are working is to use noncategorical funds as a major support mechanism for the delivery of alcohol and drug services and to fully utilize the capability we find within such mechanisms as title XX of the Social Security Act and title XVIII and XIV of the medical assistance program.

We think that these are rich areas in which the alcohol and drug delivery system can be integrated in the future into the total delivery system, but we feel at this juncture that we need the support of the thrust that you as the Congress have spearheaded to help us in the local community to develop those mechanisms for the continuation of the deliverance of service.

Therefore, our priorities are to look toward the increase in the proportion of funds that go to formula grants both in the alcohol and drug area while at the same time attempting to maintain some of the commitments that the Federal Government has had in initiating programs through project grant proposals and programs. We think that this dual approach has a tremendous potential and can have great impact on the delivery of services.

Also, Mr. Chairman, we understand it is part of the total bill you are considering, and we would like to call attention to the legislation which created within the Office of Education, the program to implement the Alcohol and Drug Abuse Education Act. We believe it is worthy of an appropriation that is consistent with our needs and prevention.

If you have any comment or questions I would be happy to respond to them.

Mr. FLOOD. No. Thank you very much.

NEIGHBORHOOD HEALTH CENTERS

WITNESSES

DAVID LOPEZ, EAST HARLEM TENANT COUNCIL
JOSEPH MORALES, EAST HARLEM TENANT COUNCIL

Mr. FLOOD. Mr. David Lopez and Joseph Morales, East Harlem Tenant Council.

Mr. LOPEZ. Mr. Chairman, members of the subcommittee, we are honored to appear before you today to appeal to you on behalf of our community for increased Government support of neighborhood health centers.

My name is David Lopez. I am vice chairman of the board of directors of the East Harlem Tenants Council. Accompanying me is Jose Morales, Jr., project director of the East Harlem Tenants Council Neighborhood Health Center.

The East Harlem Tenants Council is a community based, multiservice agency that services the East Harlem community of New York City. The council was founded in 1964 with the objective of improving the housing conditions through tenant organizations. However, because housing conditions exist side by side with other problems, the council, in the past 10 years, has created and developed many programs including: new housing, day care centers, a food co-op, an alcoholism prevention program and services for the elderly. Now, under the direc-

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tion of Mr. Morales, we are planning a family-oriented neighborhood health center.

Before discussing the health center, I would like to provide you with a brief overview of the demography of East Harlem. East Harlem has a population of 154,000, of which 45 percent are Puerto Rican and 35 percent black. According to the 1970 census date, half the families have an income of less than $6,000 and approximately one-third of the population receives public assistance. In addition to high levels of unemployment, crime, homicide, and family disintegration, the people of East Harlem also experience a disproportionately high prevalence of morbidity and mortality in such areas as infant mortality, drug dependence, early infancy diseases and infectious diseases.

Although East Harlem has many medical facilities, these are located mainly near the upper east side of Manhattan and cater primarily to the upper income population. Dr. Louise Johnson of Mount Sinai School of Medicine, in a study of East Harlem, stated that half the medical visits were made outside the area and that the majority of medical visits were to clinics or hospital outpatient departments. This substantiates the fact that these people receive episodic and fragmented care rather than personal, continuous primary care. Among existing health facilities, none are representative of community efforts or are community operated and most ignore the beliefs, attitudes, and lifestyles of the East Harlem Puerto Rican and Black consumer.

The main access to primary medical care for East Harlemites is the emergency room of the local hospital. Hospital primary care is more costly than care offered by a neighborhood health center.

It is also a well known fact that New York City is in severe financial straits and that it has begun a major pruning of its services. The health department has not been exempted from these cutbacks and has been forced to close several of its health stations including two in East Harlem.

Into this setting the East Harlem Tenants Council is presently organizing a comprehensive health center that will partially make up for this total deficit in the present health care system. The East Harlem Tenants Council Neighborhood Health Center, now in its infancy stage, has been established to provide people of the East Harlem community with culturally oriented health care and to insure for that population the accessibility to a regional system of secondary and tertiary health care through our backup hospitals.

Services will be delivered efficiently and with dignity to an initial registered population of 3,000 people that will rise to 6,000 at the end of the first year. It is our commitment that this center will be a catalyst in the reorganization of primary health care delivery in East Harlem. The services of the health center, its educational program, training and research, its very character will reflect the sociocultural and linguistic characteristics of its consumer population.

At our center, the focus is on the family unit as opposed to the individual. Whole families will be registered and have their health care needs assessed. Treatment, whether preventive or curative in nature, will be done by teams of health personnel which include

doctors, nurse practitioners, and community health workers. As each family is registered they will be assigned to a team that from then on will be responsible for the services to that family. Where applicable and possible, team members will also followup a patient when a referral has been made.

We hope to begin the development of the concept of regional care where the entry into the health system through the primary care site and arrangements are made with secondary and tertiary facilities for backup in subspecialty and inpatient care. We have already made backup arrangements with the Hospital for Joint Diseases and Medical Center and Mount Sinai Hospital and Medical Center. Both these facilities are accessible to our population. The planning for this program was developed through a partnership between the East Harlem Tenants Council and the Department of Community Medicine of the Mount Sinai School of Medicine.

The present program constitutes an effort of the community to fill part of the gap between health needs and health resources, particularly in the area of primary care and in the organization of a backup system that assures the consumers the possibility of having all types of health care when the consumer needs it and demands it.

Today our country's administration is proposing:

1. a cutback of 20 to 25 percent for neighborhood health centers, which simply means;

2. the termination of numerous health centers across the country and the strangulation of those being developed, like our center in East Harlem;

3. the elimination of medicaid reimbursement for adult dental care; and

4. that Federal matching contribution of medicaid be cut from 50 to 40 percent in the 13 States with the highest per capita income.

We believe, committee members, that our citizens have been hit with more than enough measures that cutback. One can be pennywise and dollar foolish. If our already depression-ridden people are denied the basic human right of decent health care, how can this Nation expect patience and support through the rough times ahead.

In essence, I am here representing the position against the administrations' cutback for neighborhood health centers which service a proportionately high number of this country's disadvantaged.

Our position is that Congress and this administration must earmark $230 million for neighborhood health centers to stay alive in this country. This money is not an additional handout to the poor; it is merely sufficient to make available to community health agencies such as ours, resources needed to bring the health care system back into the business of taking care of people.

On behalf of the East Harlem Tenants Council, thank you for your generous interest in the improvement of health services for the people of East Harlem.

Mr. FLOOD. Thank you very much.

Mr. George Hecht, chairman of the American Parents Committee.

WITNESSES

GEORGE J. HECHT, CHAIRMAN, AMERICAN PARENTS COMMITTEE
MS. MARILYN MARCOSSON, EXECUTIVE SECRETARY

Mr. HECHT. Mr. Chairman, may I first present Marilyn Marcosson, who is the executive secretary of the American Parents Committee. She lives and works in Washington and is available to you and your staff and to any Members of Congress for consultation about any matters dealing with Federal services for children.

Mr. Chairman, members of the committee, my name is George J. Hecht, and I am the founder and chairman of the American Parents Committee and publisher of Parents' magazine. I appreciate the opportunity to appear before you again, Chairman Flood. The American Parents Committee, formed in 1947, is the oldest group lobbying exclusively on behalf of Federal legislation for children.

Although we are concerned with a variety of programs I will today limit myself to the health needs of our Nation's children.

Children represent 40 percent of our current population and 100 percent of our future. Yet, children account for only 10 percent of the spending of our Federal health dollars. This is a decline from 1960, when children accounted for 50 percent of our health spending. I cannot argue that spending on adult health programs should be lowered, but the American Parents Committee believes that increasing the proportion of money spent on children's health is a sound investment.

I would like to address the attention of the committee to four separate areas:

1. National Institute of Child Health and Human Development.
2. Maternal and Child Health.
3. The Center for Disease Control.
4. Family Planning.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

The National Institute of Child Health and Human Development this year is the prime source of research in areas of population and child health.

In child health, the program of research includes the health of the mother; the effect of her health on the child both before and after birth; and the survival of the child after birth. Areas of concern to NICHHD include noninfectious disorders leading to brain damage; the sudden infant death syndrome; prenatal nutrition and low birth weights, and mental retardation, among others.

Each year 126,000 retarded children are born. The multi-disciplinary approach of NICHHD, which has mental retardation as its special assignment, offers the best chance to make prevention a reality.

In the area of population research, NICHHD works in four areas: (1) the development of improved methods of fertility regulation, including the improvement of contraceptive technology and control of infertility; (2) studies of biological and genetic implications of contraceptive use; (3) investigations of the social and behavioral aspects of population problems and dynamics; and (4) basic biomedical research in the population sciences.

I cannot stress too much the need for improved contraceptive technology and research. The goal of a safe, effective, low cost, reversible birth control technique for either men or women that does not have the delitorious effects of the pill should be a national goal. The NICHHD also works on infertility control. The agony of a couple that wants to conceive a child and cannot is deep and troubling.

The current state of the art too often results in multiple births with all the problems and likelihood for infant survival that accompanies multiple birth.

In fiscal 1975 the appropriation for the National Institute of Child Health and Human Development was $141,966,000. For fiscal 1976 the administration has requested only $106,062,000. A decrease of almost $36 million.

Admittedly this year, research into problems of the aging has been separated from NICHHD with the creation of a new National Institute on Aging. However, the estimated fiscal 1975 expenditures for aging were only $8,683,000. Subtracting this amount from the current appropriation leaves a balance of $133,283,000, some $27 million more than the administration request.

The American Parents Committee therefore believes that to keep the level of research and services of NICHHD alive, an appropriation of $140,500,000 should be made.

MATERNAL AND CHILD HEALTH (TITLE V OF THE SOCIAL SECURITY ACT)

The maternal and child health program has a long history, going back to President Roosevelt's original Social Security Act in 1935. Yet, 40 years after its enactment we confront a program where only 1 out of every 22 eligible children is being served.

Congress in the past had made improvements in the program designed to more effectively define the deficiencies in health care for mothers and children and to offer services to those groups. In a series of amendments the Congress told the States that beginning in 1972 they would have to provide at least one program in each of five areas: The areas were (1) maternal and infant care, (2) children and youth care, (3) regional newborn intensive care, (4) family planning and (5) dental care.

At that time only two States had projects in all five areas, and eight States had no projects at all. Although 209 projects now exist throughout the United States, another 163 are needed to meet the requirements of the law.

According to Ralph Pardee, deputy associate director of MCH, the cost of funding these programs would be $81 million. Under the current program only $23 million is slated for new project development. In fact, it is only because of the action of this subcommittee and the full House that the $23 million remains spendable in the 1975 or 1976 budget because President Ford proposed a rescission of $23 million for MCH that the House rejected.

The administration has proposed slashing the MCH program from its current appropriation of $295 million to $211 million. A cut of over $63 million or over 21 percent. A 21-percent reduction when the law requires more than a 50-percent increase in projects.

There can be little doubt about either the need or efficacy of this program. On the needs side we know the United States ranks 15th in

the world in infant mortality. Because our reporting requirements are strict and our recordkeeping good the overall national ranking may be slightly off. That, however, cannot be used as an excuse for figures on infant mortality within the United States. In 1973 among white babies there were 15.3 deaths per 1,000 live births before the 1st year. Among nonwhite babies there were 26.2 deaths per 1,000 births before the 1st year. Nonwhite babies have a 70-percent better chance of dying before their 1st birthday than white babies. Yet, according to a recent study by the National Academy of Sciences, the 1969 New York City rate of 21.9 deaths per 1,000 births could have been reduced to 14.7 per 1,000. These excess deaths were preventable with adequate health care.

While other examples could be given on the needs side I think it important that we look to the efficacy of the program. One measure of success in the child health programs has been the decline in hospital admissions among those children served. In 1968, 7.7 percent of the children needed hospitalization while in 1974 the figure was 2.4 percent.

Again, other examples of the pluses of this program can be given but I will let others do that.

Given the history of the program and the additional requirements on the States, the American Parents Committee proposes that MCH programs be funded at $204 million; crippled children programs at $80,290,000; research and training at $27,960,000; section 516 (hold harmless) at $25 million and sudden infant death syndrome at $2,750,000. This would be a total of $340 million for the maternal and child health program, as compared with the 1975 appropriation of $294,868,000.

CENTER FOR DISEASE CONTROL

While the center for disease control has many aspects, some are of vital concern to our Nation's children.

We remember the scourge of diphtheria and whooping cough, the thousands of children in iron lungs and braces with polio, the massive birth defects that followed outbreaks of rubella.

Because of the very success of immunization, we have another problem. Many of today's young parents simply have not had their children immunized. The diseases are not widespread, they are not on the front pages or featured on the evening news and people forget about them. And, it even looks like the budget makers at OMB have forgotten about them. But these diseases can come back. In 1970, Dr. John J. Witte, Chief of the Immunization Branch of the CDC's State and Community Services Branch said there was a threat of an epidemic of polio in central city areas and some rural sections unless vigorous vaccination efforts are carried out.

Although we have been blessed in not having an epidemic outbreak of polio, individual cases have been increasing since 1964. In 1964, we reached our peak polio immunity level of 87.6 percent.

I have received data from the 1974 immunization survey and the results are not good. In both central cities and standard metropolitan statistical areas (SMAS), immunization against polio and DTP (diphtheria, tetanus, and whooping cough) have fallen from the 1969 level.

In 1974, 4 out of every 10 central city children between the ages of 1 and 4 was not vaccinated against polio. In the SMSA's the polio

vaccination rate was only 68.1 percent, down from 72.5 percent in 1969. In central city children the 1969 rate was 62.4 percent, compared to 60.0 percent in 1974. In fact, the decline in polio vaccination has been greater in the SMSA's than in the central city.

In 1974, 3 out of every 10 central city children were not vaccinated against DTP, compared to a 73.8-percent rate in 1969. In the SMSA's, the dropoff has been even more dramatic. In the last 5 years there has been an almost 10-percent drop in the number of children immunized. In 1969, 87.6 percent of the children between 1 and 4 were vaccinated, in 1974 only 77.9 percent were covered.

For measles and rubella the figures are better. They show an increase in the level of immunization between 1969 and 1974, but the numbers are still low. In 1974, 62.5 percent in the central city were vaccinated against measles and 68.5 percent of the children in SMSA's. For german measles, the figures are even lower. In central cities only 61.1 percent were immune and only 62.3 percent in SMSA's.

The administration has proposed cutting the immunization program to $4.9 million. The American Parents Committee believes the minimum necessary for immunization programs is $13 million.

In other programs run by the CDC, we recommend that $32 million be appropriated for venereal disease. Venereal disease among teenagers is pandemic, with the number of reported cases almost quadrupling between 1960 and 1972.

We recommend that $9.9 million be appropriated for lead-based-paint poisoning. The ingestion of lead paint results in brain damage and retardation. It is a preventable problem, and the program should continue to grow.

FAMILY PLANNING

I doubt, Mr. Chairman, if there is a single Federal program that has greater cost-effectiveness than family planning. Even beyond its cost-effectiveness are the social benefits and well-being that is a direct result of a family being able to plan for, and control, its size.

As the late Alan Guttmacher said: "No woman is completely free unless she is wholly capable of controlling her fertility, and no baby receives its full birthright unless it is born gleefully wanted by its parents."

I understand that no new authorization has yet been passed and that family planning is operating under a continuing resolution following President Ford's veto of the Health Revenue Sharing and Health Services Act, last December.

However, the Senate has already passed the proper authorization, setting the figure at $150,175,000. The House Interstate and Foreign Commerce Committee has reported a bill with an authorization of $110 million. It is expected that this bill will be reported to the floor soon. I could not let this opportunity pass without supporting this authorization and appropriation.

To follow the guidelines of the HEW 5-year plan for family services we should be spending $250 million in fiscal 1976. Yet the administration has proposed a 20-percent cut from current spending. A cut from spending that has already been frozen because of the continuing resolution.

We recommend that the family planning appropriation be $150 million. There is no doubt that this is a spendable amount. The latest figures show that 3.2 million people, predominantly poor women, were served in federally assisted family planning centers. Yet the same survey showed that here are at least 7.5 million women eligible for assistance in the poor and near-poor categories. This number is probably rising because of current economic conditions.

The administration requested for family planning for fiscal 1976 is $79,435,000, a drop of over $200 million from both actual 1974 dollars and projected 1975 expenditures.

The administration justifies this drop, as it has in so many other programs, by saying that either the States will make up the difference or they will get the additional money from reimbursable programs such as medicaid. No one in the Congress knows better than this committee that therein lies the rub. In the first instance the States simply don't have the money to pick up the programs. In the second instance, this body knows that medicaid, in gross terms, is not a health program, but a health payment program. Without program money we cannot be assured that the people involved would get the same level of counseling, In fact it is a safe bet they would get less counseling.

Sexually active teenagers in the Detroit Planned Parenthood Clinic are required to participate in a rap session with trained couselors before they receive services. What doctor is going to spend that time with them? How many teenagers feel more comfortable going into a family planning clinic rather than going to see a private doctor or waiting in a hospital clinic?

Family planning is a program specific project; it should not be subjected to the budget cuts proposed by the administration.

CONCLUSION

Mr. Chairman, I am concerned about the health of our economy as well as the health of our children. But it is clear to me that a dollar spent on preventing or correcting a children's health problem could save many dollars when that child grows up. It can also, most importantly, give us a healthy, productive member of society.

I have a supplementary table which shows the administration's request for the coming year, the APC's recommendation, and what was appropriated in fiscal 1970. I would like to have that attached.

[The table referred to follows:]

TABLE 1

	Administration request	APC recommends	1975 appropriation
Maternal and child health	211, 422, 000	340, 000, 000	294, 868, 000
Family planning	79, 435, 000	150, 000, 000	100, 615, 000
Center for disease control	133, 311, 000	175, 294, 000	149, 906, 000
National Institute of Child Health and Human Development	106, 062, 000	140, 500, 000	141, 966, 000

MAY 14, 1975.

REDUCTION IN HEW BUDGET FOR 1976

WITNESSES

DR. FRANK ROGERS, PRESIDENT, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS
FRANK WOOLEY, EXECUTIVE DIRECTOR

Mr. NATCHER. Our next witness is Mr. Frank Wooley.

Mr. WOOLEY. Dr. Rogers is the president. We would like to have him give the statement.

Mr. NATCHER. We are glad to have you before the committee and we will be pleased to hear from you.

Dr. ROGERS. We want to thank you for being able to share these views with the committee. We represent the Association of American Physicians and Surgeons.

I am Frank Rogers, a physician in practice in Whittier, Calif. Mr. Frank Wooley is with me from the association. He is its executive director.

We sought this opportunity to testify, not to ask for subsidies, but to set in motion some incisive ideas that may help restrain this subcommittee—and the Congress—from continuing the catastrophic climb in HEW spending.

Reductions in the 1976 HEW budget will serve to counter the pressures for passage of multibillion-dollar proposals to politicalize private health insurance for unemployed, and the more costly proposals that would completely politicalize all medical care—proposals deceptively labeled "national health insurance"—that might well bankrupt the Nation.

Incisive ideas we seek to set in motion in our testimony are contained in charts and graphs, which we hope will convey meaningful messages to many of your colleagues through the printed hearings.

We ask that we be allowed to file a longer statement than I will be presenting to you.

Mr. NATCHER. Without objection, it is so ordered.

Dr. ROGERS. We plan to invite your colleagues' constituents—including the 61 percent who didn't vote in 1974—to help convey these messages to their Congressman. We believe the continuous campaigns of Congressmen will create excellent opportunities for all constituents to communicate the messages in the attached charts.

Chart 1 shows that the inflation index has risen over three times since 1945—from 48 to 156. Though this thermometer reading of the body politic may not be fully understood by all, the next chart brings into sharp focus the long view of legalized thievery that has been going on since 1940.

Chart 2 shows that the value of the dollar has shrunk from a 1940 value of $1.01 to 24 cents in 1974. This means to the elderly or disabled

that from every $1.01 saved in 1940, three-quarters of the value of these savings has been stolen by inflation.

Chart 3 gives the short view of legalized thievery, showing that based on the value of the dollar in 1967 being $1, the value of each dollar saved in 1970 has shrunk from 93 cents to 64 cents, according to latest figures available.

Chart 4 compares government spending with population, and shows that government spending increased from $45.6 billion in 1942 when the population was only 135 million to $487.8 billion in 1974 when the population was estimated to be about 211 million.

Chart 5 shows how government spending per capita—Federal, State and local—has gone up from $33 per person in 1913 to $1,066 per person in 1965; and then on up to $2,290 per person in 1974. The enormity of government spending is emphasized by per-family figures—multiplying $2,290×4 shows that annual government spending per family of four is now over $9,000.

Chart 6 shows the government take—the percentage of everyone's earnings spent by government. In 1940, 25 percent of everything everyone earned was spent by government. In 1974, the government take had risen to 48 percent. Some may find this hard to believe, for such facts are often clouded by deceit, misrepresentation, and deliberate schemes to keep people from realizing the truth.

Chart 7 shows that 13 percent of the government take came from real estate taxes, 37 percent from Federal and State income taxes, and the balance from inflation and other taxes. While the Federal and State income taxes of the average person amounts to about 18 or 19 percent of his total income, when other taxes are added in the total amounts to 48 percent.

Chart 8 emphasizes the important point that the government take is now 48 percent. The Survey of Current Business of the U.S. Department of Commerce—cuttting through all the red tape and confusion about authorizations, outlays, trust funds and other minutia connected with government redtape shows clearly that the government spends 48 percent of the total earnings of everyone.

Chart 9 shows that wild government spending has increased the public debt from $43 billion in 1940 to $596 billion in 1976. The Secretary of Treasury says the Federal Government will have to borrow $70 billion more in this fiscal year, and may have to borrow $86 billion more in fiscal 1976. This will mean that the Government can do only one thing: run the printing presses.

Chart 10 shows that the cumulative spending of HEW since 1954 is $682 billion. This is $86 billion more than the total indebtedness of the United States. This means that HEW has spent $3,232 per person for every man, woman, and child in the United States—more than $12,000 for every family of four. The HEW cumulative spending curve now stands almost vertical.

Chart 11 shows the enormity of HEW spending in relationship to spending for defense, interest on the debt, the space program, and other major departments; and that HEW spending is almost double the $77 billion annual rate of savings of all citizens reported in 1974. Obviously, HEW can continue its unbridled spending only through use of printing press money.

Chart 12 shows that HEW spending has gone from $23.2 billion in 1965 to $118 billion in 1976.

Mr. NATCHER. Doctor, you understand that figure now includes all of the trust fund money, social security, railroad retirement?

Dr. ROGERS. Yes, sir.

Mr. NATCHER. As far as this bill is concerned that is before our committee at this time, we have spending proposals in the bill and authorizations totaling $36.7 billion. Do you understand that?

Dr. ROGERS. I understand that, and we have looked at that.

Mr. NATCHER. In other words, just as a matter of keeping the record straight, the figure you use of course, of $118.4 billion, is the figure that we have before the committee. Your figure is correct. But it includes all the trust funds.

Dr. ROGERS. This would have been true at $111 billion last year and $94 billion the year before.

Chart 13 shows HEW spending in relationship to Defense spending. In 1960, 47 percent of all Federal spending was for Defense, and only 16.8 percent was for HEW. Now, HEW spending is 36.5 percent of total Federal spending, and Defense spending is less than 25 percent.

Thus, the statement that the major part of our budget is for Defense is now incorrect. HEW's spending has now surpassed Defense spending, and now accounts for 36½ percent of all Federal spending.

Chart 14 shows that in 1960, profits after taxes of all corporations in the United States were $26.7 billion, and that HEW spending was much less. But in 1974, HEW spent more than all the profits after taxes of all corporations. In other words, if all of the income of all corporations were confiscated—as is done in Communist countries—this amount would not pay for HEW spending.

Chart 15 shows that HEW actuaries promised on a pile of statistics that medicare in the first year of operation would cost only $900 million—and that the cost would gradually go up to $1.7 billion in 1975.

While there were strong objections by doctors, insurance actuaries, and others to acceptance of these HEW estimates, Congress at that time apparently did not see through the misrepresentation and chicanery of the bureaucracy, and irresponsibly chose to believe the bureaucratic soothesayers who had an interest in betraying the people.

Actual hospital costs the first full year of operation were more than double the amount HEW promised. Hospital costs are now $10.9 billion per year—and when supplemental medical program costs are added, the total annual medicare costs are $14.9 billion. Comparing promised cost and actual cost in 1974, actual hospital costs are 6 times promised costs, and actual total costs are 8 or 9 times the costs estimated by HEW.

Chart 16 gives the sources of comparison of 1974 medicare hospital costs with the cost estimates of HEW. These comparisons should be significant to Members of Congress in evaluating HEW cost estimates for pending proposals for so-called national health insurance, and similar schemes.

Chart 17 shows that the percentage of HEW spending paid to doctors in 1974 amounted to only 3.3 percent of the total HEW spending for that year. Obviously, when the Federal bureaucracy blames doctors for the increased cost of HEW, this canard should be laid to rest by every person interested in truth and the credibility of our Government.

This has been of particular interest to me because, out of the budget for HEW, $94 billion in this year, only 3.3 percent of the total spending for physicians. HEW officials, and some Members of Congress, are clubbing what we believe to be the finest medical profession in the world.

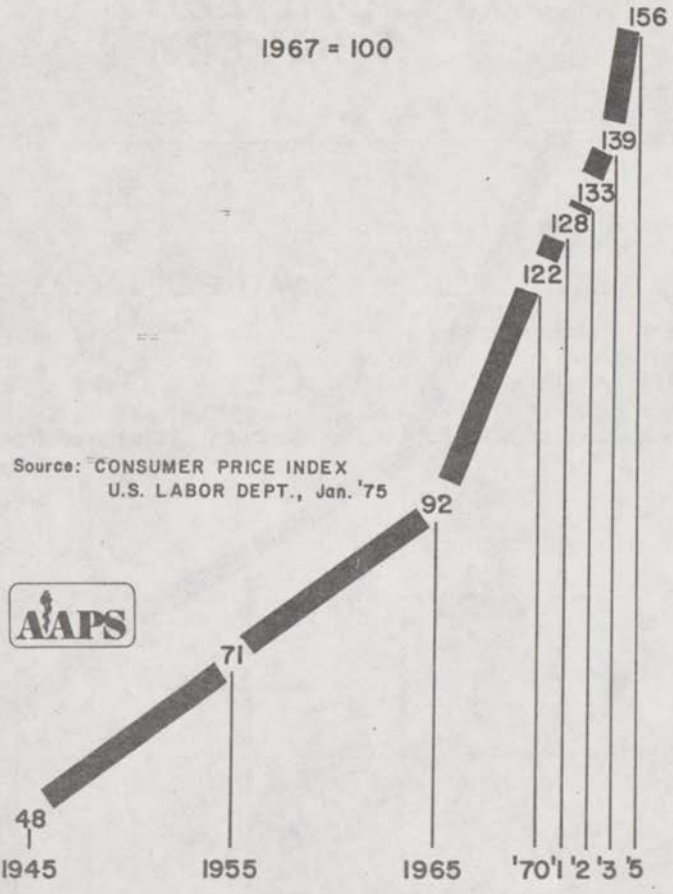
Chart 18 shows HEW spending for 1974 at $97 billion, and that payments to doctors under medicare and medicaid totaled only $3.251 billion. The source of these figures is the Special Analysis of the U.S. Budget for fiscal 1975.

Chart 19 compares medical and health spending by the Federal Government with that of State and local governments. In 1929, such Federal spending was much less than State and local spending, and continued to be less in 1965. But in 1970 the comparison was much different, and in 1974 when HEW spent more than $28 billion, local and State governments spent less than half that amount. (This is what happens when centralized government makes puppets out of local and State governments by the device of spend and spend, tax and tax, elect and elect.)

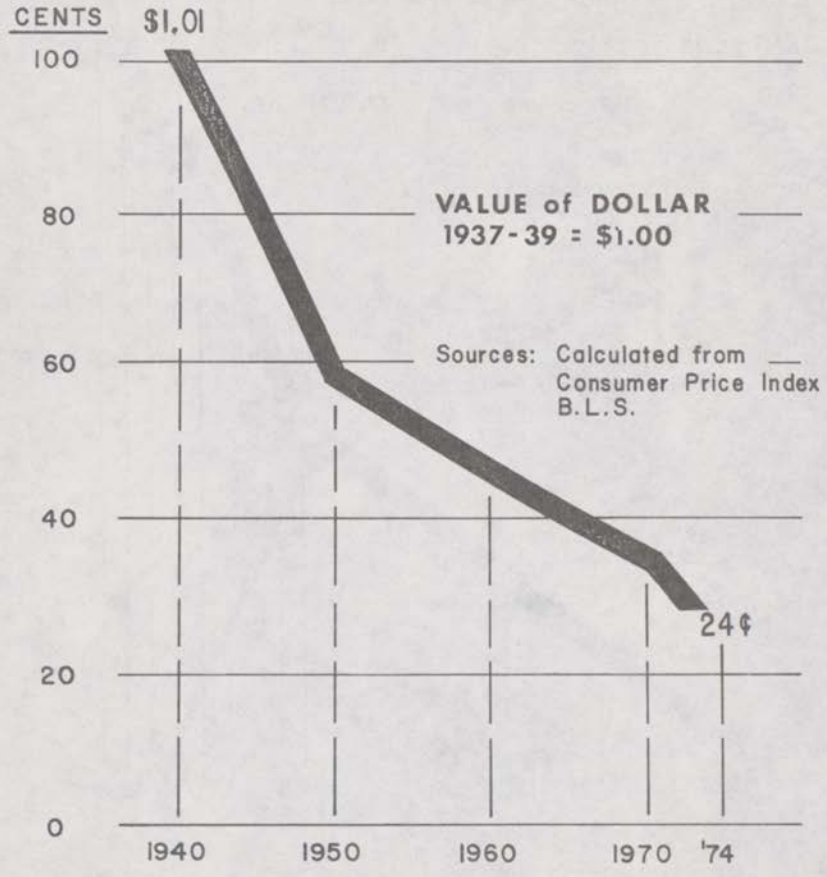
Chart 20 comparing public and private spending for health is based on data in the January 1975 Social Security Bulletin which, by its comments appears to take pride in the fact that public spending for health which was about 25 percent of all spending in 1960, has now risen to become nearly half of all spending for health.

[The charts referred to follow:]

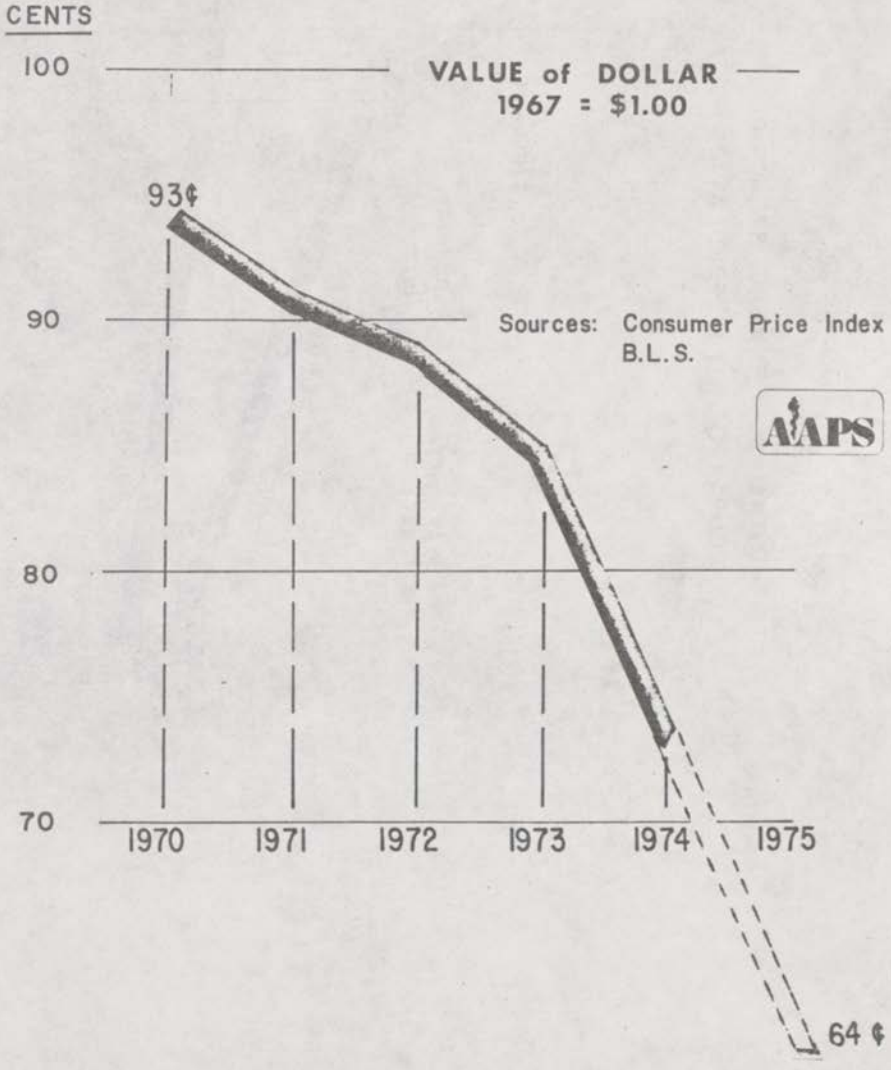
INFLATION


1967 = 100
156
139
133
128
122
92
71
48
Source: CONSUMER PRICE INDEX
U.S. LABOR DEPT., Jan. '75
AAPS
1945
1955
1965
'70
'1
'2
'3
'5

Long View of LEGALIZED THIEVERY

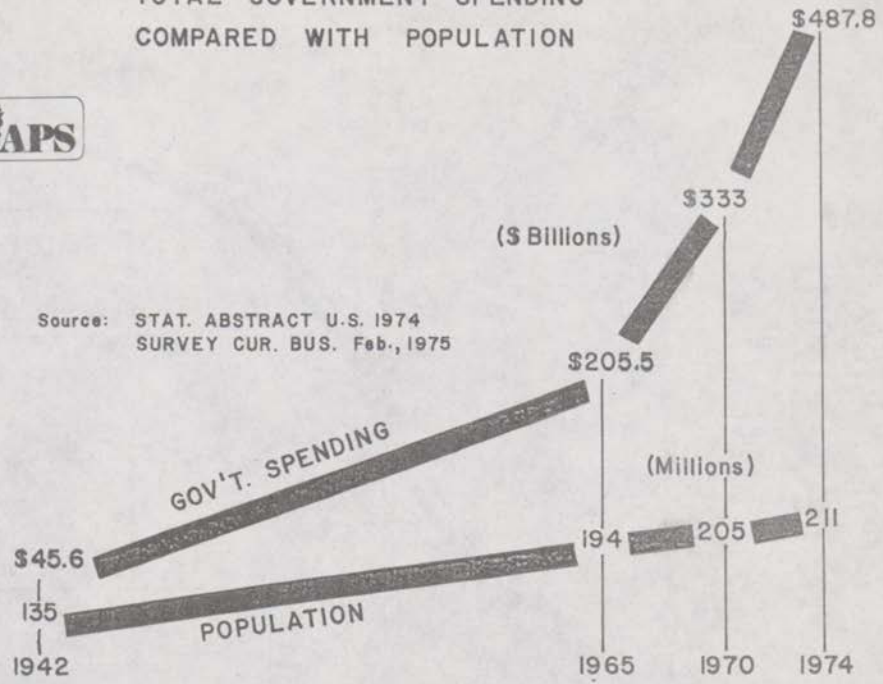


Short View of LEGALIZED THIEVERY

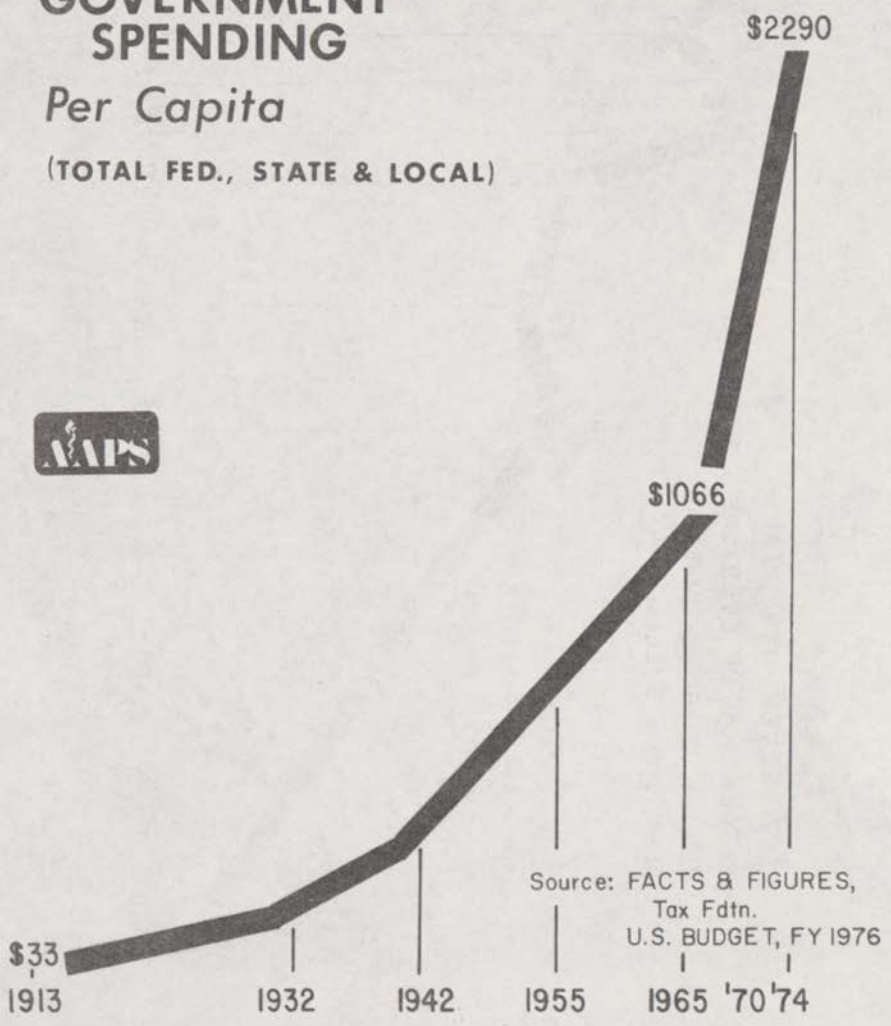


TOTAL GOVERNMENT SPENDING COMPARED WITH POPULATION

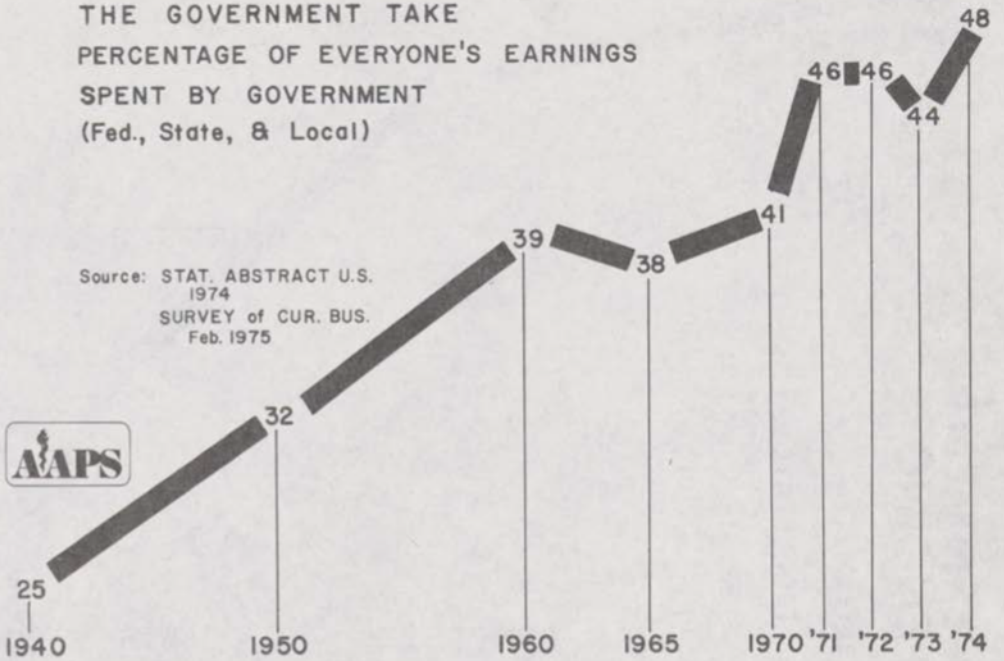
AAPS

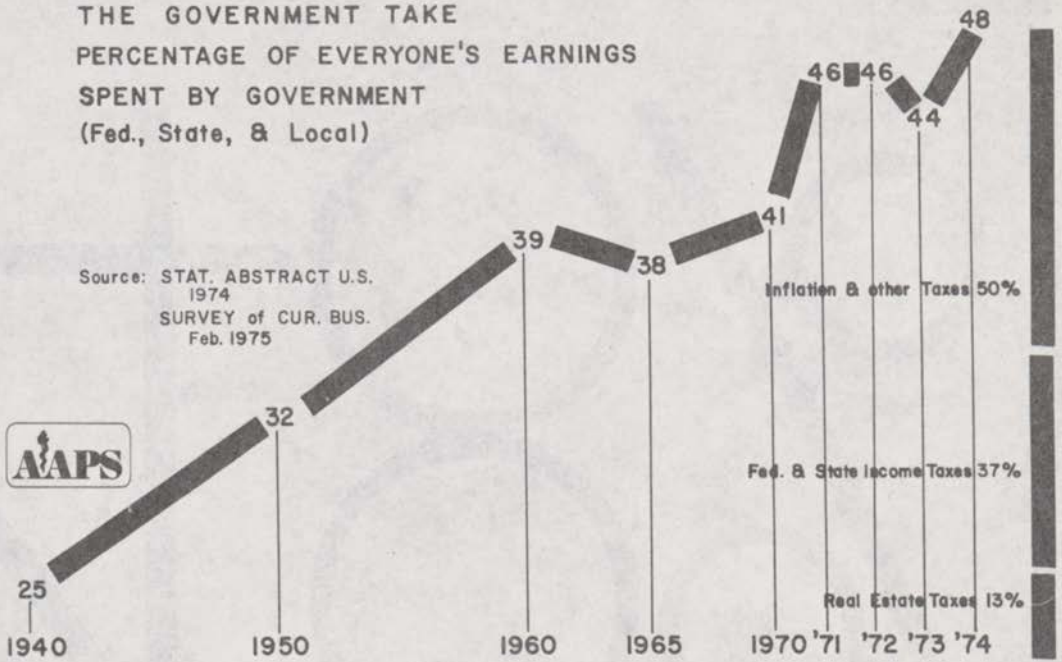


Source: STAT. ABSTRACT U.S. 1974
SURVEY CUR. BUS. Feb., 1975

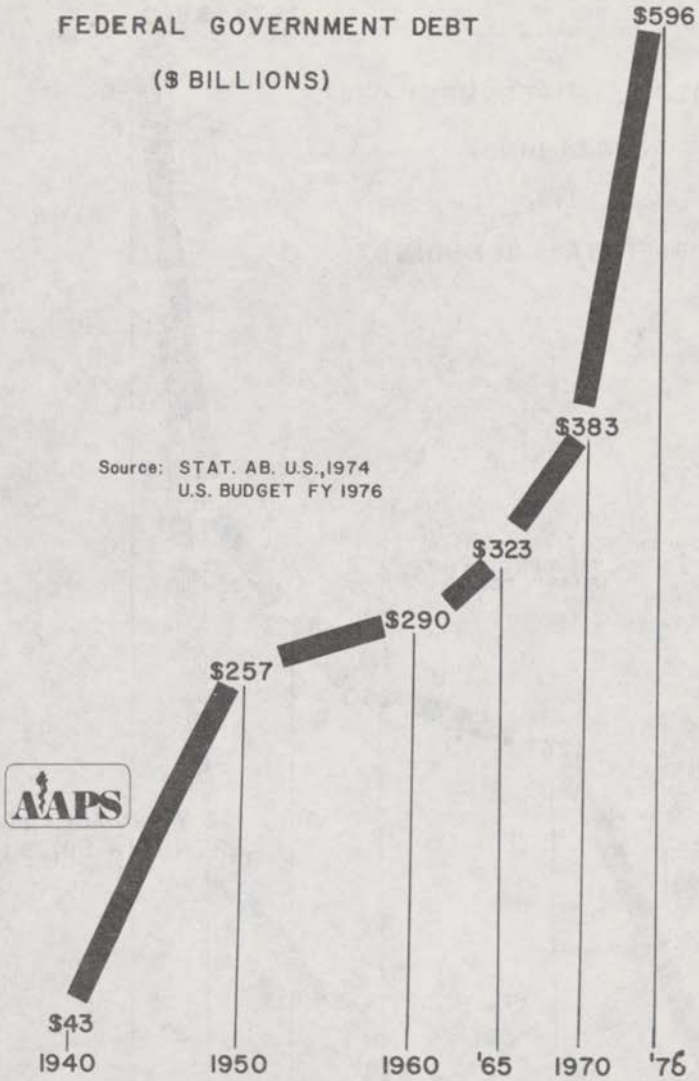

GOVERNMENT SPENDING
Per Capita
(TOTAL FED., STATE & LOCAL)
AAPS
$2290
$1066
$33
1913
1932
1942
1955
1965
'70
'74
Source: FACTS & FIGURES, Tax Fdtn.
U.S. BUDGET, FY 1976

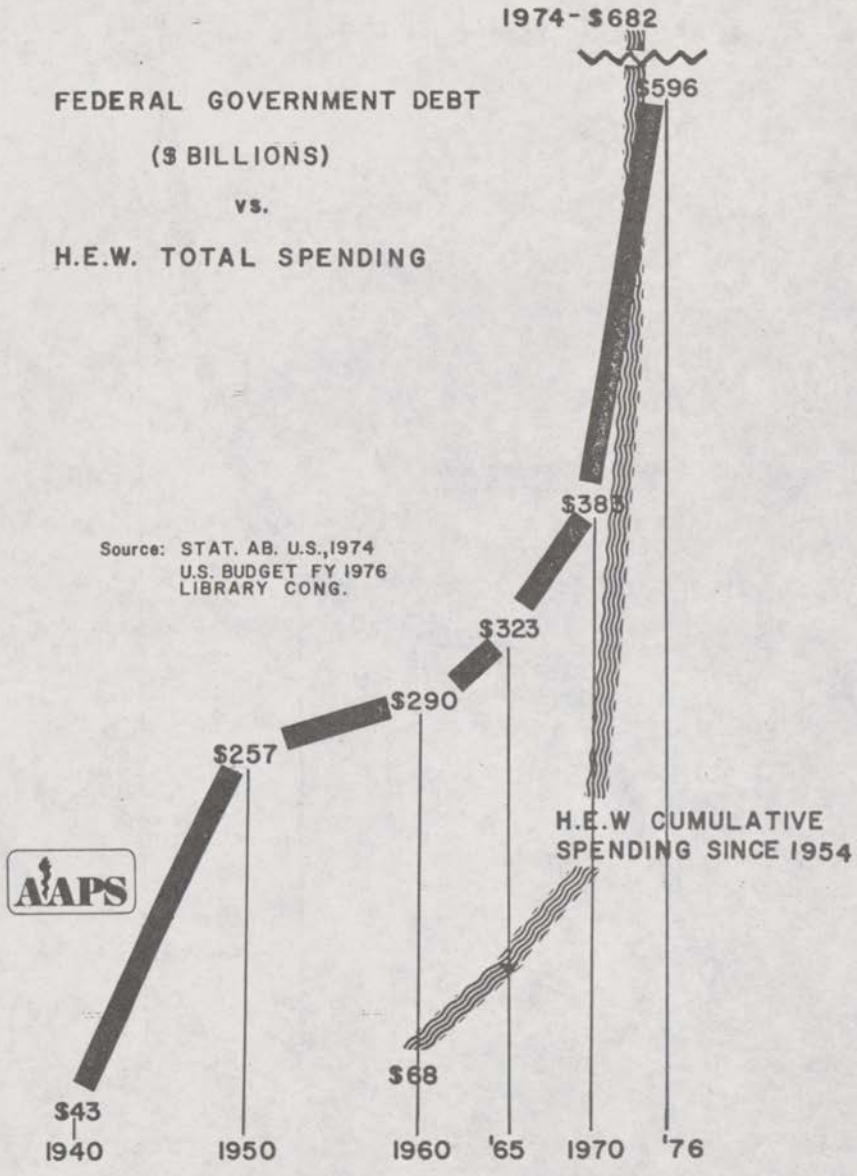
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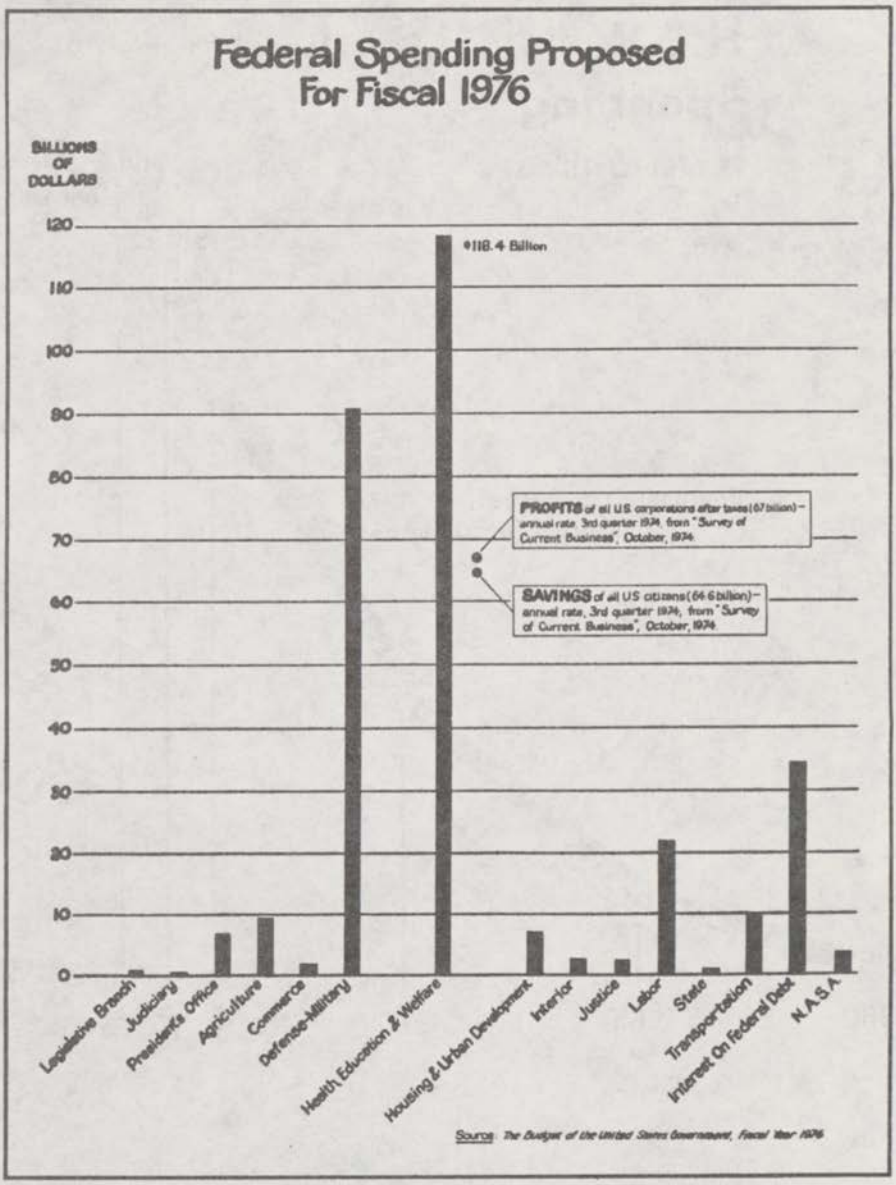

THE GOVERNMENT TAKE
PERCENTAGE OF EVERYONE'S EARNINGS
SPENT BY GOVERNMENT
(Fed., State, & Local)
Source: STAT. ABSTRACT U.S. 1974
SURVEY of CUR. BUS. Feb. 1975
AAPS
25
32
39
38
41
46
46
44
48
1940
1950
1960
1965
1970
'71
'72
'73
'74


THE GOVERNMENT TAKE
PERCENTAGE OF EVERYONE'S EARNINGS
SPENT BY GOVERNMENT
(Fed., State, & Local)
Source: STAT. ABSTRACT U.S. 1974
SURVEY of CUR. BUS. Feb. 1975
AAPS
25
32
39
38
41
46
46
44
48
1940
1950
1960
1965
1970
'71
'72
'73
'74
Inflation & other Taxes 50%
Fed. & State Income Taxes 37%
Real Estate Taxes 13%

47%
AIPS

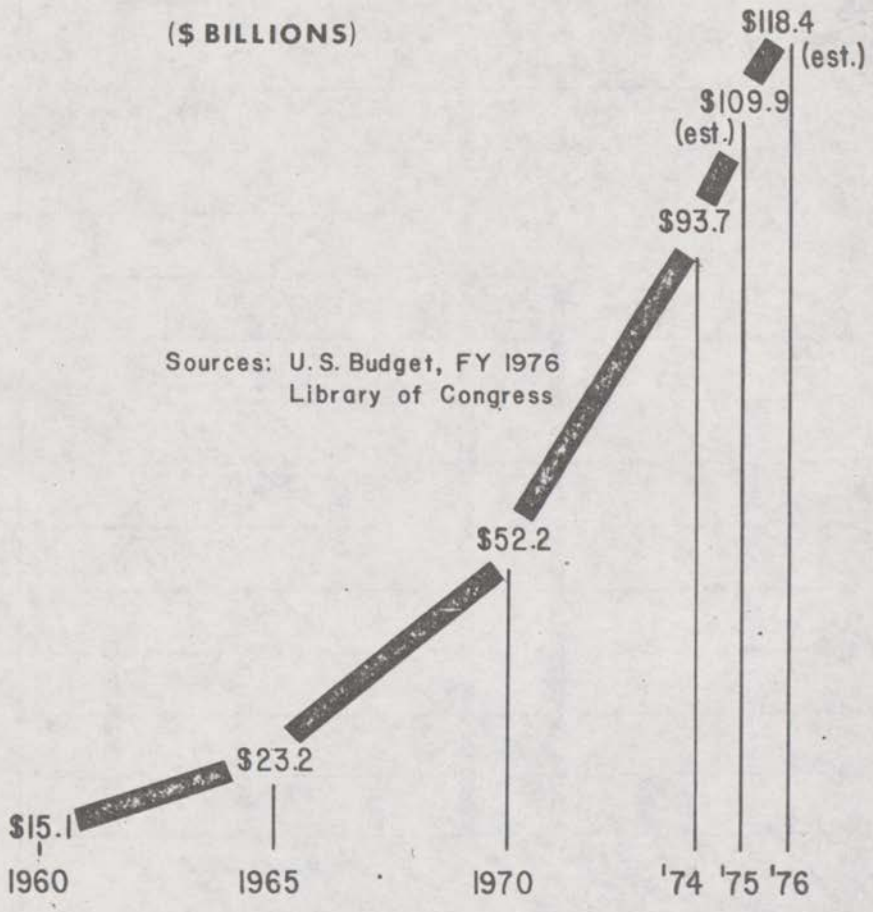

FEDERAL GOVERNMENT DEBT
($ BILLIONS)
Source: STAT. AB. U.S., 1974
U.S. BUDGET FY 1976
$43
$257
$290
$323
$383
$596
1940
1950
1960
'65
1970
'76
AAPS


1974-$682
$596
FEDERAL GOVERNMENT DEBT
($ BILLIONS)
vs.
H.E.W. TOTAL SPENDING
$385
Source: STAT. AB. U.S., 1974
U.S. BUDGET FY 1976
LIBRARY CONG.
$323
$290
$257
H.E.W CUMULATIVE
SPENDING SINCE 1954
AAPS
$68
$43
1940
1950
1960
'65
1970
'76

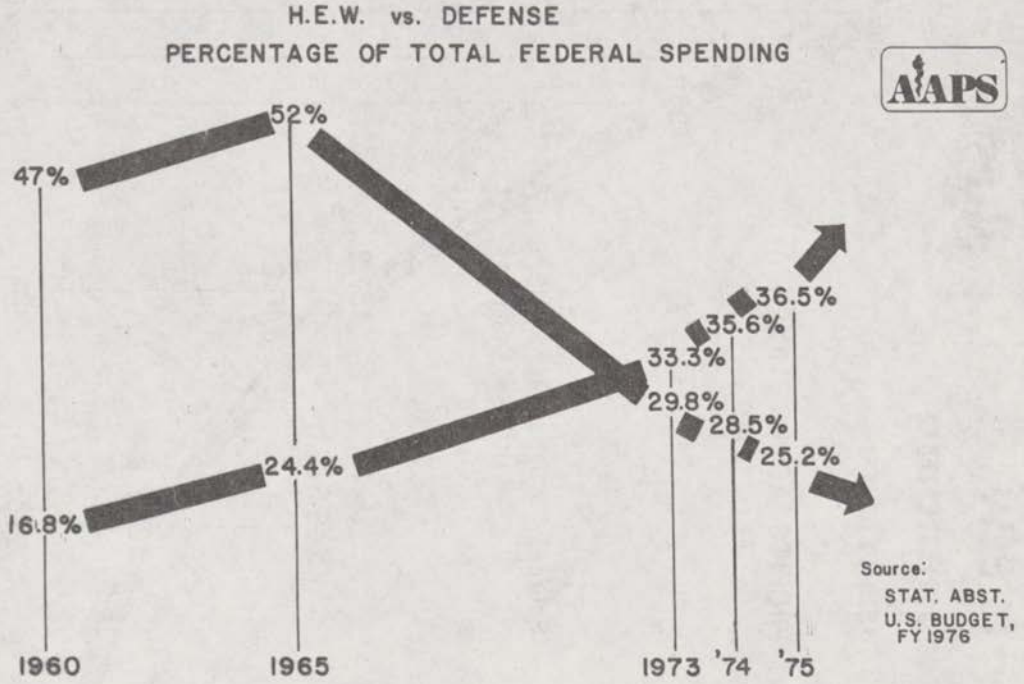

Federal Spending Proposed
For Fiscal 1976
BILLIONS OF DOLLARS
120
110
100
90
80
70
60
50
40
30
20
10
0
$118.4 Billion
PROFITS of all U.S. corporations after taxes ($87 billion) – annual rate, 3rd quarter 1974, from "Survey of Current Business", October, 1974
SAVINGS of all U.S. citizens ($46 billion) – annual rate, 3rd quarter 1974, from "Survey of Current Business", October, 1974
Legislative Branch
Judiciary
President's Office
Agriculture
Commerce
Defense-Military
Health Education & Welfare
Housing & Urban Development
Interior
Justice
Labor
State
Transportation
Interest On Federal Debt
N.A.S.A.
Source: The Budget of the United States Government, Fiscal Year 1976

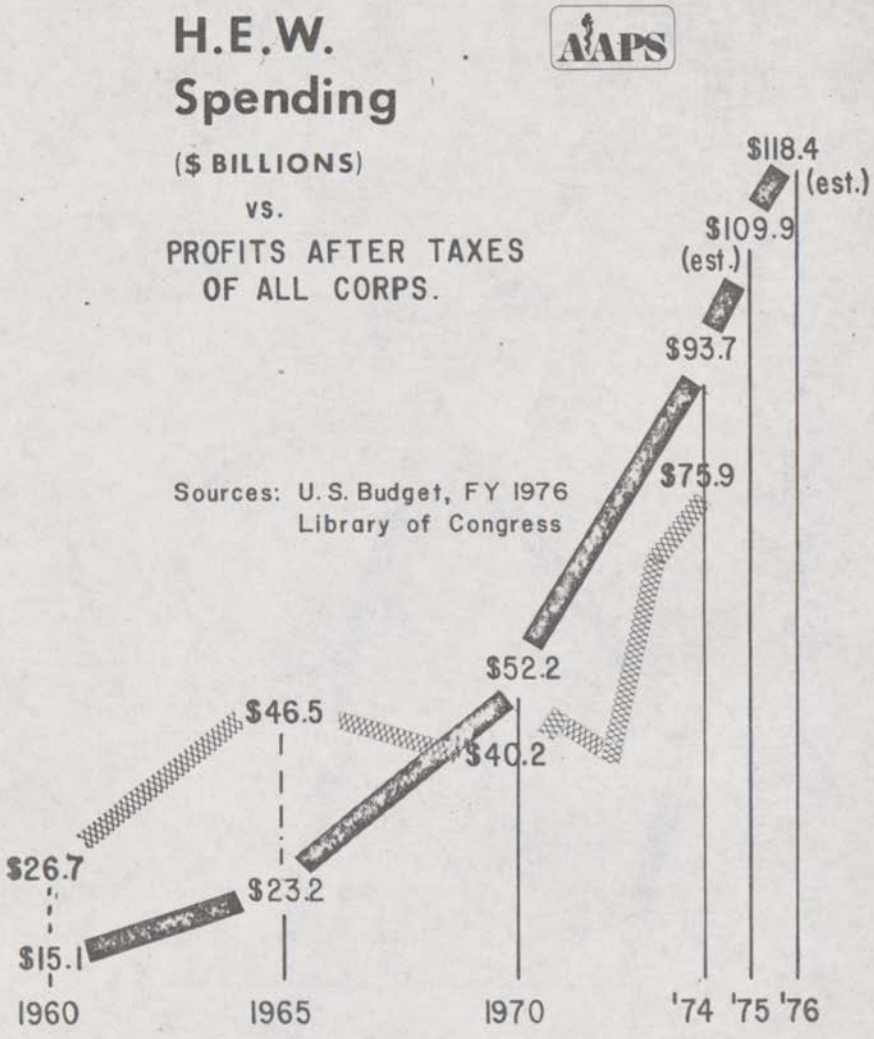
H.E.W. Spending

(S BILLIONS)



Sources: U.S. Budget, FY 1976
Library of Congress

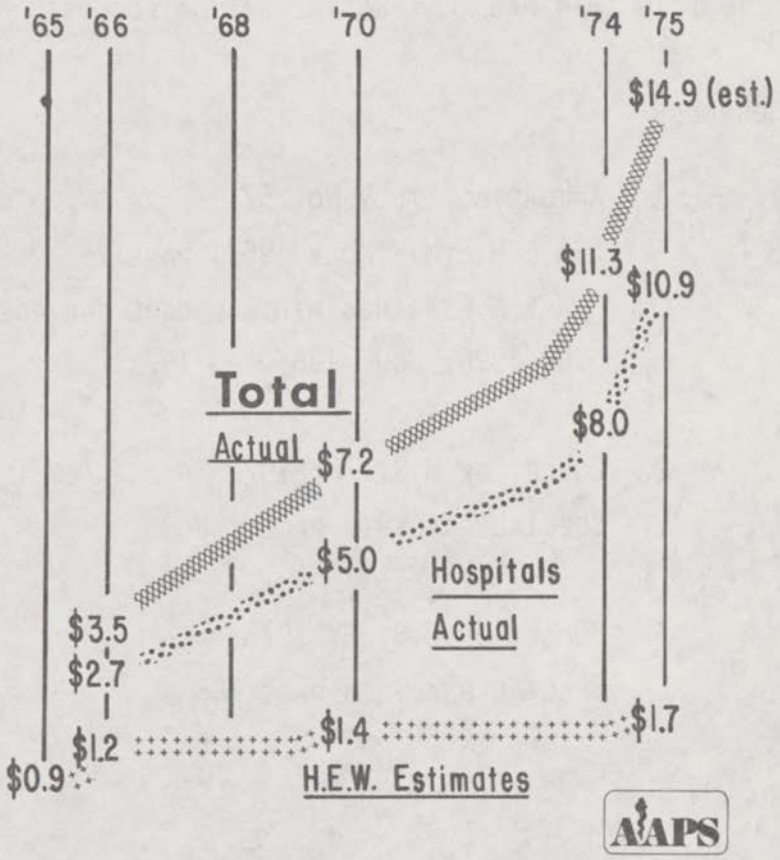

H.E.W. vs. DEFENSE
PERCENTAGE OF TOTAL FEDERAL SPENDING
AAPS
47%
52%
16.8%
24.4%
33.3%
29.8%
36.5%
35.6%
28.5%
25.2%
1960
1965
1973
'74
'75
Source:
STAT. ABST.
U.S. BUDGET, FY 1976


H.E.W.
Spending
($ BILLIONS)
vs.
PROFITS AFTER TAXES
OF ALL CORPS.
AAPS
Sources: U.S. Budget, FY 1976
Library of Congress
$118.4
(est.)
$109.9
(est.)
$93.7
$75.9
$52.2
$46.5
$40.2
$26.7
$23.2
$15.1
1960
1965
1970
'74
'75
'76

MEDICARE COST

ESTIMATED v ACTUAL

(Billions)



MEDICARE COSTS
(HOSPITAL)
ESTIMATED V ACTUAL

ACTUAL IN 1974 WAS 6 TIMES THE ESTIMATED COST

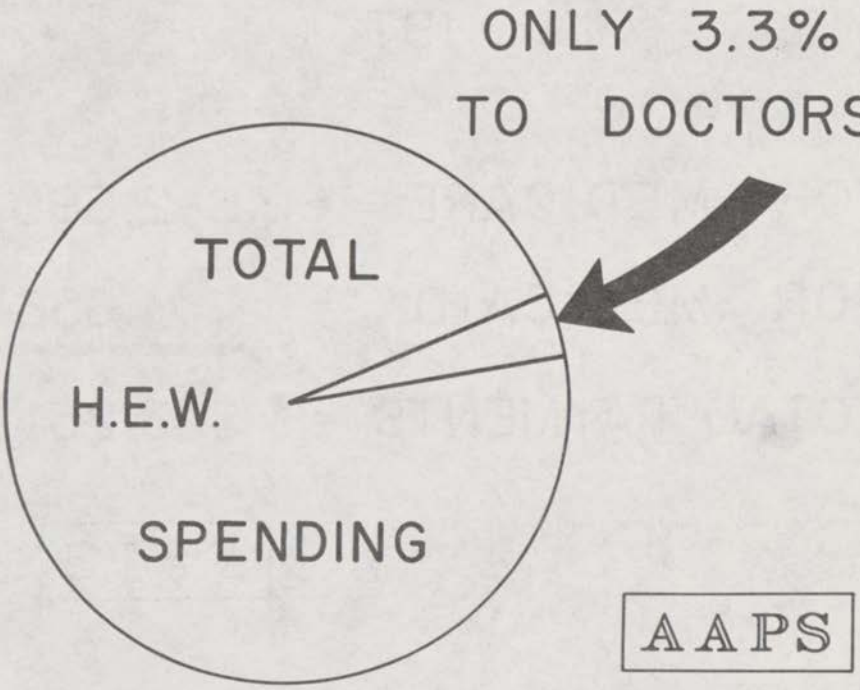
SOURCES:

1. ACTUARIAL STUDY No. 57
   SSA - H.E.W. JULY 1963, PAGE 25
   W & M HEARINGS MEDICAL CARE FOR AGED
   HR 3920, Nov. 1963, P. 197

2. BUDGET OF U.S., FY 1975
   SPECIAL ANALYSIS PAGE 148

3. BUDGET OF U.S. FY 1976
   SPECIAL ANALYSIS PAGE 183

PERCENTAGE OF PAYMENTS TO DOCTORS FOR MEDICARE AND MEDICAID OUT OF TOTAL H.E.W. SPENDING



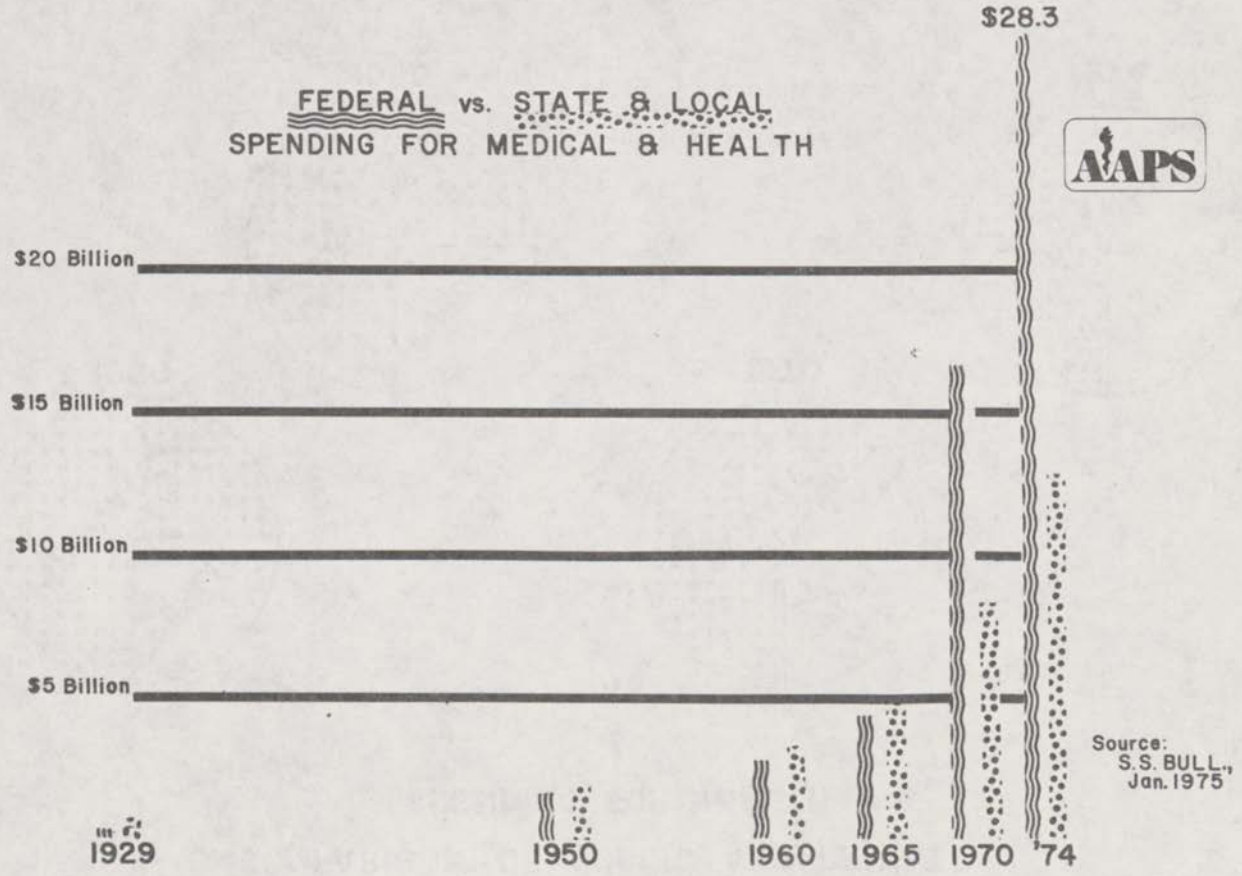
TOTAL H.E.W. SPENDING FOR 1974 = $ 97 BILLION

PAYMENTS TO DOCTORS IN 1974:

FOR MEDICARE	=	$ 2.595
FOR MEDICAID	=	.656
TOTAL PAYMENTS	=	$ 3.251

Source: U.S. Budget Special Analysis
Fiscal Year 1975, p. 148-149

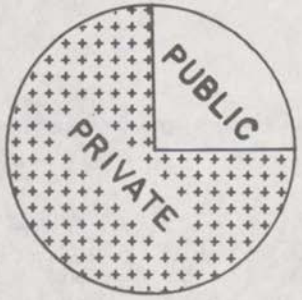
AAPS


$28.3
FEDERAL vs. STATE & LOCAL
SPENDING FOR MEDICAL & HEALTH
AAPS
$20 Billion
$15 Billion
$10 Billion
$5 Billion
Source:
S.S. BULL.,
Jan. 1975
1929
1950
1960
1965
1970
'74

COMPARISON OF PUBLIC AND PRIVATE SPENDING FOR HEALTH



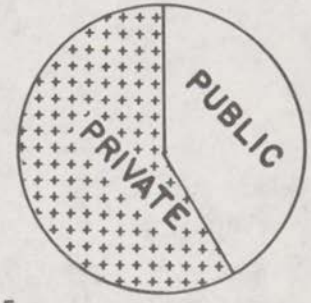
1960



1965



1970



1974

Source: U.S. BUDGET,
FY 1976
S.S. BULL., Jan. 1975

Dr. ROGERS. We are now reaping the whirlwind of failure to follow commonsense fiscal policy. It is pertinent to point out that Russia was deliberately driven through a period of increased government spending for the express purpose of destroying private capitalism. In the selected works of Lenin is the significant statement:

> State monopoly capitalism is the fullest material preparation for socialism; it is its threshold; it is that rung on the historical ladder between which and the rung called socialism there are no intervening rungs.

Even John Maynard Keynes, the Fabian-Socialist economist whose disciples have misled the free world, recognized the deadly trap of inflation. In a book, "The Economic Consequences of the Peace," beginning on page 235, he said:

> Lenin is said to have declared that the best way to destroy the capitalist system was to debauch the currency. By a continuing process of inflation, governments can confiscate, secretly and unobserved, an important part of the wealth of their citizens.
>
> By this method, they not only confiscate, but they confiscate arbitrarily, and while the process impoverishes many, it actually enriches some. The sight of this arbitrary rearrangement of riches strikes, not only at security, but at confidence in the equity of the existing distribution of wealth.
>
> Those to whom the system brings windfalls, beyond their deserts and even beyond their expectations or desires, become "profiteers," who are the object of the hatred of the bourgeoise, whom the inflation has impoverished, not less than the proletariat.
>
> As the inflation proceeds and the real value of the currency fluctuates wildly from month to month, all permanent relations between debtors and creditors, which forms the ultimate foundation of capitalism, become so utterly disordered as to be almost meaningless; and the process of wealth-getting degenerates into a gamble and a lottery.
>
> Lenin was certainly right. There is no subtler, no surer means of overturning the existing basis of society than to debauch the currency. The process engages all the hidden forces of economic law on the side of destruction, and does it in a manner which not one man in a million is able to diagnose.
>
> In the latter stages of the war all the belligerent governments practiced, from necessity of incompetence, what a Bolshevist might have done from design. Even now, when the war is over, most of them continue out of weakness the same malpractices.
>
> But further, the governments of Europe, being many of them are at this moment reckless in their methods as well as weak seek to direct on to a class known as profiteers the popular indignation against the more obvious consequences of their vicious methods. These profiteers are, broadly speaking, the entrepreneur class of capitalists, that is to say, the active and constructive element in the whole capitalistic society, who in a period of rapidly rising prices cannot help get rich quick whether they wish it or desire it or not. If prices are continually rising, every trader who has purchased for stock, owns property and plant inevitably makes profits. By directing hatred against this class, therefore, the European governments are carrying a step further the fatal process which the subtle mind of Lenin had consciously conceived.
>
> The profiteers are a consequence and not a cause of rising prices.
>
> Perhaps it is historically true that no order of society ever perishes save by its own hand.

Tersely translated: Put the central government suction pump of inflation on the pocketbook of every private citizen, suck most of the earnings out of the private sector into the public sector, and the country will collapse into Socialist dictatorship.

What the committee has to decide is this:

Will it continue on down the road that these charts show we are going by throwing the gasoline of more Government spending on the fire of inflation, which will further debauch the currency; cheat

the people out of their earnings; and pave the way for destruction, tyranny and the failures of political control of all our private affairs?

Or will it stop the irresponsible increase in Government spending in order to restore honesty in money, and thereby facilitate a productive, free-choice, willing-exchange economy upon which the successes of the United States are based?

Spending for health was about 25 percent of all spending in 1960. Now welfare spending accounts for nearly one-half of all spending for health.

In concluding, the failure of Government to follow a rational, commonsense fiscal policy is about to represent a whirlwind of disaster. Your Nation and mine, Mr. Chairman, is on the very brink of collapse.

Russia was deliberately driven through a period of increased Government spending for the express purpose of destroying private capitalism, which is the key to our success and to our ultimate survival as a nation. To paraphrase Lenin, which I think is of significance here: "State monopoly capitalism is the fullest material preparation for socialism. It is that rung on the ladder toward socialism between which there is no intervening rung."

In other words, put a suction pump on the pocketbook of all private citizens, siphon insidiously out of the private sector into the public sector, and the country will collapse into dictatorship and socialism.

Finally, I would hope that each member of your committee has an opportunity to look at our statement, and that each will vote ultimately not to continue down the road to ruin that we are pursuing now by throwing gasoline of irresponsible Government spending on the fires of inflation.

The basic question is whether you, as individual committee members, will further vote to debauch the currency, to cheat the people out of their earnings, and to pave the way for destruction of private enterprise, or will you take the giant step to stop irresponsible Government spending, and turn this Nation back toward the productive, free-choice, willing-exchange economy which made our country the envy of the world.

Thank you.

Mr. NATCHER. Dr. Rogers, we want to thank you for your appearance before our committee and for your statement.

Thank you very much, gentlemen.

Mr. WOOLEY. We appreciate being here.

NATIONAL HEART AND LUNG INSTITUTE

WITNESS

DR. ELLIOT RAPAPORT, PRESIDENT, AMERICAN HEART ASSOCIATION

Mr. NATCHER. Our next witness is Dr. Elliot Rapaport, president of the American Heart Association. We are glad to hear from you. We are pleased to have you before the committee.

[The statement follows:]

STATEMENT OF ELLIOT RAPAPORT, M.D., PRESIDENT OF THE AMERICAN HEART ASSOCIATION

In preparing my testimony on the extension of the National Heart, Blood Vessel, Lung and Blood Act of 1972, I took a close look at the entire program of the National Heart and Lung Institute (NHLI), and the minimum resources needed to sustain its most essential and promising, continuing and new, activities. I also reviewed the cautious testimony offered by the Heart Association during the appropriations process for fiscal 1975. As a final step in this approach I developed budget estimates for each category of NHLI obligation (grants, fellowships, intramural research, etc.), based upon demonstrated needs and potential for improving health care in America. The dollar figure which we are recommending for NHLI appropriations for fiscal 1976—$410 million—is the sum of the individual program requirements mentioned above.

We know that Congress will have to make some difficult decisions to avoid unacceptable budget deficits in 1976. Accordingly, we hope that our analysis of the budgetary needs of NHLI and the public benefits to be derived therefrom will be of assistance to you in setting appropriations levels.

Here are the various factors we have taken into consideration:

1. RESEARCH GRANTS AND PROGRAM PROJECTS

In the area of grant support, stability is the most important criterion. The award rate of NHLI for approved applications dropped from 47.0 percent in 1969 to 32.8 percent in 1973. This has had an unsettling effect on the entire research community.

Under the congressionally approved budget for the current fiscal year, NHLI will be able to spend up to $145 million for regular grants and program projects. (Even at this level, the Institute will only be able to fund 49 percent of approved applications.) To provide for a stable research grant program for the Institute we calculated a budgetary need of $160 million. This is a no-growth budget, allowing only a 10-percent inflationary margin over the fiscal year 1975 grant program.

2. RESEARCH MANPOWER DEVELOPMENT

Two years ago, I participated in an independent American Heart Association study to quantify the needs for training research scientists for cardiovascular investigation. (The results of this study, expressed in a letter to Dr. Henry Simmons, are attached.) We concluded that 500 new researchers must enter training each year merely to preserve the existing pool of active investigators in heart and blood vessel diseases.

In applying this conclusion to the appropriations picture, I have assumed an average postdoctoral training program of 2½ years. This would require a minimum of 1,250 active fellowships and training awards for cardiovascular research at any one time. Secondly, I have assumed (in keeping with the implications of the National Research Service Awards Act) that 25 percent of these will be individual awards and the remainder training support through institutions. Thirdly, I have used an average cost for individual research fellowships of $15,200, and for institutional training grants of $18,050 (both including overhead), and allowed for a 5-percent cost-of-living increase in stipend levels.

This comes to a $23 million commitment to provide a minimum level of research training in cardiovascular areas during fiscal year 1976. Considering the manpower development needed to advance research in blood and lung diseases, we arrived at a conservative estimate for all research training costs at NHLI of $32 million.

3. CONTRACT RESEARCH

Contracts have increased in importance as a mechanism for Federal support of biomedical research. This is because they permit the supporting institution to develop practical conclusions to hypotheses which have been suggested as the result of other scientific inquiry. Furthermore, the contract mechanism allows the intensive coordination of large-scale trials often required for such confirmatory investigations.

For instance, there is good scientific evidence associating certain "risk factors"—including high blood lipids, high blood pressure, and smoking—with an increased incidence of coronary heart disease. The effect of intervening and controlling these risk factors on the likelihood of cardiovascular incident is, however, not as certain. For this reason, the Institute has embarked upon a large (12,000 subjects) and expensive endeavor, known as the multiple risk factor intervention trial. Similar imperatives for contract research in 1976, including amounts necessary to maintain programs supported at a comparable level in 1975, are indicated in the following table:

	Millions
Heart and vascular diseases:	
Clinical trials:	
MRFIT	$8.0
HDFP	5.2
Lipid metabolism	7.5
Other clinical applications	2.5
Cardiac diseases	2.5
Devices and technology	9.0
Hypertension education	2.0
New initiatives (include but not limited to): Animal models, diagnostic instrumentation; protecting ischemic myocardium; quantifying infarct size; tobacco working group	21.3
Total	58.0
Lung diseases:	
Respiratory diseases (include but not limited to): Indent. lung cells, respiratory mucus, blood gas sensors; ECMO pathology center; alpha-1-antitrypsin; neonatal RDS education; animal model fibrosis; pediatric pulmonary function; ALA contract on epidemiology; computer assistant education; noninvasive measurement of pulmonary artery pressure; epidemiology of sarcoidosis; minority program	9.0
Blood diseases and blood resources:	
Blood resources	1.5
Hepatitis program	1.5
Thrombosis and hemorrhagic	1.5
Devices and materials	3.0
Sickle cell research	2.5
Sickle cell clinics	2.0
Subtotal	12.0
Total, NHLI	79.0

4. CENTERS AND CONTROL PROGRAMS

It is well recognized that the scientific community must do a better job in translating research findings to the professional and the public. The concept of National Research and Demonstration Centers is a unique approach to developing a continuous flow of information from the researcher to the practicing physician and the man in the street. The concept is so exciting that 49 completed applications were submitted in response to the October 1972 solicitation. Since the NHLI budget did not have sufficient funds available, after supporting basic and applied research under traditional mechanisms, only three Centers could be funded (including one in heart). The time has come to test this concept! We suggested last year that there should be at least one National Heart and Blood Vessel Research Demonstration Center in each HEW region. This will require substantial financial commitment, even in a startup period. $20,000,000 would be a minimum requirement.

Moreover, we must realize that the translation of information in the traditional forms of public and professional education may not be enough. The prevention and control of cardiovascular and cerebrovascular disease may depend upon changes in lifestyle and standards of clinical care. To do this, funds are needed for basic research in behavior development, looking for ways

to help people to acquire the new habits to which they aspire. New public education programs will then have to be designed and tested based on these findings. We must also develop new modules for continuing education to improve the practice of preventive medicine and to keep medical practice consistent with the levels indicated by scientific development. Finally, we need pilot projects to demonstrate new approaches to health care delivery for the treatment of high blood pressure, a major cause of heart attack and stroke.

The cost effectiveness of the preventive approach to health problems has been well documented. Nevertheless, public commitment has been limited. For instance, there have been no appropriations under section 414 of the Heart Act for the programs authorized therein.

For these reasons, $20 million should be added to the NHLI appropriation for fiscal year 1976 for prevention, education, and control programs, and that amount should be earmarked for said programs in the committee report.

5. INTRAMURAL RESEARCH

Intramural research should be supported at levels which approximate the existing levels of support for these activities. Some of the major research efforts planned for intramural research in fiscal 1976 include:

1. Further research on human plasma apolipoproteins.
2. Studies of animal models of hyperlipidemia and atherosclerosis.
3. Clinical studies aimed at determining the metabolic defects in patients with different types of hyperlipoproteinemia.
4. Studies of the phosphorylation of platelet myosin.
5. Characterization of human heart contractile proteins.
6. Studies of the various processes leading to the genesis of atherosclerosis.
7. Studies of heart disease by means of echocardiography.
8. Further research on the reduction of ischemic injury by nitroglycerin during acute myocardial infarction.
9. The type II coronary intervention study.

6. CONSTRUCTION

The full potential of the Research and Demonstration Centers cannot be realized without new facilities. Construction funds must be authorized to create, through renovation, remodeling, or otherwise, structures in which these new interdisciplinary centers can operate with maximum effectiveness. Furthermore, the lack of Federal funds for the construction of research facilities in the recent past has resulted in an inferior "plant" in some research institutions. Payment of construction money in conjunction with ordinary grants will not only help to assure that the quality of our research installations does not fall below that of other countries, but will also be a source of stimulus to the economy. We estimate that $15 million could be wisely used for both kinds of construction.

SUMMARY

In summary, the Heart Association recommends an appropriation of $410 million for the National Heart and Lung Institute in 1976. That sum is not an abstract figure but represents the amount necessary to support the various aspects of the HNLI program at minimum levels.

This is how we arrived at this figure:

Category of obligation:	*Fiscal year 1976*
Research grants and program projects	$160,000,000
SCOR's	40,000,000
Control programs	20,000,000
Centers	20,000,000
Construction	15,000,000
Manpower development	32,000,000
Intramural research	25,000,000
Contracts	80,000,000
Management and program services	18,000,000
Total	410,000,000

MAY 30, 1973.

HENRY E. SIMMONS, M.D.,
Deputy Assistant Secretary for Health, Department of Health, Education, and Welfare, HEW North, Room 5622, Washington, D.C.

DEAR DR. SIMMONS: On the occasion of our meeting on April 18 and in a subsequent telephone conversation you asked the American Heart Association to make specific suggestions concerning the problem of training for biomedical research. As we understand it, you asked us for a quantative estimate of the need for biomedical research personnel as opposed to demand. We have found this an extremely difficult question to approach, but several meetings have been held, and we have some suggestions we would like to submit. Participating in the preparation of this position paper have been Dr. Paul N. Yu, President of the American Heart Association; Dr. Edgar Haber, Chairman of the Research Committee; Dr. Elliot Rapaport, Past Chairman of the Research Committee; Dr. Roland Schneckloth, Associate Director for Research of the American Heart Association; and Dr. Richard S. Ross, President-elect of the American Heart Association.

The approach we have taken is based upon certain assumptions. First, it must be assumed that biomedical research has yielded results which are useful to society. Second, many of the most useful and innovative advances come from young investigators who are under age 45. Based upon these two assumptions, it is obvious that if biomedical research is to continue at the same rate in the future, investigators lost to this especially active pool must be replaced. The output of the training program must, therefore, equal the attrition rate.

We have based our analysis on a survey conducted in February, 1973, of 403 NHLI research grants which represented a sample of 1,016 grants which were active at the time. These grants, special fellowships, and program projects have been analyzed to identify the number of investigators under age 45 who are actively engaged in cardiovascular research. No training grants are included. Not included were investigators engaged in research in the fields of pulmonary, kidney, and blood disease. Portions of the fields of thrombosis were, however, included in the survey. Care was taken to be sure that no investigator was counted twice. This survey of 403 grants was extrapolated to 1,016 grants which are outstanding, and a figure of 2,451 active investigators under age 45 resulted from this survey.

If the 2,500 investigators under age 45 are evenly distributed throughout the 35 to 45 age bracket, 250 of them, or 10 percent, would pass out of this especially creative and productive decade each year. This does not take into consideration attrition due to death, retirement, or shifting fields; and this has been estimated to be approximately 4 percent. These calculations indicate that 14 percent of the 2,500 man pool must be replaced each year. This means that 350 new biomedical research scientists must enter the cardiovascular field each year.

To supply this need for 350 biomedical research persons each year, we would suggest a program as outlined in the following table:

Age		Number	Attrition (percent)
30	Finish residency training		
30 to 32	Phase 1, research training	500	25
32 to 35	Phase 2, researdh training	375	5
35	Enter research pool	350	
35 to 45	Most productive decade	2,500	14
	10 percent become 46; 4 percent die or change fields	350	

The objective of this program is the maintenance of the investigator pool at its current level of about 2,500, and in order to do this, 500 trainees must enter the program each year.

We view research training as being divided into two phases. The first phase provides primary training to young men and women indicating interest, and in the eyes of their preceptors, having potential for research careers. Government support for phase 1 training would be of two types, the first of which would be similar to the current fellowship program and would be designed to provide a support mechanism for trainees in the environment in which institutional support did not exist or with preceptors who did not have institutional support. We feel that a 25 percent attrition rate must be accepted at this stage of training because it is impossible to judge a candidate's potential for research accurately before he has been exposed to a research environment. Some will find that they

do not have talent for research, or will be so advised by their preceptors. Others will decide that they cannot accept the economic sacrifice associated with a career in research and will elect to leave the training program for practice. This primary screening is absolutely essential, however, if high quality trainees are to be identified for entrance into the phase 2 training.

We visualize the phase 2 research training as being similar to the established investigatorship program of the American Heart Association and the Research Career Development Awards of the NIH. This phase 2 training of 3 to 5 years is considered to be the most important stage in the training process and one in which the investigator becomes highly productive while completing his training. It is anticipated that attrition at this level will be small. This is based upon the American Heart Association experience with the established investigators which indicates that 94 percent of the 277 investigators trained in this program had remained in academic medicine and research. Therefore, it is estimated that this pool of 375 in phase 2 training would yield the 350 required each year to replace the attrition from the existing research pool.

The attrition rates in both phase 1 and phase 2 must be minimized. We feel that this is best accomplished by careful selection for phase 1 training. Institutional training support should be given only to institutional units in a limited number of medical centers where there is evidence of excellence in research as judged on the basis of past productivity, grant support, and the number of active investigators available to serve as trainors. The selection of trainees should be overseen by an institutional training committee, probably appointed by the dean of the medical school. Obviously, it would not be possible to conduct central peer review prior to appointment, but quality control of the program can be assured by retrospective analysis of the appointments. Trainees' salaries would have to be adjusted to match the level of third year residency training. Research training should be clearly separated from clinical training. The so-called pay back provision as introduced in H.R. 5640 could also be implemented as a method of limiting attrition, but we feel that more important measures would be the quality control on the admission to the program.

There is need for some central mechanism whereby the priorities for training in various disciplines can be assessed. Needs for scientists in certain disciplines must be identified and training priorities adjusted approprately. This is an extremely difficult task in that the lag time or response time of the training mechanism is extremely slow; and, therefore, a decision to train more men in a certain research specialty has to be made five years in advance.

An essential feature of phase 1 training would also be in the contribution to the training institution in the form of salary support, facilities, equipment, etc. It is estimated that this might represent about one-third of the total institutional grant, two-thirds being allocated for stipends.

The phase 2 program would provide support for persons who would be primarily engaged in research; and it is anticipated that during this period they would be productive, not just receiving training. An essential feature of the phase 2 program would be a system of phasing out NIH support and phasing in institutional support. For example, at the end of 3 years, the institution would have to make a decision as to its intentions for a given investigator and be prepared to provide 50 percent of support in the fifth year and 75 percent in the sixth year and 100 percent in the seventh and subsequent years. Thus, there would be total support from this program for 4 years, some support for 6 years, and the total institutional commitment would begin in the seventh year.

It must be recognized that the program outlined above is a minimal program designed to supply 350 new productive cardiovascular research persons each year and, therefore, maintain the pool at its current size. If the research effort of the country is to be increased in accordance with the national heart, blood vessel, lung, and blood program of 1972, the program as outlined would also have to be increased. These figures can be utilized, however, as a baseline for such predictions; and thus, if the effort is to be increased by a certain fraction, it will be possible to calculate the necessary increase in input.

It is also important to recognize that this minimal program does not include scientists devoted to lung, blood, or kidney research. This is in no way meant to ignore the importance of these fields; but no hard data are available; and, therefore, it was not possible to make any accurate extrapolation into these fields. It could be estimated, however, that a program of equal size would be necessary to supply the needs of these three fields.

Another important omission is that of basic science training. We recognize that discoveries leading to major breakthroughs in the important problem area may

well come from basic science disciplines, such as biochemistry and immunology. Therefore, the research pool in these areas must also be maintained. We have no data upon which to estimate the requirements, but a guess would be that an equivalent number of trainees would be necessary here as well. Thus, the total trainee input in a given year might be close to three times that estimated in the table if the needs of lung, kidney, blood, and basic science disciplines are to be included. It must also be remembered that our calculations are based upon NHLI data alone and do not take into consideration the investigators supported by the American Heart Association and other private funds.

Therefore, there are three reasons why our estimates are falsely low: (1) Clinical investigators in lung, kidney, and blood disease have not been considered. (2) Basic scientists have not been included. (3) Data on NHLI supported investigators was used in preparation of the projections of need, and investigators supported by other funds were not counted.

We recognize that the legislation H.R. 5640 provides an approach to the important problem of training, and we do not view the outline contained in this letter as being in conflict with that legislation but, rather, as providing details which we hope will be of value in the design of a working program.

We hope that the above will be of some value to you in considering the future training needs. We would hope that after you have had a chance to review this document that we might have an opportunity to come to your office again and discuss this matter with you and Dr. Edwards. We offer the services of the Heart Association to you as you move forward in this area.

Sincerely yours,

PAUL N. YU, M.D.,
President, American Heart Association.
RICHARD S. ROSS, M.D.,
President-elect, American Heart Association.

Dr. RAPAPORT. Thank you, Mr. Chairman.

I am pleased to have the privilege of testifying on the proposed budget of the National Heart and Lung Institute. The written testimony which I have submitted for the record is the result of considerable analysis, reflection, and I might add ultimately compromise.

We are also concerned with fiscal restraint and we hope that we are, in fact, tighter in fiscal restraint against the health care needs.

Nevertheless, the American Heart Association is recommending a budget for the National Heart and Lung Institute in fiscal 1976 of $410 million.

I would emphasize, as we did in our testimony before this subcommittee last year, the Heart Association really has turned away from the practice of urging a high ball park figure with the expectation that some fraction of it might eventually lead to the Institute's appropriation. Rather the bottom line figure in our testimony on the last page of our testimony of $410 million is our best judgment of the program needs of the Institute and the level of funds it can effectively spend.

We believe, Mr. Chairman, that that is a conservative estimate.

Frankly, we think that the disparity which has developed between authorization and appropriation levels has created much confusion and skepticism, both among the public and the scientific communities. I believe at the present time it's about 60 percent between the authorization and the appropriation levels.

Now, more than ever, we feel it's imperative to bring authorization and appropriation figures together at a more realistic level. Promise should be in rough accord with reality.

The Heart Act of 1972 provides for an authorization of $475 million for the National Heart Institute's regular programs for the current fiscal year and an additional $45 million in prevention, education, and control activities. Neither the layman nor the scientist is able to rec-

oncile these amounts with the $324 million actually appropriated for fiscal 1975.

Accordingly, in preparing testimony for the extension of the Heart Act and for my appearance before this subcommittee, I have used the exact same approach. I have tried to examine each program operated by, or authorized for, the Institute in even greater detail than we did last year. We have arrived at minimum needs for each category of expenditure. All the details of this are in the written testimony.

We believe that the recommendation of $410 million is realistic, balanced, and critical. It's our hope that you and the Congress will provide an appropriation at this level for the Institute.

Thank you, Mr. Chairman.

Mr. NATCHER. Doctor, thank you very much.

We appreciate your appearing before our committee at this time. It has been a pleasure having you here.

Dr. RAPAPORT. Thank you, sir. It's my pleasure and privilege to be here, sir.

Mr. NATCHER. Thank you very much, gentlemen.

THURSDAY, MAY 15, 1975.

MENTAL ILLNESS

WITNESS

BERTRAM J. BLACK, PROFESSOR OF PSYCHIATRY (REHABILITATION), ALBERT EINSTEIN COLLEGE OF MEDICINE, NEW YORK, AND DIRECTOR, MENTAL HEALTH REHABILITATION SERVICES, BRONX PSYCHIATRIC CENTER, AND CONSULTANT TO INTERNATIONAL COMMITTEE AGAINST MENTAL ILLNESS

Mr. FLOOD. The first witness is Bertram Black of the International Committee Against Mental Illness.

Go ahead.

Dr. BLACK. Thank you, Mr. Chairman.

I will make it fast because you have a very busy agenda.

My name is Bertram J. Black. I am professor of psychiatry (rehabilitation) at the Albert Einstein College of Medicine in New York and director of Mental Health Rehabilitation Services at the Bronx Psychiatric Center. I am here speaking as a consultant to the International Committee Against Mental Illness, which now has a major interest in psychiatric rehabilitation. I have had almost a generation of experience in the rehabilitation of the physically and of the mentally disabled. The agency I headed for 17 years before joining the Einstein faculty, Altro Health and Rehabilitation Services, was one of the world pioneers in introducing vocational rehabilitation services to the mentally ill and the mentally handicapped. My concern in recent years has been with the severely disabled populations of the mental hospitals and mental health centers, most of whom turn out on closer examination to be multiply disabled.

Unfortunately for the way in which the human services are arranged in this country this is a very large group of people who

frequently fall between the therapeutically oriented mental health services, on the one hand, and the rehabilitation programs designed primarily for the physically disabled on the other. During the last year for which figures are available the very excellent Federal-State vocational rehabilitation services devoted over 42 percent of their efforts toward the rehabilitation of persons described as emotionally disturbed or mentally handicapped, most of whom are mentally retarded or behavioral disorders.

This total number, however, is but a small proportion of the many individuals for whom this excellent service, and the sheltered work and work activity programs that stem from it, should have been made available. There has not been unwillingness on the part of the divisions and offices of vocational rehabilitation, nor of the network of voluntary services aided through this program; there just have not been sufficient funds available.

Over the past 20 years we have learned that a great many more human beings with serious disabilities in the mental areas can be returned to self sufficiency and productive participation in society through the utilization of modern techniques in medical and vocational rehabilitation. Unfortunately, there has been insufficient research or real evaluation of demonstrations to pinpoint the characteristics of the disabled or the precise service structures that are most cost effective. We do know, nevertheless, that we are continually surprised and heart warmed at the extent of clinical successes when the services are made available.

It has therefore been particularly discouraging that so little of the research resources of our great country have actually been devoted to rehabilitation of the mentally ill. In not one of the 19 research and training centers established through the Rehabilitation Act has this field become a major commitment. And none has expressed concern for the severely disabled, in which alcoholism, drug addictions, and physical impairments demand the best coordination between specialties in psychiatry, rehabilitation medicine, and others. Even in the field of mental health, only now does a newly designated Rockland Research Institute, of the New York State Department of Mental Hygiene, express interest in making rehabilitation its major research and training focus. But without start-up help from the Rehabilitation Services Administration, I doubt that even this effort will be able to perform.

I could regale you with case story after case story of severely mentally ill men and women, young and old, who with the right combination of vocational rehabilitation, education, and training along with decent medical service return to self-sufficiency to an extent undreamed of in the heyday of the large mental hospitals. We in the field of rehabilitation seem to have sufficiently sold our colleagues in medical psychiatry and in the developmental services so that they are recommending greater and greater numbers for deinstitutionalization, but there are not the resources to make this possible.

I most particularly would like to call your committee's attention to an area of need for vocational rehabilitation that will become an extremely pressing problem for the future. That is the rehabilitation of adolescents and young adults who in increasing numbers are be-

coming the in-patients and the long term out-patients of the mental health services.

Long-term studies of the characteristics of mentally ill populations in this country, and particularly in the very excellent lifetime "registers" kept at Camberwell and Salford in England, young folk in the age range of 16 to 25 with multiple handicaps, including mental illness and neurological damage and physical abnormalities, are fast becoming the "long term chronically ill" population of the future. Many of these older adolescents and young adults are among the most troublesome of behavior disorders and became the a-social persons who swell our ranks of criminals. In my own hospital I have watched the proportion of these young people rise in the last 5 years from something under 8 percent of the chronically ill to over 25 percent. Since this is in a setting with much above the average in community services and with an active network of rehabilitation programs, I am sure that elsewhere the proportion is rising well above the one-third level.

For these young people we need services, but more than anything else we need research. We must have careful examination of the nature of their disabilities in relation to their potential for productive participation in society. We need to understand more fully what combination of treatment and rehabilitation approaches will be most successful and cost effective. We have to bring the highest skills of medical and psychiatric practice together with occupational education, remedial education, rehabilitation counseling and special vocational support settings.

We must have greater information as to what modalities will work at earlier ages to prevent the establishment of such chronicity and helplessness at the older ages. A generation from now we should not have to face, with this group of young people, the inadequacy of services we are dealing with in attempting to return today's adult mentally ill back to society.

I mentioned case registries in England as a source of information. Much of what we do know comes from exchanges with other countries where greater attention has been paid to rehabilitation of the psychiatrically disabled. In Britain, Scandinavia, and Holland, for example, there have been longer histories of excellent services and careful research from which we can learn a great deal. In many of the less well-developed countries there is evident great interest in how we are handling the deinstitutionalization of the severely mentally ill. On the other hand, we should be interested in how some of them develop what are alternatives to the large hospital systems they so far have avoided. As has been aptly demonstrated in service to the physically disabled, rehabilitation is a binding force for goodwill and understanding. The World Health Organization and the ILO are urging governments to play a more active role in rehabilitation. There is great need on our part to participate internationally in projects in rehabilitation of the psychiatrically disabled.

I urge upon the Congress the most adequate support possible for increasing the appropriation available under the Rehabilitation Act. Even closing the gap between the authorization in the act and the appropriation would be of great help. On the one hand this would make more greatly available the current service program to this very

large group of mentally ill and mentally handicapped; and on the other hand it should make it possible to undertake the research, the experimentation, the demonstration that is necessary to design the most effective service, both in human and cost terms, to the severely disabled among this population. Please see this as a rehabilitation issue, and do not let it fall between the stools of vocational rehabilitation, mental health, and social services, as has so often been the case in the past. Now that Congress has recognized that vocational rehabilitation belongs as part of our country's efforts in human development it should provide the fiscal support it so richly deserves.

Thank you.

Mr. FLOOD. Thank you, Doctor.

Dr. BLACK. Thank you.

NATIONAL HEART AND LUNG INSTITUTE AND NATIONAL LIBRARY OF MEDICINE

WITNESS

DR. CHARLES FISCH, PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY

Mr. FLOOD. Dr. Charles Fisch, president of the American College of Cardiology.

Dr. FISCH. Mr. Chairman and members of the committee, I am Dr. Charles Fisch, president of the American College of Cardiology; and professor of medicine and director, Cordiovascular Division, Indiana University School of Medicine. With me is Dr. Sylvan Weinberg, clinical professor of medicine, Wright State University, Dayton, Ohio, and chairman of the American College of Cardiology's Committee on Government Relations.

As you may know, the American College of Cardiology is a professional medical specialty society of more than 6,000 physicians and scientists who specialize in heart disease and related matters.

We appreciate very much this opportunity to appear before this committee to share our views concerning the fiscal year 1976 appropriations for the National Heart and Lung Institute and the National Library of Medicine. The primary purpose of our statement is to share with you or thoughts concerning priorities, general funding levels, and general directions for these two components of the Nation's health research and education effort.

NATIONAL HEART AND LUNG INSTITUTE

At the outset, we would like this committee to know that in our judgment, the National Heart and Lung Institute, under the extremely capable leadership of the Acting Director, Dr. Robert Ringler, has continued its outstanding leadership in the fight against cardiovascular diseases. We look forward to the appointment of a full director for this vital Institute.

In regard to our general philosophy concerning the budget of NHLI, we should like this committee to know that we understand

the need for fiscal restraint in times such as these, and for this reason we have recommended a total budget of $434 million for NHLI. This figures is about $84 million below the level authorized by legislation for fiscal year 1975.

As you will note, throughout this testimony, our priorities are people, as opposed to such items as facilities. We feel strongly that in times of tight money, the emphasis should be on training people and providing them with the necessary resources to engage in productive research, to train others, and to communicate their knowledge to citizens of our Nation. We feel very strongly, Mr. Chairman, that the recipient institutions should provide the necessary facilities.

The administration has proposed that the National Heart and Lung Institute budget for fiscal year 1976 be reduced by $31 million. The effect of such a reduction would, in our opinion, be threefold:

(1) No new programs, either targeted or individual, could be initiated;

(2) Ongoing programs would have to be curtailed significantly;

(3) Research training programs could be funded at only two-thirds of the needed levels.

I will now make a brief statement about the individual components of the budget, namely:

(1) Research grants;
(2) Manpower programs;
(3) Research contracts;
(4) Prevention, control and education (a new program);
(5) Intramural research;
(6) Research management and program services.

RESEARCH GRANTS

In this category, we would recommend an addtion of $32 million to the fiscal year 1975 level of $183 million, bringing the total to $214 million. We believe the emphasis here should be on the regular research grant program, ischemic heart disease element of the SCOR program and National Research and Development Center's program. Finally, we think the Research Career Development Awards program should be increased by $2 million to the level of fiscal year 1969.

MANPOWER PROGRAMS

In 1969 the Manpower programs were funded at approximately $25 million. In fiscal year 1975, the funding level was only about $20 million. We believe there should be sufficient funding for fiscal year 1976 to support about 2,000 cardiovascular trainees at a total cost of $32 million.

RESEARCH CONTRACTS

We believe that the total effort in research contracts for fiscal year 1976 should be increased by $34 million. While our position is that, in most instances, individual research grants are the most effective and productive approach to development of new knowledge, targeted research remains an essential component of the fight against heart disease.

NEW PROGRAM

We are very much interested in a proposed new program, namely, one of prevention, control and education within the National Heart and Lung Institute. It is our understanding that this office would be involved in research in health education. It would also concentrate on the problem of education and therapy of hypertension, currently a major national health problem, and on preventive cardiology such as, for example, aggressive investigation of risk factors in coronary artery disease. The recommended total for the new program in prevention, control and education is $21.5 million, of which $15 million would support the heart and vascular portion.

INTRAMURAL RESEARCH AND RESEARCH MANAGEMENT AND PROGRAM SERVICES

We recommend that the Intramural Research budget be increased by $1 million and the Research Management and Program Services by $4 million.

THE NATIONAL LIBRARY OF MEDICINE (NLM)

The National Library of Medicine is the sole national institution charged with the task of accumulating and organizing the world's biomedical literature and disseminating necessary information to the health sciences community. For the past several years, the cost of acquiring materials has been increasing at an annual rate of about 12 to 15 percent. Furthermore, while demand for NIM services from the biomedical community has grown enormously over the past few years, the NLM's authorized manpower levels have declined about 14 percent since fiscal year 1968.

For the above reasons, we recommend an increase in the number of positions allowed for NLM from 460 to 500.

Finally, we wish to recommend to this committee that sufficient additional funds be included in NLM's budget to permit the construction of the Lister Hill National Center for Biomedical Communications. We understand the figure is about $20 million. We are also told that had HEW gone ahead with the construction of this Center in fiscal year 1968, the cost to the Government would have been only about $12 milion. Therefore, we urge this committee to see that this project is commenced as soon as possible before inflation takes an even greater toll.

CONCLUSION

Mr. Chairman, on behalf of the American College of Cardiology, I wish to express our extreme pleasure at your having afforded us this opportunity to share our views and judgments with you. As we have noted throughout this testimony, our emphasis and priorities are on human resources. Additionally, we have sought to thread our way through the budgets of these two important parts of the NIH in order to underscore those programs which we feel are producing the greatest benefits for the country in the area of heart disease prevention, research, education, and treatment.

Thank you.

[The budget follows:]

COMPARATIVE NHLI BUDGET

	1975		American College of Cardiology recommendation, 1976		President's recommendation, 1976 total
	Heart and vascular	Total	Heart and vascular	Total	
Research grants	118,354	183,214	150,154	214,505	165,735
Manpower programs	12,879	19,932	24,879	35,541	20,954
Research contracts	58,947	81,713	80,947	115,638	63,828
Intramural research		24,638		25,638	24,699
Research management and program services		17,860		21,860	17,578
Prevention, control, education			15,000	21,428	
Total	190,180	327,357	270,980	434,610	292,794
Recommended increase over 1975			80,800	107,253	

Dr. FISCH. Our presentation will include a comparative NHLI budget for 1975, the budget recommended by the college, and the President's recommendation.

Thank you, Mr. Chairman.

Mr. FLOOD. Thank you, Doctor.

Dr. FISCH. Thank you.

[Dr. Fisch's statement follows:]

STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY—FISCAL YEAR 1976 HEALTH APPROPRIATIONS

Mr. Chairman and members of the committee, I am Dr. Charles Fisch, president of the American College of Cardiology and professor of medicine and director,, Cardiovascular Division, Indiana University School of Medicine. With me is Dr. Sylvan Weinberg, chairman of the American College of Cardiology's Committee on Government Relations.

As you may know, the American College of Cardiology is a professional medical specialty society of more than 6,300 physicians and scientists who specialize in heart disease and matters related thereto.

We very much appreciate this opportunity to appear before this important committee and to share our views concerning the fiscal year 1976 appropriations for the National Heart and Lung Institute and the National Library of Medicine. As you will note in the statement to follow, we have suggested specific dollar amounts for most of the elements of these important institutions. The primary purpose of our statement, however, is to share with you our thoughts concerning priorities, general funding levels, and general directions for these two components of the Nation's health research and education effort.

NATIONAL HEART AND LUNG INSTITUTE

At the outset, we would like this committee to know that in our judgment, the National Heart and Lung Institute under the extremely capable leadership of the acting director, Dr. Robert Ringler, has exerted outstanding leadership in the fight against the cardiovascular diseases. We look forward to the appointment of a full director for this vital Institute.

In regard to our general philosophy concerning the budget of NHLI, we should like this committee to know that we understand the need for fiscal restraint in times such as these. The easiest and simplest modus operandi for the college would be to recommend full funding at the authorization level. This we have not done.

Instead we have recommended a total budgetary figure of $434,610,000 for NHLI. This figure is about $84 million below the level authorized by the subdivision for fiscal year 1975. As you know, National Heart, Blood Vessel, Lung and Blood Act passed by Congress in 1972 authorized $400 million, $460 million, and $520 million for the fiscal years 1973, 1974, and 1975, respectively.

As you will note throughout this testimony, our priorities are placed on people as opposed to things, such as construction. In short, we feel that in times of tight money, the emphasis should be on training people and providing them with the necessary resources to engage in productive research, to train others in the field, and to communicate their knowledge to patients and potential patients throughout the Nation.

The administration has proposed that the National Heart and Lung Institute budget for fiscal year 1976 be reduced by $31 million. Such a reduction will necessitate a lessening of the important efforts being exerted by NHLI.

To be more specific, the actual effects of the above-mentioned proposed reduction in funding would be as follows:

(1) New programs designed to answer broad and important questions relative to cardiovascular disease will not be initiated;

(2) Ongoing clinical and basic research will have to be curtailed significantly;

(3) Individual research fellowships and research training programs will have to be funded at only two-thirds of the needed levels;

(4) Investigator-initiated projects and program projects would have to be most seriously curtailed.

RESEARCH GRANTS

As a counterproposal to the administration's request in the area of research grants, we would recommend an addition of $32 million to the fiscal year 1975 level of $183 million bringing the total to $214 million. We believe the emphasis here should be on the regular research grant program, ischemic heart disease element of the SCOR program, National Research and Development Center's program (this alone would cost an additional $5 million). Finally, we think the Research Career Development Awards program should be increased at least to the level it was back in 1969 (this addition would cost approximately $2 million).

MANPOWER PROGRAMS

Once again, we would like to recall that back in 1969 the manpower programs were funded at approximately $25 million. In fiscal year 1975, the funding level was only about $20 million. We believe there should be sufficient funding for for fiscal year 1976 (approximately $32 million) to support about 2,000 cardiovascular trainees. By having this level of support, the Nation would be relatively confident of having approximately 1,000 "graduates" each year.

RESEARCH CONTRACTS

We believe that the total effort in research contracts for fiscal year 1975 (approximately $82 million) should be increased by $34 million. This would permit concentration on such vital areas as sudden death, control of infarct size, assist devices (from the biometric aspect), development of a primate model of atherosclerosis and development of much needed diagnostic instrumentation. While our position is that in most instances individual research grants are the most effective and productive approach to development of new knowledge, targeted research remains an essential component of the fight against heart disease.

NEW PROGRAM

We are very excited about a new program that has been proposed; namely, one of prevention, control, and education within the National Heart and Lung Institute. It is our understanding that this office would be involved in research in health education. It would also concentrate on the problem of education and therapy of hypertension, a major national health problem and on preventative cardiology such as for example aggressive investigation of risk factors in coronary artery disease.

In our judgment, the new Continuing Medical Education Research Centers will need at least $500,000 each to get off the ground. As an initial investment, we would recommend the funding of four such centers for a total appropriation of $2 million. The recommended total for the new program in prevention, control, and education is $21.5 million of which $15 million would support the heart and vascular portion. We strongly urge this committee to take a very close look at this new program in the hope that you will agree with us that it is worthy of your support.

INTRAMURAL RESEARCH AND RESEARCH MANAGEMENT AND PROGRAM SERVICES

We recommend that the intramural research budget be increased by $1 million and the research management and program services by $4 million.

THE NATIONAL LIBRARY OF MEDICINE (NLM)

The National Library of Medicine is the sole national institution charged with the task of accumulating and organizing the world's biomedical literature and disseminating necessary information to the health sciences community. For the past several years, the cost of acquiring materials has been increasing at an annual rate of about 12–15 percent. Furthermore, while demand for NLM services from the biomedical community has grown enormously over the past few years, the NLM's authorized manpower levels have declined about 14 percent since fiscal year 1968. Any reduction in funds compounded by no additional increases in personnel levels in fiscal year 1976 most certainly will lead to an erosion of essential library services.

For the above reasons, we recommend an increase in the number of positions allowed for NLM from 460 to 500. In essence, we are seeking a 10-percent increase in the number of positions. We believe that the staff at NLM is effectively used at present. We also believe that with increasing demands on its services, NLM will absolutely need an increase in its staff allotment.

Finally, we wish to recommend to this committee that sufficient additional funds be included in NLM's budget to permit the construction of the Lister Hill National Center for Biomedical Communications. We understand the figure is about $20 million. We are also told that had HEW gone ahead with the construction of this center in fiscal year 1968, the cost to the Government would only have been about $12 million. Therefore, we urge this committee to see that this project is commenced as soon as possible before inflation takes an even greater toll.

CONCLUSION

Mr. Chairman, on behalf of the American College of Cardiology, I wish to express our extreme pleasure at your having afforded us thus opportunity to share our views and judgments with you. As we have noted throughout this testimony, our emphasis and priorities are on human resources. Additionally, we have sought to thread our way through the budgets of these two important parts of the NIH in order to underscore those programs which we feel are producing the greatest benefits for the country in the area of heart disease prevention, research, education, and treatment. We are very grateful for this opportunity to appear before you.

Thank you!!

COMPARATIVE NHLI BUDGET

	1975		American College of Cardiology recommendation, 1976		President's recommendation, 1976 total
	Heart and vascular	Total	Heart and vascular	Total	
Research grants	118,354	183,214	150,154	214,505	165,735
Manpower programs	12,879	19,932	24,879	35,541	20,954
Research contracts	58,947	81,713	80,947	115,638	63,828
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Prevention, control, education			15,000	21,428	
Total	190,180	327,357	270,980	434,610	292,794
Recommended increase over 1975			80,800	107,253	

American College of Cardiology proposed increase for heart and vascular programs of the NHLI, 1976

1. Research grants:	
Regular research grant	20,000,000
Ischemic SCOR	2,000,000
National R. & D	8,000,000
Research career development awards	1,800,000

American College of Cardiology proposed increase for heart and vascular programs of the NHLI, 1976—Continued

1. Research grants—Continued	
Total	31, 800, 000
2. Manpower programs	12, 000, 000
3. Research contracts	22, 000, 000
4. Intramural research	1, 000, 000
5. Research management and program services	4, 000, 000
6. Prevention control and education	15, 000, 000
Total	85, 800, 000

Digestive Diseases Research

WITNESS

DR. JOHN SESSIONS, HEAD, GASTROENTEROLOGY, UNIVERSITY OF NORTH CAROLINA MEDICAL CENTER; AND SPOKESMAN, AMERICAN GASTROENTEROLOGICAL ASSOCIATION

Mr. Flood. Fred Kern, president elect, American Gastroenterological Association.

Dr. Sessions. Mr. Chairman, there has been a change in the cast of characters.

I am Dr. John Sessions. I am head of gastroenterology at the University of North Carolina Medical Center and have been selected by the American Gastroenterological Association to serve as their spokesman in matters dealing with appropriations for digestive disease research.

I would like to submit for the record copies of the formal testimony.

Mr. Flood. Very well.

[The material follows:]

Testimony of the American Gastroenterological Association Concerning Appropriations for Digestive Disease

Mr. Chairman, I am John Sessions, head of gastroenterology at the University of North Carolina Medical Center. I have been chosen by the American Gastroenterological Association as their spokesman to testify concerning appropriations for digestive disease research.

As we have observed your work over the past several years, and particularly over the past several months in dealing with the proposed administration rescissions, many of us who are involved in digestive disease research have become ever more grateful for your protection of basic biomedical research, and of those institutions and programs which carry out that research.

No doubt you will find it necessary again to mount an effort against the new proposed administration budget, which, were it permitted, would continue the instability of institutional, project, and training support that began several years ago. We of the American Gastroenterological Association are certain that you and your committee will not harm the efforts in digestive disease, especially in preventing research on the emerging opportunities we see before us.

As you know, the proposed cutbacks for the National Institute of Arthritis, Metabolism, and Digestive Diseases amounts to about $25 million less for the upcoming fiscal year than was available in fiscal year 1975. The Institute has received cutbacks over the last several years, and frankly, if enacted, the administration's budget would be nothing short of disastrous. You know as well as we that in the last several years of relatively level budgeting, inflation has cut into research so that funding support has been diminished by 25 to 35 percent. Now the administration proposes appropriations language which would cut back the authorized appropriations from $173 million to $148 million, a drop of nearly 15 percent, and this cutback, added to those already caused by inflation, would mean that since 1971, the amount of research that can be done by the Institute has dropped almost 50 percent.

In the last several years since the name of the Institute was changed to National Institute of Arthritis, Metabolism, and Digestive Disease, we have been appearing before you requesting assistance in funding for various programs we thought were ripe for exploitation, as well as for increased support in basic research. I would like to review for you where we stand in the particular programs you supported by action of this committee.

GALLSTONES

You will recall that we emphasized 2 years ago that gallstones affect approximately 16 million people in the United States, of which one-third are operated on each year at an estimated cost (including hospitalization and loss of productive capacity) of $1.5 billion annually. We told you that we had made considerable progress in our knowledge concerning gallstone formation, and that as a result of these studies a new medical approach to the treatment of gallstones seemed to be at hand.

Your committee was agreeable to supporting new research in the field, and since that time a multicentered national study has been initiated to test the effectiveness of a new chemotherapy agent designed to dissolve gallstones, thus eliminating the need for removal by surgery. The results of preliminary studies, which employ the use of a natural-occurring bile salt have in fact demonstrated the usefulness of this agent, chenodeoxycholic acid.

The available funds permitted a program for the synthesis and toxicologic study of the agent, and has led to FDA approval of it for investigative study.

Consequent to the appropriation, the Institute awarded an initial contract to Ceders-Sinai Medical Center in Los Angeles to supervise and participate in a long-term collaborative clinical study, which will run above 5 years .

Mr. Chairman, this is the first comprehensive study undertaken to determine the efficacy of a medication for gallstone dissolution and through additional research, to find out how gallstones are formed and what causes their formation. About 900 patients will be treated at 10 medical centers throughout the country, and panels of distinguished gastroenterologists and researchers all across the United States have been formed to assist in the study. Patient recruitment will begin on June 1, just a little more than a week from now.

This approach, provided it is proved free of undesirable side effects, may offer an alternative to surgery for many patients and may save millions of dollars a year in hospital and related costs.

It should be stated quite clearly that had it not been for the support of this committee, this effort simply could not have been mounted, and if the administration budget of that year had been agreed to, such an effort could not have been mounted for years.

DIARRHEA, ILEITIS, AND COLITIS

Last year we discussed with you progress in the areas of diarrhea, ileitis, and colitis. The committee again supported our requests for assistance. Today we can point to the fact that through a study done by the Communicable Disease Center, and through studies supported by NIH, we have confirmed our suspicions that many forms of diarrhea and even the so-called "Travelers Diarrhea" are the results of a chemical product or toxin produced by a type of bacteria that heretofore had not been recognized. This knowledge undoubtedly will revolutionize both the prevention and treatment of many forms of diarrhea. Knowing of your interest in the armed services of this Nation, we hasten to say that over 15 percent of the illness in the armed services is due to specific and nonspecific forms of diarrhea, and that these new observations undoubtedly will serve to improve also the treatment of patients in the Armed Forces afflicted with these diseases.

Also aided by your interest is an in-depth study of Crohn's disease (regional enteritis) which is a chronic inflammatory condition of the small intestine. This disorder causes severe pain, fever, and weight loss, with prolonged periods of hospitaliaztion, and frequently necessitates abdominal surgery involving removal of affected portions of the intestine. The Institute is now able to support the evaluation of certain drugs in 14 research centers across the country, which hopefully would prevent intensification and recurrence of this disease.

Additionally, in the past year we have been able to develop a new test for the detection of ileitis, which will permit us to distinguish it from other inflammatory bowel conditions. This test could also prove useful in monitoring the success of the therapy for ileitis patients. Research leading to this useful dis-

covery was supported by the NIH, but also by the National Foundation for Ileitis and Colitis. (Mr. Irwin Rosenthal, president of the foundation, will appear before you shortly.)

Again the kind of support given by this committee last year is already bearing fruit and because some of the programs that were initiated are multi-year, will bear fruit for years to come.

ENDOSCOPY

Over the last several years, we have commented to this committee upon the rapid advances of endoscopy. Your support has helped this rapidly developing field. We can report that just this week NIAMDD will be making three contract awards to evaluate the various instruments which have been developed, to determine the application of endoscopy in relation to digestive diseases. We understand that there will be one 1-year contract, and two 2-year contracts, which will total $300,000 this year, and $200,000 for the next 2 years.

Endoscopy has evolved rapidly. Currently the instruments can perform a number of vital tasks, and are far advanced from their form of a few years ago, when the flexible light tube was developed, which could be used for viewing the internal surfaces of the digestive tract. The endoscopes now can suture, apply clips, and apply adhesives. Promising developments are within our grasp for the cauterization of bleeding ulcers with laser beams, and the inquiry into the nature of pancreatic diseases (the pancreas in the past was the least accessible human organ).

The support of this committee, again, was vital in the development of the instrument and its evaluation for use.

COMMENT ON PAST OPPORTUNITIES THAT WERE DESCRIBED TO THE COMMITTEE

Clearly, this committee has been very responsive to the opportunities which we have suggested lay before us. Generally, it can be said that year by year we know more about the basic processes of life, and year by year we learn more about the application of the new knowledge to specific disease processes.

As in past years, we have other suggestions to make about areas where significant opportunities lie before us for exploitation. This year we would like to discuss opportunities in hepatitis research, in hormone research, and in the overall study of the entire field of digestive diesase.

HEPATITIS

Hepatitis is an inflammation of the liver, which in most instances is caused by viruses. About 11 years ago workers at NIH and the University of Pennsylvania found a substance in the blood of an Australian aborigine that led to the discovery of the major hepatitis virus, the so-called serum hepatitis virus found in the blood of patients with this disease. As a result of a series of important observations over the past 10 years, we now have the opportunity to develop a vaccine against viral hepatitis. As a matter of fact, just several weeks ago, the first of such vaccines was described and it is currently being studied in chimpanzees before being applied to man. It is our hope that in the course of the next few years such a vaccine will be fully developed, thoroughly tested, and available for human use.

We have also learned something about how viral hepatitis may lead to chronic liver disease and cirrhosis. This had always been an enigma, but there is much to suggest that acute viral hepatitis may lead to cirrhosis and chronic hepatitis as a result of an allergen and so-called immune complexes. These studies will now have a high priority, and if they prove to be correct, they will give us a way, hopefully, to prevent viral hepatitis from leading to cirrhosis and chronic hepatitis.

HORMONES

During the past 10 years, six hormones that regulate digestive functions have been isolated from the lining of the stomach and duodenum, and their chemical nature determined in animals. They are known to exist in humans, but only one has been chemically identified. Several of these hormones are known to be involved in disease processes. For example, in the last 3 or 4 years several of these have been found to provide clues as to how certain malignant tumors exert their effects on the body.

There are two areas of opportunities which should be followed up immediately. First, there is a need for research funds to fully define these hormones, and to provide the means for the development of chemical procedures so that biomedical researchers will be able to examine and investigate their method of action. Secondly, the supply of these hormones for investigation is very limited. The hormones, in quantity, are needed to determine their exact actions and metabolism in man and to develop methods for measuring their effects. The supply of natural and synthetic hormones could be rapidly increased through contracting for the supply from private sources. These hormones and their study are of immense importance, and their purchase could speed research. It is estimated that the sum of $500,000 would be needed annually to purchase the required supply.

OVERALL STUDY OF DIGESTIVE DISEASES, PREVENTION, CURE, AND HEALTH DELIVERY

Mr. Chairman, when the Congress changed the name of the Institute which funds most of the NIH programs in digestive diseases to the National Institute of Arthritis, Metabolism, and Digestive Disease, it was decided to have a national conference on digestive diseases in order to develop an overall view of digestive disease research and care.

From that conference, a white paper was developed, which called for a systematic review of research on digestive disease; that is, where we have been, where we are now, and what opportunities are available for us to exploit in the future.

That study, funded by the Institute, has just about been accomplished. I include as an attachment a synopsis of the study. Over 500 gastroenterologists across the country participated in that study. We found the exercise to be an excellent one, because it defined more sharply for us the state of the art and what our opportunties are. Scientists from other nations also participated.

As we went through the discipline of self-evaluation, we determined that a similarly intense look at digestive disease manpower and care is necessary. We need to understand better the patterns of manpower development and training in our specialty, the role and function of gastroenterologists, the number required, and projections of needed distribution, as well as the patterns of patient care. We believe that we are ready as a specialty to embark on this study, and request funding from the Congress for it. No legislative authorization is necessary for this, though such support would be welcomed. We believe an earmarked amount of funds, about $300,000, would be sufficient for a 2-year study of the situation.

There are many matters which should be studied.

The study group would evaluate the present situation as to the prevalence and management of digestive diseases in the country. This evaluation would be based upon epidemiologic study of the incidence, duration, and mortality rate of digestive diseases, of the facilities available (both governmental and private) to take care of patients with digestive diseases, and the manpower presently available in these programs and activities.

All Federal departments and agencies (and hopefully State and local agencies as well) which administer health programs and activities related to digestive diseases would be surveyed.

The study group would, furthermore, identify specific areas and programs in which improvement of the management of digestive disease can be accomplished, including biological, behavioral, nutritional, environmental, and social procedures, depending upon the present stage of knowledge and financial resources which could be made available on the basis of reasonable expectation in keeping with cost-benefit calculations.

The study group would, on the basis of this evaluation and identification of needs as well as possible improvements, develop and recommend a long-range plan to be implemented. This plan should cover the following, among others:

1. Institution of preventive measures based on education, particularly nutritional; elimination of environmental hazards; and, where applicable, vaccination.
2. Detection of diseases in the presymptomatic stages, specifically by screening.
3. Development of criteria for diagnosis and management of established diseases.
4. Organization of a health care system dealing with digestive diseases including primary care rendered by physicians in private or in group practice, in community health centers, in community hospitals, and highly specialized care in special centers affiliated with medical centers, including teaching hos-

pitals. Special consideration would be given to the coordination of the described facilities.

5. Development of procedures for the rehabilitation of patients with disabling digestive diseases.

6. Improvement of training in digestive diseases for professionals with varying levels of education and experience who are concerned with this area.

7. Investigation of the efficacy and safety of diagnostic and therapeutic modalities in digestive diseases by organization of appropriate clinical trials.

8. Establishment of a standardized nomenclature of all digestive diseases, similar to the one recently developed for liver diseases by the International Association for the Study of Liver in cooperation with the Fogarty International Center; the National Institute of Arthritis, Metabolism, and Digestive Diseases; and the World Health Organization.

9. Maintenance of the survey of the research potential in digestive diseases in continuation of the just completed survey organized by the National Institute of Arthritis, Metabolism, and Digestive Diseases.

It should be noted that one of the major parts of this study would deal with medical manpower to deal with digestive diseases. We need badly a survey of the number of medical personnel who deal with the diseases, what their levels of training are, how they are organized to work, how much primary care is delivered, and what patterns might be evolved to improve care. We must also determine how many specialists are needed now and in the coming years.

Mr. Chairman, we believe that this study is vital to the care of our nation's people who are afflicted with digestive disease, and we believe that the time to do the study is now. We are hopeful that the committee, as it has in the past, will agree to the funding of this activity.

FUNDING RECOMMENDATIONS

We would like to make two recommendations, one regarding Institute funding overall, and the second regarding the particular research opportunities we see immediately ahead.

As to the Institute, we believe that the President's proposed budget should be rejected out of hand, that in fact funding should be increased 15 percent beyond the 1975 budget, in order to provide for inflationary costs and also provide increased funding for new research starts in areas of excellent opportunity.

As to digestive disease research specifically, we are hopeful that this committe will, in report or bill language, assure a continuation of the levels of funding in 1976, at least at the level of 1975 plus a percentage increase to provide for inflation costs, and in addition, provide an earmarked sum of $2 million to provide for the new work in hepatitis and hormone research, and to provide for the study which we have outlined regarding digestive disease, and for other new research opportunities which exist.

Dr. SESSIONS. I would also like to submit a synopsis that has been developed by the AGA on the status of research in digestive diseases. This synopsis has been developed in the past 2 years, funded by the NIH, to show where we are in the field of research and where we can most profitably proceed.

Finally, I would like to submit two articles dealing with gallstones, one entitled, "Gallstones, 1971," and another "Gallstones, 1975." This shows rather clearly and briefly the progress in this important area.

[The synopsis and articles follow:]

ATTACHMENT TO THE TESTIMONY OF THE AMERICAN GASTROENTEROLOGICAL ASSOCIATION

Overview

DIGESTIVE DISEASES RESEARCH AND RESEARCH OPPORTUNITIES

Where are we now and what are the most promising research opportunities in digestive diseases? These questions are answered in detail in this report. However, a brief overview might be helpful. Here are some of the highlights covered in the report—capsule summaries of just a few of the recent research

advances that have been made and the substantial research opportunities these advances offer.

Peptic diseases

Gastric and peptic ulcers.—Ulcers of the stomach and duodenum occur when there is an excessive secretion of acid and pepsin. Recent studies have shown that certain types of antihistamines and synthetic prostaglandins are effective inhibitors of acid secretion * * *. A new and improved operation for ulcers—selective vagotomy—cuts only those branches of the vagus nerve that go to the acid producing portion of the stomach, thus avoiding the unwanted side-effects of surgery.

Promising as these preliminary results are, only controlled studies on the effects of these new agents and surgical techniques will clearly define their role in ulcer therapy * * *. Prevention: in the search for a simple test to accurately identify ulcer prone persons, measurement of the concentration of pepsinogen in the blood shows the most promise and should be vigorously pursued.

Liver disease

Viral hepatitis.—In an important advance in the battle against viral hepatitis, one type of antigen has been found in the blood of patients with type B hepatitis, and another, closely related antigent has been found in patients with type A—a finding that could lead to the isolation of the entire virus and to the production of a vaccine effective against both types of hepatitis.

Cirrhosis.—Significant progress has been made in the understanding of cirrhosis of the liver induced by alcohol. Studies have shown that alcohol causes an increase in liver fat; this may result in changes that predispose patients to cirrhosis and other severe forms of liver disease. It is a clue to the mechanism by which liver cell injury is perpetuated * * * further knowledge of this mechanism would be invaluable in the prevention of chronic liver disease.

Life support systems.—In cases of liver failure, many dramatic forms of life support systems have been advocated to sustain vital functions while awaiting recovery of the liver. Some of these measures, such as exchange transfusions and use of an "artificial liver," have given preliminary encouraging results and deserve further evaluation.

Inflammatory bowel diseases

Ileitis and colitis.—Basic research into the causes of ileitis and colitis—inflammation of the small and large intestine—has yielded several reports of a transmissable agent which transfers the lesions of these disorders into animals. Also, there is evidence of a microorganism present in ulcerative colitis. * * * The isolation and identification of such agents could well lead to a major breakthrough in this field.

Concerted investigations into the immunological aspects of ileitis and colitis are beginning to yield valuable information concerning the role of basic body defense mechanisms. Studies of patients who underwent surgery for ileitis are leading to improvement of surgical techniques * * * such as the construction of a continent internal ileostomy in certain groups of patients who require radical removal of the colon.

Gallbladder and biliary diseases

Gallstones.—Studies have shown that oral administration of chenodeoycholic acid, a substance naturally secreted in human bile, can dissolve cholesterol gallstones—which account for 80 to 90 percent of the gallstones that afflict humans—in some patients. * * * Currently, a comprehensive study is being conducted to evaluate the safety and efficacy of this agent for gallstone dissolution.

In addition to chenodeoxycholic acid, other agents have shown promise in a long-range program to develop safe, effective, and inexpensive approaches to the dissolution of gallstones.

Pancreatic diseases

Pancreatitis.—Recent findings of considerable significance suggest that there is some abnormality of protein secretion in pancreatitis. Calcium deposits found in patients with pancreatitis may be related to this abnormal protein secretion. Studies of the relation of this secretion and calcification could lead to improved diagnosis and prevention of this debilitating and deadly disease.

Advances in instrumentation in recent years now permit access to the remote pancreas. With improvements, these instruments could provide better visualization and biopsy of the pancreas. Tissue cultures developed from these biopsies

would enable us for the first time to examine various cell types, and thus increase our understanding and control of pancreatic disease.

Intestinal absorption and secretion diseases

Diarrhea.—In an important recent advance, evidence has been found that in the secretory diarrheal diseases, such as cholera and *E. Coli*, the intestine is stimulated by a toxin to secrete excess fluid. With this information on the fundamental mechanism involved, it should be possible to develop drugs to inhibit excessive intestinal secretions. The development of vaccines similar to those now available for cholera should now be feasible for many forms of diarrhea.

Viral gastroenteritis ("stomach flu").—Recent research has uncovered a good deal of information about the lesions of viral gastroenteritis, but we have not yet isolated the infectious agent involved. Now, with the development of new organ culture techniques, there is definite promise of accomplishing this primary goal toward the development of effective vaccines.

Hyperalimentation.—For patients who have temporary lapses in bowel function and must be fed intravenously, progress has been made in producing a laboratory solution that provides all nutritional needs. Further improvements in intravenous hyperalimentation would spare many lives and much disability.

Esophageal diseases

Heartburn.—Recent studies have shown that persons with severe heartburn have a weak lower esophagael sphincter (LES)—one that would readily allow reflux, the backflow of potent digestive juices from the stomach into the esophagus. These studies also suggest that insufficient secretion of the hormone gastrin may be responsible for weakness of the LES. Should this preliminary evidence prove correct, new and more effective therapy may be developed for the control of reflux and its complications, including esophagitis, a serious condition.

Hiatal hernia.—In this condition in which the stomach protrudes into the chest, several operations have been devised to repair the hernia. Unless these operations also deal with reflux, it has been shown, they are of little use. New surgical techniques that take these factors into consideration would be much more successful.

Endoscopic instruments

Fiberendoscopy.—The development in recent years of fiberoptic endoscopes is not only one of the most promising new approaches to the diagnosis of digestive diseases but it also holds great hope for treatment, eliminating the need for surgery in certain cases. A case in point is the brilliant success of colonoscopic polypectomy, the removal of polyps from the colon for biopsy.

Because of these advances, the gastrointestinal laboratory is now capable of performing a wide variety of diagnostic and therapeutic procedures. With continued research, we can look forward to even more significant advances in the next few years * * * to the diagnosis and treatment of pancreatic and biliary diseases, bleeding gastritis, tumors of the intestinal tract, impacted gallstones, and other conditions.

In addition, the development of improved instruments and new procedures would eliminate the need for a great deal of surgery.

TEXT OF THE REPORT

Diseases of the esophagus

The esophagus, otherwise known as the gullet, is a muscular tube that propels food by wavelike contractions of its walls, called peristalsis, to the stomach where it is processed to nourish the body. Its sole function is swallowing, transporting food.

Heartburn which, despite its name, has no relation to the heart or its function, is one of the most common complaints of gastrointestinal origin. It is caused by gastroesophagael reflux—regurgitation from the stomach into the esophagus of the acid gastric juice—which is caused in turn by a weakness or incompetence of the lower esophagael sphincter (LES). Normally, the LES, a circular band of

muscle, acts as a one-way gateway between the esophagus and stomach, relaxing and opening for the passage of food and then closing shut to prevent hydrochloric acid and pepsin, the potent digestive secretions of the stomach from flowing back into the esophagus and attacking the sensitive mucous membrane lining of its walls.

Recent studies have shown that persons with severe or recurring heartburn, which may be the precursor or symptom of esophagitis (inflammation of the lining of the esophagus) or other serious condition, have a weak LES—one that would readily allow reflux. These studies have also suggested that insufficient secretion of the hormone gastrin may be resopnsible for the weakness of the LES. If this conjecture proves to be correct, new and more effective therapy than is now available may be developed for the control of reflux and its complications.

Despite the knowledge gained in numerous investigations, precisely how and why reflux occurs in one individual and not in others is unknown. An understanding of the way neural and hormonal agents interact in affecting the LES could lead to the development of new drugs, chemical and surgical methods to strengthen this key gateway to the protection and health of the esophagus.

Hiatal hernia (also called hiatus hernia) is another prevalent condition involving the esophagus; here a portion of the stomach protrudes into the chest. Several operations have been devised to repair the hiatal hernia: In addition to putting the displaced stomach into its normal location, they either form a flap valve to replace the LES or reinforce the action of the LES.

The symptoms that are now known to be caused by reflux were once attributed to hiatal hernia. Operations that simply correct the hernia without dealing with reflux are of little or no value.

Other fertile areas urgently in need of investigation include: (a) the effects of injury to the esophagus, caused by drugs, toxins, infections, heat and other factors, on reflux; (b) improved methods of preventing, diagnosing and treating esophagitis, dysphagia (trouble in swallowing) and other complications resulting from abnormal esophagael function; (c) a clearer understanding of just how the normal esophagus works—for only by such an understanding can we understand how and why some things sometimes go wrong.

Peptic diseases

Ulcers are a familiar part of the American scene. While people often joke about their ulcers, which have been called a badge of success, there is really nothing humorous about this serious, painful, chronic disease that torments an estimated 10 percent or our population (men more than women), that results in the death each year of 12,000 Americans from its complications, and that, in lost man-hours of work and medical expenses, cause over a billion dollar annual drain on the Nation's economy.

A peptic ulcer is a hole or crater-like sore in the lining of the stomach or in the first part of the small intestine just below the stomach, the duodenum. Duodenal ulcer is about ten times more prevalent than gastric ulcer (ulcers of the stomach). In a way, an ulcer is the result of the body digesting a bit of itself, for the hole in the thin mucous membrane lining is caused by the powerful digestive juices, acid and pepsin, secreted by the stomach to break down food and prepare it for absorption in the bloodstream.

Normally, the lining of the stomach and duodenum is protected from these digestive juices in some manner—a mannr that is not know and is under intensive scrutiny. Ulcers occur when there is an excessive secretion of acid and pepsin which overwhelms the resistance of the lining, or when the resistance breaks down for some reason and is unable to cope with normal amounts of these agents. Of these two factors, secretion of acid and pepsin is the factor that lends itself more readily to medical intervention. We can do something about turning off the acid spigots, but we haven't learned as yet how to bolster or rejuvenate the linings resistance.

Patients with gastric ulcers secrete normal amounts of acid, and only about half of those with duodenum ulcer secrete excessive amounts. Nevertheless. reduction of acid secretion would be beneficial in all ulcer patients, whether they hypersecrete acid or not.

While the hereditary factors leading to ulcer formation is unknown, statistics indicate that ulcer is about three times as common in close relatives of afflicted individuals than in the general population. Because prevention is the best form of treatment and because identification of those most likely to get the disease is the first and most important step in prevention, emphasis should be given to the development of simple tests that accurately identify ulcer prone persons.

Since there is a significant genetic factor in ulcer proneness, some of these tests may be based on genetic markers. As a marker for duodenal ulcer, measurement of the concentration of pepsinogen in the blood shows the most promise and should be vigorously pursued. Pepsinogen is the precursor of pepsin and its concentration in the blood can be measured by newly developed immunological tests using antibodies. As similar simple blood test to identify persons susceptible to gastric ulcer is also needed.

Present treatment methods for dealing with the secretion of acid are far from satisfactory. Antacid preparations, which neutralize acid, do not last long and are often ineffective. Sedatives, tranquilizers, antispasmodics and other drugs that inhibit or block the nervous impulses that stimulate acid production affect the whole body and have undesirable side effects. What is needed are drugs to specifically block acid secretion, and some of the newly emerging agents promise to do just that and give better control of acid levels.

Preliminary trials have shown that certain types of antihistamines, which are quite different from those used to combat allergic reactions, are effective inhibitors of acid secretion. Similar encouraging results have been found with trials of synthetic prostaglandins. These chemicals, naturally produced by the body, inhibit excessive secretion of acid and are far more potent in this function when made in the laboratory with a slight structural modification.

Promising as these preliminary results are, only prospective controlled studies of the effects of these new agents on ulcer healing, pain, recurrence and complications will clearly define the role of new agents in ulcer therapy.

The isolations, chemical identification and subsequent synthesis of the hormone gastrin, which stimulates the secretion of gastric juice, has fueled rapid advances in our knowledge of normal and pathological gastrointestinal processes, including ulcer disease. This area is still in an early stage of development and further progress may be expected. Six chemically defined hormones have been isolated from the lining of the digestive tract of animals but gastrin is the only one for which the structure of the human hormone is known. One of the hormones that may be useful in treating ulcer, is secretin which stimulates the pancreas to turn out more alkali and so neutralizes excess acid. While attention has been focused mainly on the action of these hormones on the secretion of acid, their effects on the growth and metabolism of the cells lining the stomach and intestines may be more important in understanding ulcer disease.

Vagotomy—cutting of the vagus nerves to the abdomen—is widely used in surgical treatment of ulcer. When the entire vagal trunks are cut, gastric emptying is impaired and a drainage procedure (enlarging the outlet between the stomach and intestine) is required. A new operation, highly selective vagotomy, cuts only those branches of the vagus that go to the acid secreting portion of the stomach, thus avoiding the necessity for a drainage procedure. With this technique, unwanted side effects of surgery, such as "dumping," are greatly reduced. Extensive prospective studies are needed to evaluate this new procedure.

Ulcers are commonly thought to be largely due to emotional conflicts, tensions, and stress. Some studies suggest increased anxiety in ulcer patients, while other studies show that acute psychic stress preceded the development of ulcers. However, a great many people under acute prolonged stress do not develop ulcers, and a great many others develop ulcers when apparently no stresses exist. While psychological factors doubtless play a role in ulcer disease, together with many other factors, for this is a complex multi-faceted condition, prospective studies to determine the nature and importance of that role are very much needed.

Diseases of the liver

Life cannot exist for long without the liver. The largest single organ in the human body, the liver functions as a "chemical factory," performing at least 5,000 major biomedical reactions that are known and probably more that are as yet undefined. The liver is essential for protein, carbohydrate, and fat metabolism, for the detoxification of toxins circulating in the blood, and as a storage depot for certain nutrients, such as sugars, vitamins, and minerals. Not surprisingly, an organ of such complexity is subject to a wide variety of injuries and disease states, including disorders of infectious, parasitic, nutritional, metabolic, obstructive, toxic, and malignant origin.

Fortunately, the liver has great reserve power; only a small part of it is sufficient to perform the vital tasks of the whole organ. Moreover, the liver has a capacity for regeneration unsurpassed by any other organ. Large areas

may be destroyed but new liver cells are formed to take the place of those that are lost. Medical exploitation of this capacity for regeneration would lead to a substantial reduction in the heavy toll exacted by liver disease.

The two major liver diseases, hepatitis (inflammation of the liver), which is usually not permanent, and cirrhosis (scarring of the liver), which is irreversible, are both crippling and often fatal diseases of great social and economic importance. Viral hepatitis, which has been the bane of many of the great military forces in history, from the Crusaders to our troops in Vietnam, is increasing at an alarming rate among our young, and cirrhosis, which is closely associated with alcohol consumption, is on the increase—as is the abuse of alcohol—among our adult population.

There are two main types of viral hepatitis—type A and type B caused by different although related viruses. Type A is known as infectitious hepatitis, the infection usually being of fecal origin. Type B is known as serum or syringe hepatitis and, in this type, the virus is transmitted by the intravenous injection of human blood or by an infected syringe or needle.

In an important advance that has given promise of clinical application, one type of viral antigen (the substance in the invading microbe that induces the body's immune defense system to produce antibodies) has been found in the blood of patients with type B hepatitis and a different antigen has been found in the stool of patients with type A. The substance found in type B hepatitis, called the Australia antigen, has been isolated, and the data suggest that it is closely related to the type A hepatitis virus, a finding that may lead to the isolation of the entire virus and to the production of a vaccine effective against both types of viral hepatitis.

In addition to the isolation and identification of hepatitis viruses as a required first step for the production of effective vaccines, the availability of purified viruses would provide more sensitive and specific immunological tests for the detection of the disease in patients and in donor blood and would also stimulate research into the mechanism of viral injury of the liver.

Cirrhosis, which is the seventh leading cause of death in the United States and deserves much more research than it has received in the past, and other chronic liver disease may result from viral, drug (including alcohol), toxic, or unknown causes. The mechanism by which liver cell injury is perpetuated and leads to chronic liver disease is unknown. Most people with viral hepatitis recover, but many go progressively downhill. Why is it that some patients, with no treatment, get better, while others, with intensive treatment, get worse and even die?

About 8,000 deaths in the United States each year are attributable to cirrhosis of the liver induced by alcohol. While the majority of heavy drinkers do not develop cirrhosis, many persons who imbibe moderately or only occasionally, come down with the disease. And it has been shown that the cessation of alcohol consumption is the most important single factor in the survival of cirrhotic patients. Since a great many people are not going to give up drinking, no matter what the consequences, we can only protect them by determining precisely how alcohol does the damage.

Studies have shown that alcohol causes an increase in liver fat. There is no compelling evidence that fatty liver per se leads to cirrhosis, but this does not exclude the possibility—which should be investigated—that structural changes associated with fatty liver predisposes to more severe forms of alcohol-induced liver injury.

Massive hepatic necrosis (extensive destruction of liver cells leading to liver failure and coma) may result from liver cell injury due to viruses, drugs, toxins, and diseases of other organs which affect the liver. The extremely high mortality rate from this condition—reaching 90 to 95 percent in patients with acute viral hepatitis who are over 40—would be drastically reduced if these patients could be sustained by a liver support system that would meet their metabolic needs until the liver regenerated. Such are its powers of regeneration that the liver can often resume its normal function in a few weeks.

Many dramatic forms of life support systems, analogous to the artificial kidney in the treatment of acute kidney failure have been advocated to sustain vital functions while awaiting recovery of the injured liver. These include exchange transfusion, use of an "artificial liver," and cross-transfusion with a healthy compatible individual, or with subhuman primates. Some of these measures have given preliminary encouraging results and they should be further evaluated, for, in addition to maintaining life during temporary loss of liver function, the de-

velopment of such a support system would yield a better understanding of metabolic needs during liver failure and aid in averting progression to a terminal or fatal stage.

Diseases of the gallbladder and biliary passages

Gallstone disease is a common worldwide condition of considerable medical importance. About 16 million Americans are estimated to have gallstones: in many cases, these are "silent," producing no symptoms, while in others they result in debilitating disease. In about half of the 800,000 new cases of gallstones in the United States each year, surgery, the standard form of treatment, is ultimately performed, at an average cost of $2,000 per operation. Inasmuch as an estimated 6,000 patients who have had surgery die each year, a less drastic and safer way of controlling the disease, especially in "silent" cases, has long been sought.

Of the two relatively common types of gallstone disease, one involves cholesterol and bile acid metabolism (cholesterol gallstones) and the other bile pigment metabolism (pigment gallstones). Cholesterol gallstones, which comprise 80 to 90 percent of the stones that afflict humans, result when excessive cholesterol (a substance abundant in animal fats) secreted into the bile precipitates from solution to form solid gallstones.

Recent research has suggested that formation of cholesterol gallstones is due to abnormal bile that is low in the concentration of bile acids and high in the concentration of cholesterol. Therefore, chenodeoxycholic acid, which is naturally secreted in human bile, was studied for its effect on existing cholesterol gallstones. Not only was chenodeoxycholic acid found to decrease the degree of saturation of bile with cholesterol, but oral administration of the agent also resulted in dissolution of longstanding cholesterol gallstones in some patients.

Currently, a comprehensive study is being conducted to evaluate the safety and efficacy of chenodeoxycholic acid for gallstone dissolution, and, through ancillary research, to find out how gallstones are formed and the basic cause of their formation. Other agents should also be investigated in a long-range research program to (a) determine the pathogenesis of cholesterol gallstone disease, (b) design rational, safe, and inexpensive approaches to the dissolution and disintegration of gallstones, and (c) identify specific populations with high prevalence of gallstone disease and institute a safe, effective, and inexpensive prevention program.

Pigment gallstones occur when excessive bilirubin (bile pigment) is present in bile and precipitates to form stones. These stones do not contain cholesterol and, as far is known, cannot be dissolved in the body. While less prevalent than cholesterol gallstones in westernized countries, pigment gallstones are in themselves a disease of major medical and economic importance, both here and in some areas of Asia where they are much more common. As pigment deposits often serve as a breeding ground and source for cholesterol stone formation, the importance of pigment precipitation extends far beyond the formation of pigment stones.

Thus, the ability to prevent pigment precipitation would be of great value as another approach to the prevention of cholesterol gallstones, and also as a means of treating Asian gallstone disease, currently a disorder with a high rate of mortality and disability. This capacity can come from an understanding of the events leading to pigment precipitation and such knowledge should be sought.

Diseases of the liver and biliary passages (through which bile flows from the liver to the intestines) in newborns and young children frequently reflect developmental abnormalities of hepatic injuries that occur during pregnancy or shortly after birth. The importance of these prevalent diseases in the infant and child lies in the face that their recognition may be possible at a time when irreparable damage to the liver, the brain and other organs may be prevented.

For example, a number of corrective measures, including exchange transfusion, have considerably reduced the incidence of bilirubin encephalopathy (brain damage resulting from an excessive accumulation of bile pigment in the blood) in newborn infants. However, even with improved methods of care for premature infants and with newborns with other complications, there is still a substantial risk of disability and death resulting from high bilirubin levels.

Two new preventive or therapeutic methods have been developed, which are simpler and frequently more effective than older treatments. Treatment of the mother during the last few days of pregnancy with phenobarbital or related compounds significantly lowers the infant's bilirubin level during the first days

of life—and so does exposure of the newborn infant to cool visible light. (The drug is able to cross the placental barrier and penetrate the fetal liver, and the light is believed to induce photochemical oxidation of the pigment.) In addition to evaluation of the safety of these procedures, urgent research needs include a better understanding of the structural and functional development of the hepato-biliary system during gestation and afterbirth. We need to know how the liver, which does not function in the fetus and is "immature" at birth, makes its major metabolic change in the newborn and assumes its many complex tasks. To prevent and treat cholestasis (blockage of bile in the ductal system) and other diseases to which the biliary tract in susceptible, we need information on how bile is manufactured and transported in the liver and bile ducts, how drugs, infections and other factors can interfere with its normal function, and we need to know more about the disease mechanisms involved.

Long range goals include a detailed understanding of the sequential developmental adaptation which the liver undergoes from gestation to adult life. With this information, a more rational approach to prevention of pediatric liver and biliary tract disease will be possible.

Inflammatory bowel diseases

The lower digestive tract consists of the small and large intestine (the names apply to their diameter, not to the length), which have quite different functions. The small intestine, which is about 20 feet long, is concerned with the final stages of digestion and with the absorption of the processed food through its thin mucous membrane lining into the bloodstream. The large intestine, which is about 5 feet long, reabsorbs excess water and conducts the indigestible portion of the food out of the body.

Any disruption of these essential functions can have dire consequences. The inflammatory bowel diseases, ileitis (inflammation of the ileum or lower section of the small intestine) and colitis (inflammation of the large intestine or colon), are two major disorders of these organs. Among the most serious and perplexing problems in gastroenterology today, these chronic conditions afflict about 500,000 Americans with severe pain and prolonged periods of hospitalization, striking hardest at the younger population and often dooming them to a lifetime of physical and emotional suffering. Nearly 100,000 new cases are reported each year; with an equal number undiagnosed because of widespread lack of knowledge on the part of the public and many doctors.

While these disabling conditions have long been recognized and described, limited progress has been made in combating them. The underlying causes of ileitis and colitis are still unknown and there is no cure. Most of the therapy in this field is on a purely empirical basis. No new drugs have been developed specifically to treat these bowel disorder. Both conditions are often treated by surgery. In the case of ileitis, multiple operations may be required to remove affected sections on the intestine, since the disease recurs in over 40 percent of patients who have had surgery. In some cases of colitis, it is necessary to remove the entire colon surgically and attach the remaining small intestine to an opening in the abdominal wall (ileostomy).

Despite the fact that ileitis and colitis have been neglected too long, due partly to the social stigma of diseases of the lower digestive tract, several important advances are currently being made in this field. An elaborate nationwide clinical trial is being conducted to evaluate the relative merits of corticosteroids, sulfa drugs and other medications presently being used in the treatment of ileitis. Similarly, carefully conducted follow-up studies of large number of patients who underwent surgery are leading to improvements in surgical techniques, with clearer understanding of the complications of certain types of bypass operations (in which some affected parts of the bowel are not removed), and of the varying risks of disease recurrence following different types of surgery. At the same time, animal experimentation and clinical experience have recently resulted in another advance in surgical technique, permitting construction of a continent internal ileostomy in some of the patients who require radical removal of the colon.

In another area, 15 years of concerted research efforts into immunological aspects of ileitis and colitis are beginning to yield useful information concerning the role of fundamental body defense mechanisms, such as lymphocyte function and local intestinal antibody production, in the development of these diseases. These research studies are just beginning to bear fruit in developing improved treatment methods and in determining the role of immunological factors in the pathogenesis of inflammatory bowel diseases. Such efforts should be expanded and vigorously pursued.

Another important area of investigation in these diseases has been in the field of epidemiology. Valuable preliminary information has been gained, but up to now work in this area has been limited. Studies of the genetic and familial factors in ileitis and colitis are needed in order to find a genetic "market" common to those who have these diseases, or to their families. It may then be possible to show susceptibility on an individual, racial, or environmental basis.

The most neglected area of investigation—and the most important—remains basic research into the cause of inflammatory bowel disease. While little progress has been made, there may yet be a glimmer of hope on the horizon. Recently, there have been several reports of a transmissable agent which transfers the lesions of ileitis and colitis into animals. Also, there are a few preliminary signs suggesting the involvement of a microorganism in ulcerative colitis (the most common form of chronic colitis, an ulcerating inflammation of the inner lining of the colon). When the day comes that such agents are isolated and identified—an event that can only be accomplished through basic research—then the promise of a major breakthrough in the field will at last be at hand.

Diseases of intestinal absorption and secretion

Digestion serves little purpose if there is not proper absorption of food. Abnormalities of intestinal transport processes that interfere with the passage of food into the bloodstream may produce serious gastrointestinal disease. For example, derangements of the control of absorption-secretion of water and salt give rise to diarrhea. Similarly, defective absorption of carbohydrates, fats and protein give rise to malabsorption and malnutrition.

Diarrheal disease, the world's leading killer of infants and children, particularly lethal in areas of malnutrition where resistance is low, has many causes. While diarrhea caused by viruses is generally less serious than that caused by bacteria, it is still a far less jocular condition than the terms often used to describe it "tourista," "the trots," "Montezuma's revenge") would seem to imply. The armed forces of all countries have devoted much attention to this very common ailment, for it is a major cause of disability among troops. Among the civilian populations of many countries it is omnipresent. Viral gastroenteritis ("stomach flu"), characterized by varying combinations of diarrhea, vomiting, nausea, abdominal cramps and fever, is second only to the common cold as a cause of illness in the United States. The Metropolitan Life Insurance Co. has reported that it is the most common cause of time lost from work by its female employees.

Asiatic cholera is not an important disease in the United States but the study by American researchers of the toxin produced by the bacteria that cause cholera has led to further understanding of fluid absorption and secretion by the intestine. Perhaps even more important was the discovery that the lesions found in cholera are analagous to those found in some of the common diarrheal diseases in this country, such as those caused by *E. COLI*, a colonic bacteria that we all carry in our bodies. While normally we are accustomed to these microbes, as we travel we may pick up new strains of *E. COLI* which may affiict us until we adjust to them.

In an important recent advance, evidence has been found that in the "secretory" diarrheal diseases, such as cholera and *E. COLI* toxin-mediated diarrhea, the intestine is stimulated by a toxin to actively secrete fluid. The toxin, it appears, binds to receptors on cell surfaces and stimulates certain enzymes that trigger the secretion of excess fluid.

With this information on the fundamental mechanism involved, it should be possible to develop drugs to inhibit or block excessive intestinal secretions. The development of vaccines similar to those now available for cholera should now be feasible for *E. COLI* mediated diarrhea.

Intensification of research on the relation of malnutrition and diarrheal disease is sorely needed, as, with widening food shortages, starvation and undernourishment in many underdeveloped countries are rampant and expected to mount. We know that malnutrition weakens the body's defenses against intestinal infection, but the precise mechanism of this process is not known.

We are learning more about the immunological properties of the gut—for example, that a special kind of secretary antibody is made in the lining of the intestine and that it goes directly into the intestinal tract—and this knowledge should be helpful in the primary goal of developing an immunization program to confer protection against diarrheal disease for a long period of time. (Cholera vaccine gives only temporary protection.) The interrelationship between (a) ab-

sorptive and digestive function, (b) malnutrition, (c) host defense, and (d) intestinal infection needs strong emphasis.

We know a good deal about the lesions resulting from viral gastroenteritis, but we have not yet isolated and characterized the infectious agents involved. Such investigation is not possible in humans or animals. But now, with new organ culture techniques, there is definite promise of accomplishing these preliminary objectives toward the development of effective vaccines. Using biopsies of the small intestine which are cultured and grown in test tubes, researchers can study the factors that regulate intestinal secretion and other aspects of intestinal function under controlled conditions not possible in the whole animal.

To maintain the health of patients with chronic bowel disease during temporary lapses of bowel function and to maintain life in a patient in whom massive bowel surgery has left insufficient bowel to support life, nutrition must be supplied parenterally (outside of the digestive tract). By means of a recently developed "artificial gut" system, using a plastic shunt implanted in an artery—similar to the shunt used for artificial kidney patients—sterile solutions which contain all needed nutrients can be infused into the blood of the patient. The system can be self-operated around the clock and has proven itself to be safe. What is urgently needed to maintain patients devoid of effective bowel function over prolonged periods is a better and safer high energy nutritional "mix" that would provide larger amounts and higher concentrations of nutrients than the usual intravenous feedings (which do not provide fats) and that would eliminate the undesirable side effects of such feedings. Progress has been made in producing a laboratory solution that provides all nutritional requirements and further improvement in parenteral alimentation, as the technique is professionally called, would spare many lives and much disability.

Exocrine pancreatic diseases

The pancreas, which lies deep in the abdomen, is the most powerful digestive gland in the body. Actually, the pancreas is a remarkable example of a double organ, for it is partly endocrine, secreting insulin and glucagon into the blood, and partly exocrine, producing enzymes or ferments for the digestion of all major foodstuffs, proteins, carbohydrates, and fats.

Because we know relatively little about how the normal pancreas works, our knowledge of pancreatic disease is limited. Research on the pancreas in the past has lagged behind that of other digestive organs. This may be explained in part by the erroneous notion that exocrine pancreatic diseases are uncommon, by the inaccessibility of the pancreas for clinical investigation, and by the lack of specific and rapid methods to study pancreatic function. As a result, our current ability to diagnose early stages of pancreatic disease is nonexistent, and treatment methods have scarcely changed over the past 30 years.

Acute and chronic pancreatitis (inflammation of the lining of the pancreas), the most common forms of exocrine pancreatic disease, are dramatic, debilitating and deadly. In acute pancreatitis, which comes on swiftly, paralyzing the victim with excruciating pain, it is as if the pancreatic factory that manufactures, stores and "packages" the digestive enzymes for export through the pancreatic duct into the intestines blows up and the enzymes, no longer safely "packaged," escape into the pancreatic tissue which they proceed to digest and destroy. Known as the autodigestion theory, this most widely accepted hypothesis concerning the development of acute pancreatitus postulates that the causative factors which trigger these self-attacks include alcoholism, gallstones, biliary tract disease, drugs (including diuretics and oral contraceptives), cigarette smoking and disturbances of fat metabolism. Further knowledge of the mechanism by which activation of enzymes occurs in pancreatitis could lead to the development of specific inhibitors of these enzymes.

Chronic alcoholism is the most commonly recognized condition associated with pancreatitis, but just how alcohol activates the enzymes that do the damage is obscure. Therefore, the effects of alcohol on the structure and function of pancreatic acinar cells—the cells that produce the digestive ferment—should be minutely and thoroughly defined. This investigation should include the factors that regulate these cells and the means by which they are protected against self-digestion. Certain hormones produced by the lining of the small intestine are the main regulators of pancreatic secretion and these have been isolated and are now available in synthetic form.

In a recent finding of considerable significance, preliminary evidence suggests that there is some abnormality of protein secretion in pancreatitis. Calcium

deposits found in patients with pancreatitis may be related to this abnormal protein secretion. Studies of the relation of abnormal protein secretion and calcification could lead to improved diagnosis and prevention of exocrine pancreatic disease.

The diagnosis of acute pancreatitis, which has changed very little in the past 40 years, is still based largely on history and physical examination. Serum enzyme tests, which measure the degree and duration of enzyme elevation in the blood, are widely used but often give false positive or false negative results. Recent studies indicate that measurement of certain fractions of the enzymes (isozymes) may greatly improve diagnostic accuracy. Instruments are now available for access to the pancreas in the patient, and, with improvements, these could provide better visualization and biopsy of the pancreas. Tissue cultures, developed from these biopsies, would enable us for the first time to examine the fundamental aspects of various cell types, to learn what they produce, how they are regulated by hormones and other factors, and thus increase our understanding and control of pancreatic disease.

The treatment of acute pancreatitis at present is primarily supportive and without a solid scientific basis. Today, acute hemorrhagic pancreatitis carries a 50 to 75 percent mortality. The treatment for chronic pancreatitis remains more symptomatic than definitive.

An urgent need exists for a multicenter program to standardize and evaluate forms of therapy for acute and chronic pancreatitis. Only through such an interdisciplinary effort can precise measurements be obtained to delineate the abnormalities in patients with severe pancreatitis. The causes of irreversible shock in pancreatitis are unknown and demand investigation. More information is needed about the preparation and administration of pancreatic replacement therapy.

Although long considered a nonregenerative organ, the pancreas possesses exceptional capability for regeneration. Research should be directed toward control of these processes, for, if chronic pancreatitis is characterized by loss of exocrine-endocrine function, then regeneration should normally be expected to repair such loss. A better understanding of the interrelationships between the pancreas and stomach, the pancreas and intestines, and the exocrine and endocrine portions of the pancreas would be of great value in the control of pancreatic regeneration and growth—and it also could be of fundamental significance in the treatment of the leading endocrine disease, diabetes.

Instruments for diagnosis, investigation, and treatment of digestive diseases

One of the most dramatic and significant advances in gastroenterology in recent years has been the development of fiberoptic endoscopes—extremely flexible fiberglass instruments—that can be guided by remote control to investigate, closely examine and even film various sections of the digestive trace. Fiberendoscopy, which has biopsy capabilities and is used as an adjunct rather than a replacement for X-ray examination, is not only one of the most promising new approaches to diagnosis of digestive diseases but it also holds great hope for noninvasive treatment, obviating the need for surgery in certain diseases. A case in point is the brilliant success of colonoscopic polyectomy, the removal of polys from the colon for biopsy. (Formerly, only through surgery could a sample be obtained to determine whether the condition was benign or malignant.)

There are a number of difficult problems in gastroenterology which newer endoscopic techniques may solve. How can one determine the nature of upper gastrointestinal bleeding when careful X-ray studies are inconclusive or negative? How can one be sure whether a gastric ulcer is benigh or malignant? Esophagitis often causes symptoms without X-ray findings: how can one diagnose this most common disease of the esophagus with certainty? The pancreas is practically inaccessible to diagnostic studies and its diseases are notoriously resistant to treatment: might this situation not be different if accurate nonoperative diagnostic techniques were available? Can one always differentiate "surgical from "medical jaundice without resorting to invasive diagnostic techniques? * * * These are just a few of the many questions that may be answered more easily with some of the newer endoscopic procedures.

With the replacement of the early stiff open endoscopes by flexible fiberendoscopes, the procedure became safer, more comfortable for the patient and far more informative. Using a single instrument, the forward-viewing esophogastroduodenoscope, it is now possible to examine the esophagus, stomach and duodenum. This minature but highly sophisticated device is especially useful in diagnosing benign peptic ulcer disease by biopsy and by gross appearance, cancer

by direct biopsy, and upper gastrointestinal bleeding of undetermined origin (such as from erosive gastritis, acute stress ulcer, varicose veins, etc.). Other endoscopes, which can view to the side as well as directly ahead, or which are extremely small for use in children, are available for specialized functions. Present photograph techniques provide objective records of the endoscopic findings.

Because of these advances, the gastrointestinal laboratory is now capable of performing a wide variety of diagnostic tests not possible with older, more conventional techniques. Small intestinal suction biopsy is the best method of diagnosing mucosal disease. Blind rectal suction biopsy can be helpful in the diagnosis of a variety of diseases. In one of the newer, more complex procedures, endoscopic retrograde cholingiopancreatography (ERCP), a fiberoptic side-viewing duodenoscope is used for evaluation of disorders of the pancreas and biliary tract.

While current endoscopic diagnostic and therapeutic procedures have made a major impact in the care of patients with digestive diseases, with continued research we can look forward to even more significant advances in the next few years. The prospect for profit from endoscopes gives industry adequate incentive for improvement of existing instruments and for development of new ones. In view of the bewildering array of new diberendoscopes and accessories, there will be an urgent need for the Government to protect both the patient and the physician by testing and comparing the instruments from an engineering and clinical viewpoint for safety, usefulness and efficiency. These tests should first be made in experimental animals and then, when proved safe, in man.

New instruments, or new methods of using present ones, must be developed to simplify and speed up endoscopic examinations. For example, colonoscopy may well prove to be the single most important advance in the management of colonic disease, yet the expertise and time required for the procedure substantially limits its wide application. Similarly, endoscopic examination of the pancreas and biliary tract via ERCP is a useful diagnostic procedure but it currently requires the skill of a virtuoso. The main bottleneck here, the limited maneuverability of the instrument in certain areas, is a mechanical problem that should be soluble.

There is a severe shortage of trained endoscopists and of adequate training facilities. To fill this need, a new generation of endoscopic teachers will be required, and new teaching devices must be developed which will decrease the time required for learning endoscopic manipulation. Such functions might be served in the same centers supported for evaluating and developing new instruments.

Bleeding erosive gastrities in the seriously ill is a problem where surgical intervention is often ineffective and the mortality rate is high. Because endoscopy is the only method of diagnosing this disease, it would be very desirable to be able to treat the lesion effectively via the endoscope at the time it is first discovered. Possible approaches to this problem of the control of bleeding include laser photocoagulation, electrical coagulation, coagulation by freezing, and application of tissue glues. Approaches which control gastric bleeding may well prove applicable to other bleeding lesions of the gastrointestinal tract.

The success of colonoscopic polypectomy indicates the potentialities for further extension of endoscopic treatment capabilities. Papillotomy (the removal of small tumors of the mucous membrane lining) via the duodenoscope has had preliminary promising trials in Germany and Japan: It seems to be a useful noninvasive treatment for impacted gallstones. In addition to its diagnostic capabilities, laparoscopy—endoscopic examination of the interior of the abdomen—has considerable treatment potential, as evidenced by the success of tubal ligation (binding) via this instrument.

Thus, there are many therapeutic potentialities with the use of endoscopes which merit careful exploration. Furthermore, there is a need for developing new procedures which can eliminate the need for invasive surgery.

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viewpoints on digestive diseases

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Gallstones, 1971

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For many years it was taught that one should expect cholelithiasis in females who are fair, fat, forty, and fertile: or, in other words, light-skinned, obese, middle-aged, and multiparous. Only recently has the *true* prevalence of gallstone disease in any specific population actually been determined. Just last year Bennett's group in Phoenix[1] reported the *true* prevalence of cholelithiasis (as determined by cholecystography) in a population of Pima Indians living on the Gila Reservation in Arizona. Gallstones are extraordinarily prevalent among these rather dark-skinned people of Uto-Aztecan lineage (Fig. 1). Seventy per cent of the women have gallstones by the age of 30 years, and in males the same prevalence is reached in the later decades of life. In nearly all the females, the stones appear between the ages of 20 and 30; in males, they develop gradually from ages 30 to 60. Bennett's group found no relation between the prevalence of cholelithiasis and such factors as parity, obesity, diabetes, serum cholesterol, and atherosclerosis. On the basis of his study, we can say: "Female, yes; fair, no; fat and fertile, not necessarily; forty, too old."

When the true prevalence of gallstone disease in the Pima Indians is compared to the *clinical* prevalence (Fig. 1), one gets the impression that symptoms do not appear until several years after the development of the stones and that about half the women and two thirds of the men with gallstones never have clinical symptoms.

There are no reliable statistics on the true prevalence of cholelithiasis in the general American population. Assuming, however, that at least half of all people with gallstones are asymptomatic, we can estimate the *true* prevalence from the *clinical* prevalence as reported in the Framingham Study.[2] If this estimate is correct, there are about 12 million females and 4 million males carrying gallstones. About 800,000 new cases of cholelithiasis develop each year, and approximately half of these ultimately have surgery. Gallstone disease accounts for about 5,000 to 8,000 deaths per year, and the total cost of morbidity from this disease approaches 1 billion dollars. It is obvious that gallstones are an important problem medically and financially in the general population;

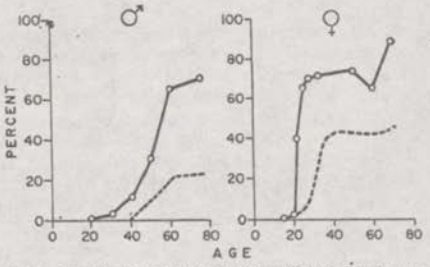


Fig. 1. The "true" (solid line) and "clinical" (dotted line) prevalence of gallbladder disease in the Pima Indians. Vertical axes represent the percentage of the total group who have gallstones; horizontal axes, the ages. Although stones develop at an earlier age in females, the prevalence in the older age groups approaches 80 per cent in both sexes. The lower curves for clinical prevalence confirm the general impression that symptomatic disease appears some time after disease demonstrable by cholecystography. Drawn from data of Sampliner et al.[1]

and in certain populations in the United States (for example, the American Indians) the problem reaches epidemic proportions.

Cholesterol Stones and Cholesterol Solubility in Bile

Virtually all of the gallstones found in American Indians and about 90 per cent of stones analysed from the American population as a whole are cholesterol stones. While other substances such as mucus and pigments may also be present, the major component is crystalline cholesterol. There is a fundamental difference, therefore, between normal bile and the bile of patients with cholesterol gallstones. Whereas normal bile is all liquid, bile from patients with cholelithiasis contains in addition cholesterol in crystalline form, which has precipitated from solution to form stones. This fact indicates that cholesterol has a limited solubility in bile.

How can we express the solubility of cholesterol in bile? Three major constituents of gallbladder bile (making up over 90 per cent of the dry weight) are conjugated bile salts, phospholipids, and cholesterol. Bile salts are water-soluble, detergent-like molecules that form small aggregates in aqueous solutions; these aggregates are called *micelles*.[3]

Lecithin, the predominant phospholipid in bile, is insoluble in aqueous systems but can be dissolved by bile salts in micelles. Cholesterol, totally insoluble in aqueous systems, is dissolved by being incorporated into the lecithin–bile-salt micelle. The capacity of these small aggregates to dissolve cholesterol is related to the relative amounts of lecithin and bile salt within them. Using triangular coordinates (Fig. 2), we are able to determine the maximum solubility of cholesterol in human, gallbladder bile[4] and to show that bile from patients with cholesterol gallstones contains too much cholesterol to be dissolved, whereas bile from normal subjects is less than saturated with cholesterol.[5,6]

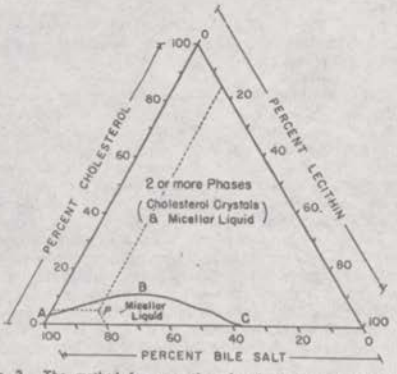


Fig. 2. The method for presenting the three major components of bile (bile salts, lecithin, and cholesterol) on triangular coordinates.[4] Bile having a composition of: 80 per cent bile salt, 5 per cent cholesterol, and 15 per cent lecithin would be represented by the point P. Line ABC represents the maximum solubility of cholesterol in varying mixtures of bile salt and lecithin. Since point P falls below this line, within the zone of a single phase of micellar liquid, this bile would be less than saturated with cholesterol. Any bile having a composition falling above line ABC would contain excess cholesterol in either supersaturated or precipitated form.

The Stages of Stone Formation[a]

We can now look at gallstone disease in relation to cholesterol solubility in bile. At some time during the life of the patient, she (or he) begins to form an abnormal bile supersaturated with cholesterol. This bile is present as a single, liquid phase, having a composition in the range shown in Figure 3A. At some later time in the life of this patient, seeding agents or other factors cause the supersaturated bile to precipitate its excess cholesterol as crystals of cholesterol monohydrate (see Fig. 3B). The liquid bile composition then returns toward saturation, and the excess cholesterol is present within it as a second, solid phase (crystals).

In order to form stones, these crystals must be trapped within the gallbladder; for if they were simply evacuated with each contraction of the gallbladder there would be no possibility of growth. Only after the crystals have become macroscopic stones, either as the result of crystal growth or by the agglomeration of many small crystals, can the patient's disease be recognized by cholecystography (see Fig. 3C). In some patients, these stones eventually cause symptoms and may necessitate surgery (see Fig. 3D).

Basically, then, there are three stages in the formation of cholesterol gallstones:

1. *The chemical stage*—hepatic formation of abnormal bile *supersaturated* with cholesterol.
2. *The physical stage*—seeding and precipitation of the excess cholesterol in bile to form a second, solid phase (crystals).
3. *The growth stage*—enlargement of the cholesterol crystals into stones large enough to be recognized by cholecystography or to cause symptoms.

The first stage of cholesterol gallstone formation probably begins with the formation of abnormal bile by the liver.[7,8] It is not clear at what age this process begins. It could begin prior to birth, in infancy, at puberty, or later. Analysis of bile obtained by duodenal drainage has shown that some young women in high-risk groups such as the American Indians already have chemical abnormalities of their bile by their late teens;[9] younger groups have not yet been studied.

To date, the presence of bile containing cholesterol crystals has not been reported in patients without gallstones—a fact which suggests that the interval between the formation of cholesterol crystals and the appearance of macroscopic stones is rather short. This theory is supported by the large amounts of excess cholesterol present in hepatic bile from patients with cholesterol gallstones.[7,8] One can estimate that if all the excess cholesterol precipitated and remained in the gallbladder, stones observable by cholecystography could be formed readily in *one week*.

What causes the precipitation of cholesterol from the supersaturated bile? This is a matter of conjecture. Any number of agents might act as seeds for the excess cholesterol to precipitate on: bacteria and intestinal contents refluxing from the duodenum, abnormal bile pigments or bile salts from the liver, abnormal mucoproteins, or foreign bodies.

It is not known whether patients with cholesterol gallstones form abnormal bile continuously or intermittently. All that is necessary for stone growth to occur is that bile supersaturated with cholesterol be present at the time of seeding (nucleation); that crystals be retained in the gallbladder; and that the net rate of growth be greater than the net rate of dissolution. Thus, if the rate of growth of stones from abnormal bile is fast compared to the rate of dissolution of stones in normal bile, only short periods of abnormal bile formation would be necessary to develop and maintain gallstones.

Prevention and Treatment

Until very recently, the only treatment for gallstones was surgery. This mode of therapy has proved to be fairly safe, the overall mortality rate for patients undergoing biliary-tract surgery being estimated at 1 to 2 per cent. In my opinion, patients with symptoms should have their stones

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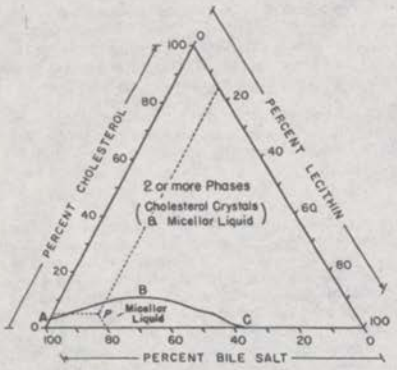


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safe method for *preventing* cholelithiasis and for *dissolving* gallstones in patients with "silent stones" will have emerged.

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ERRATUM

In the March 1971 issue the sentence beginning on line 8 of page 4 should read: Domestic surveys show that native white Americans and immigrants from northern European countries consume more milk than people of southern European extraction, Negroes, and Orientals.

VIEWPOINTS ON DIGESTIVE DISEASES

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viewpoints on digestive diseases

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CHOLESTEROL GALLSTONES, 1975



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In 1971, Dr. Donald M. Small presented in this series his prescient viewpoints on gallstones. After defining the solubility relationships of biliary bile acids, phospholipids, and cholesterol, he delineated the stages of cholesterol gallstone formation as (1) saturation, (2) crystallization, and (3) growth. Dr. Small reviewed preliminary reports concerning the dissolution of cholesterol gallstones by chenodeoxycholic acid and stressed the need to prove the safety of this agent. Now, four years later, another perspective on the status of cholesterol cholelithiasis is appropriate.

Gallstone disease in the United States afflicts 10% of the total population and 30% of the population over 65. From puberty until the seventh decade, women are afflicted three times as frequently as men. Genealogy studies support, but do not prove, the clinical impression that there is a high familial incidence of gallstones. The prevalence of gallstones is definitely increased in American Indians and in patients whose ileum is diseased or removed. Although the possible role of low-fiber diets in the etiology of human gallstones has recently been considered, the significance of diet and obesity in cholelithiasis remains unproved.

Of gallstones analyzed in this country, 85% are composed predominantly of cholesterol; the others are bilirubinate pigment stones. Calcium in gallstones may render them radiopaque and therefore visible on a plain film of the abdomen. This roentgenographic finding, however, does not differentiate pigment stones from cholesterol stones. Since the pathogenesis of cholesterol gallstones is different from that of pigment stones, the principles governing their potential for dissolution are also different. This report is concerned solely with cholesterol gallstones.

Since cholesterol-saturated bile is a prerequisite for the formation of cholesterol gallstones, the incidence of gallstones within a population is correlated with the prevalence of saturated bile. Both in experimental models and in young people at high risk for the subsequent development of gallstones (e.g., American Indian women and siblings of young patients with gallstones), saturated bile has been found to precede gallstone formation. The absence of an absolute correlation between the degree of bile saturation and gallstone formation is due partly to inadequate techniques for determining biliary cholesterol saturation, and partly to the fact that conditions favoring crystallization and stone growth must prevail before saturated bile leads to the formation of gallstones.

FACTORS INVOLVED IN BILE SATURATION

Solubility of Cholesterol in Bile

The solubility of cholesterol in bile is determined primarily by the relative proportions of bile acids, phospholipids, and cholesterol in the bile. The depiction of the solubility relationships of these three biliary lipids on triangular coordinates has been redefined by Holzbach and his associates[1] (Fig. 1), and other methods of expressing cholesterol solubility in bile have also been suggested. Metzger and others,[2] for example, define the lithogenic index of a bile sample as the ratio between the actual cholesterol content of the bile and the maximum amount of cholesterol that can be dissolved in it. Bile saturated with cholesterol has a lithogenic index of 1; supersaturated bile has an index >1; and undersaturated bile, <1.

In patients with gallstones hepatic bile contains at least as much cholesterol as gallbladder bile. This finding suggests that bile becomes saturated in the liver rather than the gallbladder. The liver can produce saturated bile in two ways: (1) by decreased synthesis and secretion of the solubilizing agents, bile acid and phospholipid, and (2) by increased synthesis and secretion of cholesterol. The evidence implicates both mechanisms.

Determinants of Biliary Lipids

The primary bile acids, cholic acid and chenodeoxycholic acid, are formed in the liver as the major catabolic

products of cholesterol and are secreted into the bile as taurine and glycine conjugates. The secondary bile acids, deoxycholic acid and lithocholic acid, are formed by bacterial 7-alpha dehydroxylation of the primary bile acids in the distal intestine. Deoxycholic acid, after being absorbed, conjugated, and secreted by the liver, participates with primary bile acids in the enterohepatic circulation. Some lithocholic acid is absorbed; but after conjugation, sulfation, and secretion by the liver, it is excreted in the feces.

Bile acid synthesis is controlled by a negative feedback mechanism, so that the rate of hepatic synthesis varies inversely with the rate of return of bile acids to the liver.

The rate of bile-acid secretion appears to be the most important determinant of biliary lipid excretion. Since bile acids increase the synthesis and secretion of biliary phospholipids, the *absolute* biliary excretion rates of lecithin and cholesterol are highest when bile-acid secretion rates are high. The *relative* proportions of lecithin and cholesterol, however, are highest when bile-acid secretion rates are low. Finally, bile acids inhibit the hepatic synthesis of cholesterol both directly and by augmenting the intestinal absorption of cholesterol—indirectly.

Size of the Bile-acid Pool

Most patients with gallstones have a smaller pool of bile acid than matched controls without stones.[3] American Indians without stones but with saturated bile also have a small pool of bile acid as well as a decrease in bile-acid secretion. In Caucasians with gallstones, the biliary secretion of bile acid has been reported to be decreased or normal.[3]

The reduced bile-acid pool in patients with gallstones can result from a decrease in either the intestinal absorption or the hepatic synthesis of bile acids. In some patients with gallstones, diminished activity of hepatic 7-alpha hydroxylase, the rate-limiting enzyme in the synthesis of bile acids, has been demonstrated.[4] This finding suggests that the synthesis of bile acid may be reduced either by an intrinsic hepatic defect or by abnormal recirculation of the bile acids.

The high incidence of gallstones in patients having regional enteritis or resection of the ileum presumably results from impaired intestinal absorption.

Altered gallbladder contractility, by increasing the frequency of bile-acid recycling, may reduce the size of the bile-acid pool[3] and lead to the production of saturated bile in individuals whose biliary cholesterol secretion is normal or elevated. If an abnormal gallbladder is responsible for the liver's production of saturated bile, cholecystectomy should improve the situation. Two studies have been reported as showing that hepatic bile becomes unsaturated after cholecystectomy; in two others, cholecystectomy was found to have no significant effect on the cholesterol saturation of bile. The role of the gallbladder in producing saturated bile thus remains uncertain.

Cholesterol synthesis and secretion

In itself, a reduced bile-acid pool does not lead to the formation of saturated bile. The bile-acid pool is reduced in patients with cirrhosis, for example; but a concomitant decrease in the secretion of cholesterol prevents the bile from becoming saturated. In patients with gallstones, on the other hand, cholesterol secretion is increased. Large amounts of cholesterol in the diet and obesity lead to the secretion of bile rich in cholesterol.

The increased secretion of biliary cholesterol in patients with cholelithiasis may result from an increase in the hepatic synthesis of cholesterol, in combination with a decrease in the conversion of cholesterol to bile acids. It has been demonstrated in such patients that the activity of hepatic HMG-CoA reductase (the rate-limiting enzyme for cholesterol synthesis) is increased.[4,5]

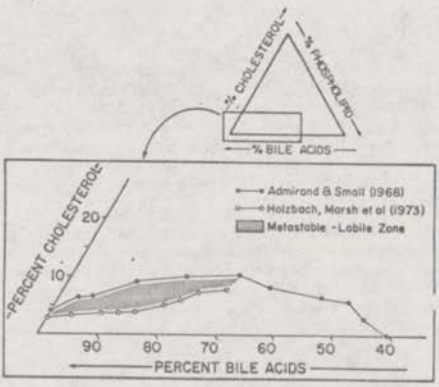


Figure 1. Bile acids, cholesterol and phospholipid composition of bile expressed on triangular coordinates as mole percentages. Points below the metastable-labile zone represent bile that is not saturated with cholesterol. Supersaturated bile is defined as metastable when nucleation of cholesterol is slow (lower limit of zone) and labile when it is rapid (upper limit). Above the zone, cholesterol is also in a crystalline or liquid crystalline phase. (Courtesy of Dr. Martin D. Carey.)

FACTORS INVOLVED IN THE CRYSTALLIZATION AND GROWTH OF GALLSTONES

Excess biliary cholesterol is held in supersaturated solution and/or precipitated as crystals. Among the agents that may form the nidus upon which cholesterol precipitates are bile pigments, bile acids, mucoproteins, foreign bodies, bacteria and refluxed intestinal contents.

Microscopic stones form either by continued growth of the precipitated crystals or by the aggregation of individual crystals. The rate of stone growth is determined by the balance between the rate of precipitation of the crystals, and the rate of their dissolution or passage into the intestinal tract. Gallstones usually grow in the gallbladder, where bile remains for several hours before being emptied into the duodenum. The frequency and efficiency of gallbladder emptying may thus play an important role in the growth stage.

TREATMENT WITH CHENODEOXYCHOLIC ACID

Since the initial report concerning the use of chenodeoxycholic acid in the treatment of gallstones,[6] three clinical trials have confirmed the efficacy of this agent in dissolving radiolucent gallstones in about two-thirds of the patients treated.[7] (Radiopaque stones do not respond.) Since the rate for spontaneous disappearance of gallstones is less than 1% per year, this phenomenon cannot explain the gradual diminution in gallstone size that occurs in most patients treated with chenodeoxycholic acid.

The daily dose of this drug employed in the reported series has ranged from 750 mg to 4.5 g per day, and the duration of treatment has ranged from 6 to 30 months. The minimum dose has been as effective as higher doses in decreasing the cholesterol saturation of bile and dissolving stones. Even lower doses (250 mg per day) have been found to decrease the saturation of bile, but their ability to dissolve gallstones has not yet been tested. Within three months after treatment is discontinued, however, bile again becomes saturated with cholesterol, and recurrence of gallstones has been reported in 10% of the patients within one year. It is obvious that continued prophylactic doses of chenodeoxycholic acid will be necessary, at least for some patients.

Adverse Reactions

When the daily dose of chenodeoxycholic acid exceeds 1 g, diarrhea often occurs as a result of bile-acid stimulation of adenylate cyclase in the colonic mucosa and the resultant secretion of water and electrolytes by the colon. The diarrhea generally disappears when the dose is lowered.

Studies in animals[8] have demonstrated that chenodeoxycholic acid causes hepatic injury, either by its direct effect upon the liver or, more likely, by an indirect effect exerted through its bacterial metabolite, lithocholic acid. In man, sulfation of lithocholic acid enhances its fecal excretion and may provide protection against hepatic injury induced by this metabolite of chenodeoxycholic acid.[8]

No evidence of hepatotoxicity has yet been reported in patients treated with chenodeoxycholic acid, and the only abnormal liver function tests found in man have been the serum transaminases. Transient elevations of these values to less than twice the upper limit of normal have been reported in as many as a third of the patients. The transaminases returned to normal, however, even while therapy was continued. Liver biopsies in patients treated with chenodeoxycholic acid have not demonstrated morphologic changes different from those seen in patients with untreated gallstones.

Fears that bile-acid therapy might increase the risk of atherosclerosis by producing lipid abnormalities have not been substantiated. Neither serum lipids nor the size of the cholesterol pool has increased in patients treated with chenodeoxycholic acid. In fact, this therapy has been associated with a decrease in the activity of HMG-CoA reductase, the rate-limiting enzyme in hepatic cholesterol synthesis.

Mechanism of Action

Both cholic acid and chenodeoxycholic acid may expand the bile-acid pool, particularly when given in larger doses (>1,000 mg per day). However, only chenodeoxycholic acid desaturates bile, dissolves gallstones, and decreases the biliary secretion[10] of cholesterol. The salutary effect of chenodeoxycholic acid on biliary lipids (Fig. 2) is probably attributable to the decrease in hepatic cholesterol synthesis and secretion associated with conversion of more than 90% of the bile-acid pool to chenodeoxycholic acid.[11]

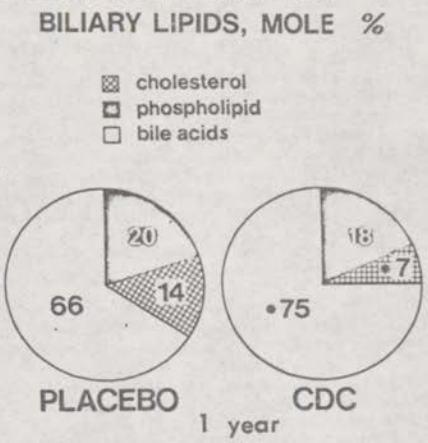


Figure 2. Composition of biliary lipids in gallstone patients after one year of treatment with chenodeoxycholic acid (750 mg per day) or a placebo.[7] The figures represent the mole percentages of bile acid, phospholipid, and cholesterol totaling 100. A significant increase in the mole percentage of bile acid ($p < 0.01$) and a significant decrease in the mole percentage of cholesterol ($p < 0.01$) occurred in the treated patients.

Desaturation of bile occurs rapidly in response to chenodeoxycholic acid, but the transfer of cholesterol from the stones to bile is a slower process. Small gallstones composed of pure cholesterol are the ones that dissolve most rapidly. Gallstone dissolution is retarded by the presence of compounds such as calcium and lecithin, which increase interfacial barriers.

TREATMENT WITH OTHER AGENTS

Phenobarbital decreases biliary cholesterol saturation while cholesterol crystals disappear from bile. Although treatment with this agent for periods up to one year was ineffective in dissolving gallstones, phenobarbital might be valuable as an adjunct to bile-acid therapy or as prophylaxis for patients in the high-risk groups. Lecithin is another agent which may improve the composition of biliary lipids but has not led to the dissolution of gallstones. The administration of glycerophosphate has recently been reported to decrease biliary cholesterol saturation in patients with gallstones, but its efficacy in dissolving stones has not yet been tested.

The possibility of preventing or treating gallstones by dietary measures has been studied, but the effectiveness of

diet in dissolving gallstones has not yet been tested. Bran increases the percentage of chenodeoxycholic acid in bile and expands the chenodeoxycholic-acid pool. A diet high in fibers improves the cholesterol solubility in bile. The capacity of bile to dissolve cholesterol was not influenced by the proportion of saturated or unsaturated fat in the diet.

OUTLOOK FOR THE FUTURE

In order to permit population screening, it will be necessary to develop a simple method for identifying the pre-stone state. Saturation of bile with cholesterol is known to be a prerequisite for gallstone formation, but the ultimate lithogenic phenomena have not been identified. The basic need, therefore, is for better understanding of (1) the roles of the gallbladder and the enterohepatic circulation in the production of saturated bile, and (2) the phenomena of cholesterol crystallization and gallstone growth.

Treatment with chenodeoxycholic acid has demonstrated the feasibility of dissolving gallstones medically, but this therapy is still experimental. While its efficacy is virtually certain, a large-scale clinical trial is necessary to prove that it is safe. We must determine whether long-term treatment with this agent is hepatotoxic in man, and whether patients susceptible to hepatic injury can be identified in advance. We also need to develop more complete criteria for predicting the therapeutic effectiveness of chenodeoxycholic acid in a given patient.

If chenodeoxycholic acid is proved to be safe as well as effective, we will still need to determine (1) the indications for its prophylactic and therapeutic application and (2) the need for continued or intermittent treatment after existing stones have been dissolved. At the same time, the potential of other therapeutic or adjuvant agents should be investigated. Ultimately, a controlled study to compare the results of cholecystectomy and medical dissolution will be required.

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Dr. SESSIONS. We have observed your work over the past several years and been particularly appreciative in the last several months of your efforts insofar as the proposed administrations rescissions.

We did want to express our appreciation to you for your continued interest and help insofar as biomedical research is concerned and particularly your activities in recent months dealing with the proposed administrative rescissions.

As you know, there are proposed cutbacks for the National Institute of Arthritis, Metabolism and Digestive Diseases. This amounts to about $25 million less than last year.

This concerns us because this proposal for reduction comes at the end of several years in which there has been a relatively level budgeting and inflation has caused about a 25- to 30-percent decrease in effective research support.

We are concerned that, if one adds to the effects of inflation this proposed reduction, we could find ourselves with only half as much support for research in 1976 as we had in 1971.

This is potentially a disastrous situation in our view.

We have enjoyed the opportunity in recent years to appear before you and tell you of areas that we think are important and ready for fruitful study and implementation.

You have been extremely helpful to us and I would like to acquaint you with progress in three areas that your committee has supported.

The first one has to do with gallstones. Two years ago we told you we thought our knowledge had developed to the point that we could not approach a medical treatment for gallstones for the first time.

With the help of your committee a multicenter nationwide program has been launched for the study of 900 patients with gallstone disease using a new chemotherapeutic energy, chenodeoxycholic acid. Preliminary results indicate that this agent is effective in dissolving gallstones.

The study will be to show how effective, under what circumstances, and, of course, to rule out any undesirable side effects.

If it develops that this approach is not only effective but nontoxic, this could offer an alternative to surgery for many patients and save millions of dollars each year in hospital and related costs as well as the significant mortality from gallstones.

I would like to state quite clearly that had it not been for the support of this committee and if the administrative budget of that year had been agreed to, this effort could not have been mounted for several years. It is underway.

The first patient will be enrolled on June 1, 1975.

Second, we spoke with you last year about diarrheal disease, ileitis, and colitis. I can report to you today that we now know that many forms of diarrhea, including the so-called, travelers diarrhea, result from a toxin produced by bacteria that we previously thought were not important in human disease.

This information is of great importance in the prevention and treatment of diarrhea. I would mention this to you particularly because 15 percent of the disabilties in the Armed Forces are due to diarrheal diseases and this information can't help but be useful in the treatment of this problem amongst our Armed Forces.

In the area of ileitis and colitis, we have a 14-center prospective study underway now that is using four drugs to determine which ones are

useful in controlling the disease, ileitis, and in preventing or decreasing the frequency of recurrence. Here again, this project could not have gotten underway and couldn't have the depth that it does without the support offered by your committee.

Mr. Irwin Rosenthal, of the National Foundation for Ileitis and Colitis, was scheduled to appear later today. He is ill and can't come, but I would like for his testimony to be introduced into the record, please.

Mr. FLOOD. Yes, that will be done.

[Mr. Rosenthal's statement follows:]

STATEMENT OF IRWIN M. ROSENTHAL

Mr. Chairman, and members of the subcommittee, I appreciate this opportunity to appear before you for the third time as president and founder of the National Foundation for Ileitis and Colitis, Inc., and president of the American Digestive Disease Society (ADDS).

We are deeply appreciative of the support you and your committee have given us over the past years, in our common search for controls and cures of digestive diseases. Eleven months ago, the ADDS awarded you the National Humanitarian Award at the Kennedy Center, for your enormous contributions to the Nation's health, and particularly to the health of those who suffer digestive disease.

Frankly, I don't know of any situation in which an award like this was more richly deserved. Everyone who has been concerned with the advancement of biomedical research is deeply in your debt. We have watched the remarkable way in which you have dealt with the proposals made by the administration over the last 5 years to cut back on the budgets for research—in each case, you and your committee, and your colleagues in the Congress, won the battle. I personally believe that these actions have assured that the researchers still have hope that they will be permitted to continue their work, that the institutions understand that the instability that would have resulted from the administration's proposals will not be permitted, that the lay persons who are developing the voluntary health organizations will continue to be supported in their attempts to help the victims of disease, and that these victims, particularly, will be able to have hope that in fact there is someone in Washington who is trying to do something to aid them. After all, we can talk and debate and discuss all we like, in Congress and outside, about levels of funding for research, but when all is said and done, what we are talking about is the health of the American people.

ILEITIS AND COLITIS

We have made some gains in recent years, because of your support. Last year, in particular, your committee and the Congress earmarked $300,000 for research in the area of diarrhea, ileitis, and colitis. We understand that some of these funds have been used, and that in fact programs are now underway. I am very hopeful that this committee will see fit to include funds to continue these programs, and in fact increase them. In my conversations with NIH researchers, many have been telling me that this area of inflammatory bowel disease is an area of research which is ripe for investigation. Of course, what is needed is more interested young scientists, who are funded in a stable way in their investigations.

I have read the testimony of the American Gastroenterological Society, and see that they have outlined the programs carried on in diarrhea and Chron's disease. We are grateful that these programs are going on, but, simply put, much more needs to be done.

For your information, Mr. Chairman, I include at this point a copy of a story which recently appeared in the New York Times, which outlines the discovery of a new ileitis test which aids in the diagnosis of that illness, and which serves to differentiate that illness from other diseases of the bowel, so that the proper disease management techniques can be used.

This discovery was reported in the New England Journal of Medicine this February 20 by Drs. Kenneth R. Falchuk, Joseph L. Perrotto, and Kurt J. Isselbacher. (Dr. Isselbacher, currently president of the American Gastroenterological Association, a brilliant researcher, has been a close friend of the ADDS,

and is a member of the Scientific Advisory Committee of the National Foundation for Ileitis and Colitis. He has testified before you several times concerning digestive disease research funding.)

NEW ILEITIS TEST AIDS IN DIAGNOSIS.—TECHNIQUE PROMISES TO TELL HOW AILMENT DIFFERS FROM OTHER DISEASES OF BOWEL

(By Lawrence X. Altman)

The first diagnostic test to distinguish ileitis from other common bowel diseases has been developed by a team of doctors at the Massachusetts General Hospital in Boston.

The experimental test's reliability must be confirmed by doctors elsewhere. Its development, however, is considered a major step forward in the care of the estimated total of 2 million Americans who suffer from ileitis and other difficult-to-treat inflammatory bowel diseases such as ulcerative colitis.

Ileitis, a disease of unknown cause, inflames and scars the bowel and runs an unpredictable course. The name suggests it is limited to the ileum, or third portion of the small intestine. But it can affect any area from the esophagus, or gullet, to the rectum, and it can damage joints, liver, skin, and other organs in the body.

Ileitis is also called regional enteritis and Crohn's disease, for Dr. Burrill B. Crohn of Mount Sinai Hospital here, who coauthored a report in 1932 that stressed the distinctiveness of the condition.

Ileitis typically produces abdominal cramps, chronic diarrhea, mild fever and loss of appetite and weight. Often the bowel becomes obstructed and requires emergency surgery, as happened twice with President Eisenhower.

PUZZLING EVEN TO EXPERTS

As Drs. Kenneth R. Falchuk, Joseph L. Perrotto and Kurt J. Isselbacher noted in reporting the new test in the February 20 issue of the New England Journal of Medicine, ileitis is distinct from ulcerative colitis. Yet features of these two life-long conditions that commonly begin in youth adulthood often overlap so much they confuse the most astute specialists in bowel disorders.

In just-published medical text on such disorders, Rear Adm. William M. Lukash, the White House physician, and Comdr. Raymond B. Johnson of the National Naval Medical Center in Bethesda, Md., said:

"It is often true that the radiologist may not be able to label the disease process with precision, or even its extent. The pathologist may not be willing to state conclusively the name of the disease whose microscopic picture he has described in his report."

Further, ileitis symptoms man mimic those produced by other conditions such as acute appendicitis. Thus Maj. Gen. Carl W. Hughes, writing in the text of Dr. Lukash and Dr. Johnson, said that the abdominal pain of the then Major Eisenhower persisted after he had surgery for acute appendicitis in 1923, "which makes one wonder if he may have regional enteritis [ileitis] all the while and, possibly, at the time of the appendectomy."

Because ileitis can be so perplexing, doctors long have sought a test to diagnose it more accurately. There is no cure for ileitis, and effective therapy differs with the various inflammatory bowel conditions. An operation to remove the colon can be an effective, but drastic treatment for ulcerative colitis. But such surgery is not considered the usual therapy for ileitis.

The new test not only may help diagnose ileitis but it also could prove useful in monitoring the success of therapy for an ileitis patient, Dr. Isselbacher said in an interview.

A CREDIT DUE TO FLEMING

The test is based an a discovery of lysozyme 53 years ago by Sir Alexander Fleming, who also discovered penicillin. Other doctors, in seeking to define the poorly understood biologic role of lysozyme, a ubiquitous enzyme, have noticed that increased levels are found in inflammatory diseases such as sarcoid and in stools of patients with inflammatory bowel disease. But the lysozyme preparations were too crude to develop a reliable test.

Now, small amounts of human lysozyme have been purified as a result of newer technology and the research interest of Dr. Elliott F. Osserman of Columbia University College of Physicians and Surgeons here.

Using Dr. Osserman's preparations and helped by funds from the National Foundation of Ileitis and Colitis here, the Boston doctors have learned that the amounts of lysozyme "were significantly greater" in the blood of ileitis patients than in the doctors own blood and in patients with ulcerative colitis and in healthy hospital workers who donated samples. No overlap existed between the very high levels in ileitis and slightly raised levels in ulcerative colitis, thus suggesting its potential application to everyday bedside medicine.

Human rysozyme is in short supply. But Dr. Isselbacher said he expected measures would be developed to produce the larger amounts necessary for standardized use in managing therapy of the 100,000 new cases of ileitis and ulcerative colitis that American doctors diagnose each year.

I call this article to your attention not only because it tells of a new vital discovery of importance to all who suffer from the disease, but also to point out to you that a significant amount of the funding for this research was provided by the National Foundation for Ileitis and Colitis. As the New York Times states: "* * * Using Dr. Elliott F. Osserman's preparation, and helped by funds from the National Foundation for Ileitis and Colitis here—in New York—the Boston doctors have learned * * *" etc. We are proud, very proud, to have been able to have aided in this research.

Mr. Chairman, the Foundation is a small one by national standards, I suppose. We are a young Foundation, but along with pointing out that the funds raised by it have contributed significantly to a new discovery which will be the base for other inquiries and the development of other procedures, we would also like to say that until last year, when this committee agreed to the earmark of funds, our small private foundation had funded research more heavily than the Federal Government in this field of ileitis and colitis research.

We are determined to do even better next year with our Foundation funding of research in the field, and we are hopeful the Congress will do the same.

DIGESTIVE DISEASE RESEARCH IN GENERAL

I would like to turn now to digestive disease research funding in general.

I am tempted not to speak about the President's proposed budget for 1976 at all—given the needs and opportunities in the field of biomedical research, it is simply ludicrous. It would set us back for years. It would upset the whole network for research that has been put together so painstakingly by many brilliant and dedicated workers over so many years.

The National Institute for Arthritis, Metabolism, and Digestive Disease has a proposed budget for fiscal year 1976 which would be $25 million less than the Institute had in fiscal year 1975. The Institute has suffered cutbacks in funds over the last several years; inflation has cut into the research dollars by 25 to 35 percent over the past 4 or 5 years; the research opportunities grow greater, and now the President proposes a further decrease of nearly 15 percent in funding for the Institute. Does he not realize that the accumulated effect of the proposed cuts and inflation will actually reduce the amount of research the Institute is able to support to an amount nearing 50 percent? What an incredible display of concern over dollars at the expense of health.

We know the administration is concerned with economies, but do they not realize that every study which has been made public about the cost/benefit ratios regarding biomedical research has shown the benefits by far outweigh the costs? We have read with great interest the statement of Dr. Hans Popper before this committee made just 2 days ago. Dr. Popper, one of the finest researchers and greatest benefactors of those who suffer with digestive disease, noted that information provided in an article printed recently in the Journal of Laboratory of Clinical Medicine entitled "The Dollar Benefits of Biomedical Research: A Cost Analysis" shows that on a cost-accounting basis it has been amply proved that the medical research dollar brings economic benefits back 20 times over in terms of reducing society's burden for medical care, hospitalization, and other forms of care for those who are disabled by diseases.

What is to happen to new research opportunities that are opening to us every day if the President's budget is agreed to? What is to happen to virtually every medical care and research facility in the country, and to every medical school? Certainly there would be a decrease in faculty at these schools, and the new schools, already destabilized by recent impoundments and rescissions, are sure to suffer further. What intelligent faculty member who could be recruited to one of the new schools actually would go, given the instability of the total situation?

And if the schools are unstable, what will be happening to the many new students who should be taught, who will be so badly needed when a national health insurance program is adopted?

A word should be said, I believe, about another instability factor that is present in the research enterprise of the Nation. It may be unpopular for me to say this, but it needs to be said. My dscussions with outstanding biomedical researchers have supported my opinions.

It is now very clear that the Institutes which deal with cancer and heart disease are being favored to the detriment of other Institutes. While their funding is being increased heavily, the other Institutes are remaining at near-level budgets, which only mean lower budgest because of inflation. The public was told by President Nixon when he signed the bill regarding the "war on cancer" that there would be increased funding in this area, but he also implied that these increases would not be detrimental to other areas of research. However, that in fact has happened because of the economic situation and the levels of funding that the Congress was finally able to appropriate in the face of determined administration resistance.

And finally, I would like to comment about another serious problem which has been emerging over the past several years. That is, budget managers since 1969 have in fact been telling biomedical researchers what is needed for programs in their fields, and even which areas are best to research. We know that the Congress distrusts every document that comes from the administration if it has been reviewed by the Secretary of HEW or by the Office of Management and Budget. We know that the NIH Administrators, unable to speak bluntly in public about their problems and needs, feel that they should say nothing rather than participate in the falsification of information. And we know that the budget cutters know nothing about biomedical research. These patterns of control over research must be broken.

AN OVERVIEW OF THE COST AND THE PAIN OF DIGESTIVE DISEASES

Mr. Chairman, the facts I spoke about last year will not go away. Digestive diseases, according to Social Security Administration estimates, affect 20 million of our citizens. More dollars are spent for medical purposes by persons suffering from digestive diseases than any other class of diseases. Digestive diseases are the most common, most distressing, and most costly of all illnesses. Unfortunately, they are also the least studied, least understood, and least likely to be treated well even when effective treatment is known.

Perhaps the most stunning comparison that can be made is that although over 10 percent of the cost of caring for sick Americans is spent on digestive diseases, less than one-tenth of 1 percent of the Federal Government's budget for health research and education is spent on digestive diseases.

One could go on and on about the costs and pain of digestive diseases. For example, peptic ulcer or its symptoms will strike about 10 percent of all male adults in the United States at some time in their lives. The annual economic loss in the United States due to peptic ulcer is estimated at just under $1 billion, if the cost of care as well as cost of disability and lost income due to premature death is included.

The ADDS and the Foundation for Ileitis and Colitis supports the American Gastroenterological Association in their call for increased funding to begin new research in hepatitis and hormones, and especially their call for a massive study into care, manpower patterns, and opportunities for better service to those who suffer the diseases.

However, we want to make sure that you understand that we believe the areas of ileitis, colitis, and other bowel disease is ripe for research exploration, and we hope that the support of last year will not be lessened this year.

SUMMARY

The mere recitation of the litany of diseases and costs will not alone produce cures. Only research will produce cures and prevent the diseases. And only money will produce the research well. And, when you come down to it, only the Congress—the administration has abdicated its responsibility in this regard—can fund the research, and ultimately, Mr. Chairman, that means you. We will give you whatever support you request, whenever you request it. Please call on us whenever you feel we would be helpful in this regard.

Dr. SESSIONS. Finally, gastrointestinal endoscopy has been mentioned to you as an important area and the support of your committee has speeded development in this area.

We are notified that just this week NIAMDD will be awarding three contracts to evaluate instruments developed for viewing the inside of the bowel and to see how these can be related to digestive diseases.

This endoscopy now allows us to remove tumors from the bowel. Also we can apply sutures and put on various agents that are helpful in inflammatory and perhaps later in neoplastic disease.

We can also study the pancreas for the first time.

Clearly, your committee has been very responsive to the opportunities that we have suggested in years past and I would like today to mention three areas that we think are now ripe for exploration and development.

These are hepatitis research, hormone research, and a study of digestive disease, care, and manpower.

Hepatitis, an inflammation of the liver, is usually caused by a virus. Studies over the last 10 years have allowed us to identify the major virus causing hepatitis and we can now produce a vaccine.

As a matter of fact, within the past few weeks there has been a report of the development and use of such a vaccine in chimpanzees. It is our hope that in the next few years a vaccine can be developed, fully developed, thoroughly tested, and be available for use in man.

Hepatitis is fifth or sixth regularly of the communicable diseases reported in this country.

Another point having to do with hepatitis is that we found that viral hepatitis can lead to chronic liver disease and sclerosis. This has been an enigma to us but we have something to indicate an allergen and immune complexes resulting from the virus infection may be the culprits.

Studies on this possible pathogenesis have a high priority in our minds and if this turns out to be correct it can give us a way to prevent the aggression of viral hepatitis leading to chronic liver disease and sclerosis.

A second area that we think is ready for intensive study is GI hormones. In the past 10 years six hormones have been isolated from the lining of the stomach and duodenum. Several of these are known to be important in disease in man, including cancer in man.

However, only one of them, gastrin, has been chemically characterized in man. There are two ways that we think hormone research can be helped. The first is to provide funds that would allow us to define these other five hormones more completely and to develop methods for assessing them and also to see their mechanisms of action.

The second thing which is related is that there is a shortage of these hormones for study. We need hormones in quantity in order to carry out these studies in man. The supply of synthetic and natural hormones could be increased if we could contract with private sources for them.

It is our estimate that a sum of $500,000 would purchase the needed supply of these hormones.

Finally, the study of digestive diseases, prevention, care, and health delivery. I have submitted for the record a study that we carried out on research needs in the area of digestive diseases. In the course of

this our specialty benefited from the discipline of looking at ourselves critically and we soon found that we felt a major need for understanding better the patterns of delivery of care, the major support systems, and other factors related to the digestive disease.

We would like to have a 2-year study that we estimate would cost $300,000. The purpose of this study would be to evaluate the present situation insofar as the prevalence of these diseases is concerned.

The second would be to identify specific areas that would lend themselves to improvement in care on a reasonable cost-benefit basis.

With these two pieces of information in hand we could develop a plan, a long-range plan, for attaching such things as preventive measures, detection by screening, criteria for diagnosis, and so forth.

In my record there are other parts of this program that are equally important but I will omit discussion for the sake of time.

I want to emphasize the fact that a major part of this study would be to determine what the present situation is in terms of manpower. We need to know how many specialties we have, what their level of training is, what our needs are for the present and for the future.

We think that our specialty is ready for this. We have shown the discipline to do it in relation to research. We would like to do it in relation to patient care and health delivery.

Finally, I would like to make funding recommendations.

First, as to the overall Institute, we believe the President's proposed budget should be rejected out of hand, that in fact funding should be increased 15 percent beyond the 1975 budget. This would be to provide for inflationary costs and also for funding of new research starts in promising areas.

Second, insofar as digestive disease research specifically is concerned, we are hopeful that this committee will in report or in bill language assure a continuation of the levels of funds in 1976 at least at the level of 1975 with a percentage increase for inflation.

Finally, we ask your help in this, and consider this quite important, that there be a specific sum of $2 million to provide for new work in hepatitis, hormone research, and to provide for the study relating to digestive diseases I have described.

I want to thank you for this chance to appear before you, Chairman Flood.

Mr. FLOOD. Thank you.

NATIONAL EYE INSTITUTE

WITNESS

MRS. SYLVIA N. RACHLIN, EXECUTIVE VICE PRESIDENT, MYOPIA INTERNATIONAL RESEARCH FOUNDATION, INC.

Mr. FLOOD. Mrs. Sylvia Rachlin, executive vice president, Myopia International Research Foundation.

Mrs. RACHLIN. Thank you again, Mr. Chairman, for allowing us the chance to express our hope and prayer for a national myopia center under the National Institute of the U.S. Public Health Service.

We are very happy to report continued progress during the past year and an increasing number of distinguished research doctors in the United States and in other nations are now helping us as evidenced by an increasing number of lay people interested in this vital program.

We submit a letter in our presentation by Mr. Gerald R. Waters, Sr., chairman, Community Services Committee, New York City Central Labor Council, on behalf of the officers and 1,250,000 members.

They want to say thank you also to you, Mr. Chairman, and to your committee, for being so interested in the public health and so dedicated in its many areas.

We know you have very little time and our presentation is in writing. We have given 20 copies to your assistant.

Best regards to everybody, Mr. Chairman and committee.

Thank you.

[Mrs. Rachlin's statement and attachments follow:]

STATEMENT OF MRS. SYLVIA N. RACHLIN, EXECUTIVE VICE PRESIDENT, MYOPIA INTERNATIONAL RESEARCH FOUNDATION, INC.

Mr. Chairman and members of the House of Representatives Subcommittee on Appropriations for Labor, Health, Education, and Welfare.

Eye care for Americans afflicted with myopia, commonly known as nearsightedness, is a billion dollar a year industry.

The Food and Drug Administration has recently referred to "100,000,000 Americans who wear eyeglasses." This would bring the cost for eye care well beyond the billion dollar mark. This statistic is particularly disturbing to the myope who feels he is regarded more as consumer than as patient.

Since its incorporation in 1963, the Myopia International Research Foundation has sought to further interest in comprehensive, interdisciplinary research into the causes, treatment and prevention of nearsightedness. More immediately, it seeks to save the eyesight of children afflicted with progressive, pathological myopia for which there is no known cure.

Because the foundation has adhered to a policy of strict academic impartiality and refrained from even the semblance of endorsement or commercialization, its exhibits have received much acclaim at meetings of the American Academy of Ophthalmology and Otolaryngology, International Congresses of Ophthalmology and elsewhere, thousands of doctors visiting and asking to be involved.

The Voice of America has twice broadcast the foundation program overseas.

To improve channels of communication among doctors interested in myopia research throughout the world, the Miopa International Research Foundation publishes and distributes myopia research papers without charge to interested doctors throughout the world.

The Myopia International Research Foundation is idealistic in its operation. No money whatsoever is spent on any administrative salaries or professional fund raisers.

Within the United States, this foundation seeks the establishment of a National Myopia Center with the following threefold structure:

1. Myopia research projects in the National Eye Institute, National Institutes of Health—

(*a*) Establishment of analytical and statistical procedures by the biometrics branch of the National Eye Institute.

(*b*) Grants to the National Eye Institute enabling myopia research projects and establishment of analytical and statistical procedures.

2. A myopia service program under the National Eye Institute—

(*a*) Collaborative study permitting the creation and development of service programs for myopes throughout the United States, and a standardization of records and reporting forms. Through their personal doctors, myopes—young and old—would participate by submitting comprehensive cumulative records to the National Myopia Center for continued analysis by research experts.

(*b*) Grants enabling myopia service programs.

3. The National Registries of Myopia Pathology, a myopia eye study bank, should be developed under the United States Public Health Service. All universities, hosiptals, other laboratories involved in eye research, and eye banks throughout the United States would participate in coordinating clinical research. Participating laboratories would receive eyes of myopes and their families which have been donated for the purpose of research into the pathology of myopia from its incipience through its advanced stages. Findings would be correlated with other research. This plan for the National Registries of Myopia Pathology, origi-

nated by the Myopia International Research Foundation, has received the enthusiastic endorsement of many individuals and organizations across the Nation.

A National Myopia Center structured upon this three-phase program would stimulate nationwide interest and participation by myopes and their families and friends in research under public and private health auspices.

It is a recognized fact that over one-third of the population is nearsighted. Countless adults have suffered loss of employment and become financial burdens to their families and the community because of pathological or degenerative changes in myopia. In addition, the Federal Treasury suffers a loss in revenue through exemptions for legal blindness, reduced earnings, and increased medical deductions for eye care.

Members of this honorable committee: Fully cognizant of the reasons for current retrenchment, the professional consensus is that myopia problems require much applied research. By mail and telephone the Myopia International Research Foundation receives daily appeals from myopes or their relatives for that answer which is not yet known to medical science. In their behalf we beg your earnest consideration and help.

COMMUNITY SERVICES COMMITTEE,
NEW YORK CITY CENTRAL LABOR COUNCIL AFL–CIO,
New York, N.Y., May 13, 1975.

MRS. SYLVIA N. RACHLIN,
Executive Vice President,
Myopia International Research Foundation, Inc.,
New York, N.Y.

MRS. RACHLIN: It has been my extreme pleasure, and privilege, to have been associated with the work of your foundation over these past years and I want you to know that the officers of the New York City Central Labor Council, AFL/CIO and myself feel privileged to be able to contribute to such a worthwhile effort.

The many thousands of individuals, union members, members of their families and retired workers who visit the eye clinics of our labor health centers, one can readily appreciate the additional thousands who stand to benefit when favorable consideration will be granted to your Myopia International Research Foundation by our Congress.

We are aware that through your foundation you are presently engaged in the promotion of communication among all those involved in myopia research, from the patient seeking relief to the doctor carrying on clinical studies.

Through the free publication and dissemination of clinical reports and observations to doctors in all parts of the world, researchers have been informed of corroborative materials for work in process and have indicated areas for further investigation in myopia research.

On behalf of the 600 individual local unions and 1,250,000 individual trade union members we represent, I trust you will receive the needed support of our Congressional leaders in the fight against the ravages of myopia.

With all best wishes, I remain

Sincerely yours,

GERALD R. WATERS, Sr.,
Director.

PERTINENT FACTS

The Myopia International Research Foundation, Inc. launched the first comprehensive, interdisciplinary research program in the United States into the causes, treatment and prevention of nearsightedness.

Our immediate goal is to save the eyesight of more than 1 million American children (besides millions around the world) who are doomed to blindness because of progressive, pathological myopia for which there is no known cure. This we are doing with the cooperation of doctors in the United States and elsewhere throughout the world.

The Myopia International Research Foundation sponsored the First International Conference on Myopia in 1964.

Since 1965 we have petitioned the Congress of the United States for the establishment of a National Myopia Center under the aegis of the U.S. Public Health Service. Each year we have appeared before subcommittees of the House of Representatives and Senate.

The Myopia International Research Foundation has been invited to exhibit at conventions of the American Academy of Ophthalmology and Otolaryngology.

An increasing number of ophthalmologists has become interested in our program.

By invitation, the Myopia International Research Foundation has had exhibits at the International Congress of Ophthalmology in Germany (1966) and in Mexico (1970). These presentations were enthusiastically attended by eminent doctors from all continents, who applauded our program and asked to be involved.

The Voice of America has twice broadcast details of our program to all nations.

Through gifts of printing, myopia research papers are published and distributed without charge to interested doctors in all nations.

The Myopia International Research Foundation is idealistic in its operation. No money whatsoever is spent on any administrative salaries or professional fund raisers.

Our intensive efforts continue daily to help widen the channels of communication among doctors interested in myopia research in all nations.

Mr. FLOOD. Thank you very much.

BASIC RESEARCH, TRAINING, AND INSTITUTIONAL SUPPORT

WITNESSES

GEORGE K. DAVIS, PH. D., DIRECTOR, DIVISION OF SPONSORED RESEARCH, UNIVERSITY OF FLORIDA

LOWELL M. GREENBAUM, PH. D., PROFESSOR, PHARMACOLOGY, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY; CAREER SCIENTIST—HEALTH RESEARCH COUNCIL OF NEW YORK CITY

BRIAN ALBERT CURTIS, PH. D., ASSISTANT DEAN FOR UNDERGRADUATE MEDICAL EDUCATION AND ASSOCIATE PROFESSOR OF PHYSIOLOGY, UNIVERSITY OF ILLINOIS, COLLEGE OF MEDICINE, PEORIA SCHOOL OF MEDICINE

Mr. FLOOD. Dr. Brian Curtis, Peoria School of Medicine; Dr. Lowell Greenbaum, Columbia University; and Dr. George Davis, University of Florida.

Mr. MICHEL. Mr. Chairman, if I might interject at this point, you have heard me speak of the new school of medicine that we now have established in my home community of Peoria as an adjunct to the University of Illinois.

They have for several years embarked upon a program of several additional medical schools under the auspices of the University of Illinois other than at the Champaign campus and in Chicago and, of course, we have one now in Peoria well underway.

While the construction is still in the foundation stage, there is another landmark here in cooperation with a big State university and they are leasing quarters from the privately endowed university, Bradley University, to get the medical school started, and we are happy to have here with us this morning the associate dean, Dr. Curtis, and I would like to present him to the committee at this point, Mr. Chairman.

Mr. FLOOD. Doctor.

Dr. DAVIS. I am George Davis. I have appeared before you before. I am chairman of the public affairs committee of the Federation of the American Societies for Experimental Biology, and Dr. Greenbaum who is here is a member of that committee and Dr. Curtis.

We have agreed to separate and take portions of this 10 minutes which you have allowed us this morning.

My comments will deal primarily with our concern about basic research. Dr. Greenbaum will address you on the subject of training and Dr. Curtis will address you on the matter of institutional support.

As I say, my comments are addressed primarily to that portion of the NIH budget which deals with the fundamental research which we consider to be so important in all of our evaluation of the work of the various institutes of the National Institutes of Health.

I suppose we all are concerned with health. Sooner or later it assumes high priority. Our usual time of putting priority on it, of course, is when we are sick and we forget about it prior to that and yet from the standpoint of the national interest in health it is the prevention that is of primary importance.

While the glamor really rests when you rescue somebody who is in desperate condition, the basic research must be done if we are ever to prevent the many ills that befall mankind.

Since fundamental research is a research for answers that are unknown perhaps that is why it is so difficult to satisfy those who want immediate results. I have presented to you my written comments. I would ask that they be incorporated into the record and that I will address you somewhat informally and perhaps give you an example of fundamental research that had unexpected return.

Some 35 years ago I was engaged in research on single cell metabolism. It happened the single cells I was using were sperm, bull sperm. It might have been entitled, "The Care and Management of Bull Sperm," and then, as now, some critic said, "Well, that is a lot of bull."

Actually I was working on a development of a diluent for semen that would help us with artificial insemination and it is today a success. I was concerned with antioxidants, the use of ascorbic acid as a means of observing these sperm so they could be kept.

In fact, some years later I was in Argentina and we used some sperm that had been preserved for 23 years and it produced viable calves. That was the fundamental research.

Now, it resulted in good results. In other words, we had a diluent. But that is not what I am going to talk about.

In my position as director of research at the University of Florida I am concerned with ophthalmology as one of our many departments.

They have told me that some years ago when they first developed the transplant cornea they had an almost untenable situation. I would like to describe it to you.

If you now are someone who has lost the use of his eyes and now are a patient waiting for a cornea to be available, you have 3 hours from the time someone was killed in an accident to get permission to use the cornea, then to transplant it to you who are waiting in a hospital bed for such an event to happen. You just let your imagination run a little bit and see the tremendous psychological trauma that is involved in this kind of a situation.

Scientists, being what we are, were reading the literature and they went back to this early work that we had done on preparation of materails to preserve single cells and they said, "Well, the cornea is a very thin membrane. We ought to be able to devise a modification of this

for the preservation of the cornea." And today that work which was done on bull sperm provided a base for what we call eye banks today.

In other words, the expected was not what came out but the unexpected far more and far more reaching results than could have been anticipated. Shall I say this is one of the reasons I am anxious that we should have support for fundamental research and then it should be continuing. It is exciting to give sight to the blind but there are many other conditions that need also fundamental research that would permit us to prevent the development of this.

When you think about it, how many thousands of people lose their sight and we would like to be able to prevent it.

I see my Congressman Don Fuqua has come in and I see, Don, you are coming down.

Mr. FUQUA. I apologize for being late. We are marking up a bill, Mr. Chairman. I wanted to come and introduce my good friend George Davis to the committee who has been here many times and I know you, as always, are treating him graciously and will provide all the funds that he asks for.

Dr. DAVIS. Thank you, Don.

Sometimes we do have an opportunity to make a giant step forward and with comparatively modest expenditure. Such an area is marine biomedicine. Last year in your conference committee, Senator Magnuson made a fervent plea for incorporation of funds for marine pharmacology. This is just one aspect of marine biomedicine.

I notice in the budget this year about $350,000 earmarked for marine biomedicine. There are about 11 laboratories that might qualify for this in all of the country today, ranging from the Pacific to the Atlantic, and including the gulf area. This would be about $30,000 each, which is hardly enough to employ a topnotch scientist in this field.

I think that the importance of this area, and the need for studies of not only drugs from the sea, but marine and plant pathology and pollution and all of the various aspects that this has, and its importance, should justify at least $2 million which would permit a core support of these laboratories and I would urge you to give real consideration to this area where, with comparatively modest expenditures, we could see, really, a pioneering effort pushed forward with a great deal of success.

Finally, let me plead for two things—one, that in your deliberations of the appropriation, you consider establishing some sort of a national policy of funding for health which includes an allocation for research, fundamental research, and training, so that we might have long-range planning possible on the part of those of us who do the work.

Finally, let me call to your attention, and I am sure my colleagues will also, that the $36,000 ceiling makes it very difficult for NIH to recruit topnotch individuals. At the proper time I would ask you to consider modifying this, what has become a very significant barrier. People who do accept, really make a sacrifice and it is, of course, a tribute to them that they are willing to do this in order that we may have as good and as qualified people as we do.

I thank you very much. I appreciate this opportunity of coming before you.

[Dr. Davis' statement follows:]

TESTIMONY OF GEORGE K. DAVIS, PH. D., ON BEHALF OF APPROPRIATIONS FOR THE NATIONAL INSTITUTES OF HEALTH

BIOGRAPHICAL HIGHLIGHTS

Current position.—Director, Division of Sponsored Research, University of Florida, Gainesville.

Education.—B.S., Pennsylvania State University, 1932, Ph. D., Cornell University, 1937.

Professor of Nutrition, University of Florida.

President, American Institute of Nutrition.

Chairman, Public Affairs Committee, Federation of American Societies for Experimental Biology.

President-elect, Society for Environmental Geochemistry and Health.

Internationally known for trace element research.

Chairman, Section on Use and Management of Biological Resources of the International Biological program, 1974.

Author or coauthor of 270 scientific papers.

Member, National Academy of Sciences/National Research Council, Food and Nutrition Board, 1961–69.

Testimony before the Labor, Health, Education, and Welfare Subcommittee of the Committee on Appropriations, House of Representatives, 94th Congress, first session:

Mr. Chairman and distinguished members of the committee: gentlemen, I am George K. Davis, director of the Division of Sponsored Research of the University of Florida, Gainesville, Fla., and also chairman of the Public Affairs Committee of the Federation of American Societies for Experimental Biology, often referred to by the acronym FASEB.

There are special concerns which I wish to bring to your attention as you consider appropriations for the National Institutes of Health. There is little disagreement that the Nation's health is, and should be, one of the primary concerns of the Federal Government. The ramifications of this concern are so broad, however, that setting priorities within a finite amount of fiscal resources becomes a major problem and, in large measure, it is your Subcommittee which must resolve the priorities.

It would be helpful if there could be a visible, and therefore available, national health policy that would project special roles for the NIH and an allocation of resources within which priorities could be set. This allocation could be as a percentage of the national budget, or a percentage of the gross national product, or some other guideline that would provide consistency in funding. This is an action that requires long-term and continuous study, and I urge this subcommittee to adopt procedures leading to such a goal.

In the current budget consideration you must, of necessity, develop a balance in the appropriations that will support basic research, applications of research findings, training of personnel to carry out research, and to provide health care delivery and to assist in providing facilities to make health care available to our citizens.

As a professional concerned with university research, I have had an opportunity to evaluate the results that stem from funds provided by the appropriations which support the National Institutes of Health. The drama which surrounds the restoration of someone with a seemingly hopeless illness is hard to match. Research in our opthalmology department at the University of Florida, for example, supported by the National Eye Institute, among others, has been particularly effective in developing the techniques that make corneal transplants an effective way of restoring sight to the blind.

Not long ago a woman from Pensacola, Fla., came to the J. Hillis Miller Health Center of the University of Florida, unable to see to the extent that her husband had to lead her by the hand into the clinic. The corneal transplant operation was successful, and there is today, in the office of the chairman, a piece of art that this lady created after the restoration of her sight and presented as a gift in appreciation. For sheer drama, this kind of health care delivery is hard to match.

However, I should like to suggest that much basic research, seemingly unrelated to corneal transplants, went into the background leading to the ultimate success of this operation. It involved research in medicine, biochemistry, micro-

biology, immunology, pharmacology, zoology, physics, materials engineering, chemistry virology, nutrition, pathology, and opthalmology.

When transplants were first tried, it was necessary to get the tissue from a person, usually killed in an accident, and within 3 hours of death, perform the transplant operation. Imagine, if you will, the problems of waiting, on the part of the blind recipient, of getting release from the family of the accident victim, and all with the knowledge that the tissue transplant probably would be rejected by the recipient.

Let me trace one small bit of basic research, in which I had a very minor role, that helped immeasurably in solving this problem. Years ago, animal husbandmen were working on semen preservation as part of artificial insemination problems. This meant developing from basic research, a knowledge of single cell metabolism and nutrition of sperm that was to be preserved for a long period in a viable state. This led to development of a diluent that contained nutrients such as antioxidants vitamin C and vitamin E. The success of this work suggested to other scientists, years later, that such a diluent would be effective in preserving corneas. With modifications it worked, and today eye banks make possible having corneas available when needed and not fortuitously, as was initially the case.

Looking back, the support of that basic research on the nutrition of single cells was well worth the investment, even though at the time it sounded foolish to many laymen.

It's a lot less dramatic, but how much more rewarding it would be if we could develop the knowledge that would enable us to prevent the disease that caused the destruction of the cornea, and therefore the blindness. This is the basic research that needs support today. I can't tell you whether this should be research support from General Medical Science; from the Eye Institute; from Allergy and Infectious Diseases; from Arthritis, Metabolism, and Digestive Diseases; or from some other source. I am sure that support of the basic research, in all of these Institutes, is one of our most astute investments.

As I examine the proposed budget for appropriations, it is brought home very forcefully that the fiscal 1976 budget recommended for those Institutes with special responsibility for basic research, are the Institutes where major reductions are recommended. It may not be a glamorous area, but when the program on cellular and molecular basis for disease in NIGMS is being cut by over $12 million, between 1975 and 1976, it suggests that our priorities are being mixed up. We are saying that development of the means of preventing disease, as well as improved knowledge of how to cure disease, must take a backseat. This is wrong, and I urge that you take this into consideration as you prepare the appropriations act. I have spent some time on the story of corneal transplants. When you examine the budget recommendations for the National Eye Institute you again note that those debilitating diseases, which affect so many of our people, are areas scheduled for reduced support.

Because I believe, as a matter of national priority, consistent support is needed for the research that has ultimate goals of disease prevention, I must urge that responsibility be taken for assuring a continuous flow of trained personnel who can be instrumental in carrying out the needed fundamental research. The yo-yo type of funding of predoctoral and postdoctoral training has within it the element of reducing this country to a second-rate power in intelligence leadership in the health and health-related fields. Support of training is a must if we are to attract the bright young minds into work that is so necessary if we are to find the answers to disease prevention.

Because it is relatively new, the National Institute of Environmental Health Sciences has not attracted the attention it deserves. As we look ahead at the delivery of adequate health care to all of our people, it must become evident that escalating costs of treatment become more and more difficult to provide for rich, poor, or middle-income citizens alike.

If we are to maintain fiscal sanity, it is inevitable that we as a people must give much more attention to preventative medicine. If medical costs are to be kept in bounds, it's almost axiomatic that we'll have to keep well. That means we will have to pay increasing attention to our environment. The NIEHS is the avenue through which research can be supported to relate the environment to health and health maintenance as related to environmental conditions.

Let me speak specifically to the area of marine biomedicine as a part of NIEHS. This is an area of research that has tremendous potential but very little support. Last year the conference report on appropriations stressed the importance of this area and Senator Magnuson urged the development of marine phar-

macology. This is a small part of the potential of marine biomedicine. I note that the proposed budget for NIEHS includes slightly more than $350,000 for marine biomedicine. This is to develop areas of marine pharmacology or new drugs from the sea, to support marine animal pathology—extremely important as we turn more and more toward food production—and that means healthy animals and plants from marine sources, evaluation of naturally occurring and introduced toxicants in the marine area, and much, much more. The amount budgeted is hardly enough to support work in one laboratory. I'd like to suggest that this item alone should be increased to a figure of $2 million and earmarked for qualified laboratories as core program support so that we may see real progress in marine biomedicine in the next few years. It is an opportunity to pioneer that should not be allowed to pass us by.

In placing emphasis on an example of basic research that is returning tremendous dividends in eye surgery and on an area that offers such unusual opportunities as does biomedicine, I am trying to place in perspective the concerns informed citizens and professionals have for a consistent health policy as exhibited by the appropriations act.

If we do not have the trained personnel seeking the solutions to problems through fundamental research, then we are condemning ourselves to an ever-escalating pattern of expense for health care. The kidney dialysis machines, the heart-lung assemblies, are wonderful and expensive but we need to prevent kidney breakdown and heart degeneration, or the cost of patient care and care for increasing numbers of patients may bankrupt us. Our first priority should be a consistent pattern of support for training predoctoral and postdoctoral students.

Second priority has to be support of basic research through the NIH. This is a national priority. For the individual who is ill, top priority is restoration of health. But in terms of the Nation, knowledge of how to prevent the illness with its cost in human resources is much more important. Looking to the future and the health of the Nation, support of basic research must not be neglected or given low priority.

I have often told my colleagues that the most exciting experimental results are not worth very much if these are not communicated to those who can use them. This brings me to a third priority, that of supporting information resources. I urge you to support those programs of information exchange which permit scientists and citizens alike to have access to the information which is being developed in our efforts to meet the health needs of our country.

In our excitement over cancer and heart disease, we tend to neglect other areas that drain our human resources in very significant ways. Think, if you will, of how many people have dental problems. Actually, these are our most common need for professional help and perhaps one of the most promising areas for preventative medicine. This area is subjected to a cut in the proposed budget of the administration.

Arthritis is known to all of us, but how many people think of urinary calculi—kidney stones—as a major disease? Yet the hospital discharge records indicate an occurrence more than half that of all malignant neoplasms. But best estimates are that only one in six cases are hospitalized. Again, this is a promising area where basic research could lead us to a real advance in preventative medicine.

Others have presented pertinent details about the programs of basic research in the different Institutes. Let me close, however, by urging support of what I choose to call health education for the public. Most of us give very little thought to our health until we lose it. We abuse our bodies and, not infrequently, our brains until disease strikes, and then we go to the physician or dentist and expect an immediate restoration to good health. We complain of the cost. We demand that the health professional know what's wrong and the latest information on how to treat the problems.

How much more desirable, in fact how necessary, for our citizens, including all of us, to know what are good health practices and how to prevent the multitude of ills that beset mankind. This is a role of health education and while we have many answers and guidelines, we have many unknowns. Only as we meet the challenge of research and communication can we hope to establish a rational approach to total health care.

Mr. FLOOD. Thank you.

Who is next?

Dr. GREENBAUM. I am Dr. Greenbaum from Columbia University and, if you will, my expertise is in the training of biomedical scientists.

Mr. Chairman and members of the committee, I am most grateful for this opportunity to appear before you once again to testify on behalf of the Federation of the American Society for Experimental Biology. Before I begin my testimony, may I commend the committee for their past decision in relation to the fiscal year 1975 budget. Your efforts in the appropriations for the NIH and NIMH for fiscal year 1975 were instrumental in maintaining the viability of biomedical research and training.

I would like to direct your attention today to the fact that despite your efforts, important programs in the biomedical area are in a state of disarray, particularly, training programs. These, as you know, are required to train biomedical scientists and faculty to staff our medical and related professional schools in the future. The problem lies in the inadequate budget requests by the executive branch for training programs over the last 3 years, which despite congressional restoration, is beginning to have a deleterious effect on these programs. The difficulties for training program directors to recruit students and to maintain quality programs in the face of impounded funds, rescission budgeting and inadequate budget requests are very great. How, for example, do we convince bright young minds that biomedical science is an important career in the face of the lack of moral and financial support by our executive branch. These same students often have lucrative professional choices or scholarship opportunities in other areas which would deplete us of quality person power in biomedical disciplines.

I am sure that you are aware that questions have been raised about predoctoral training support—how necessary is it and is it necessary in all disciplines?

Some of us have been involved over the past few years in obtaining the facts for your use in these matters. Our conclusions based on these investigations, is that great care has to be exerted in making blanket generalities for all disciplines. For example, a report which I am pleased to present to you entitled "Current Status of Manpower and Training in Pharmacology in the United States," formulated by a task force of the American Society for Pharmacology and Experimental Therapeutics which I chaired, clearly shows that if Federal funding is withdrawn from predoctoral training in pharmacology the number of pharmacologists will, in just a few years, drop to inadequate levels (from 180 per year to 30 per year). Other disciplines may differ and here we await the ongoing inquiry and report of the National Academy of Science. However, it is clear that while adjustments in areas of training may be necessary—if one believes in targeted training—great care must be taken in the process of making these adjustments that training programs are not destroyed across the board. The lag time between dissolution of a training program and renewal of a trained individual takes many years.

What about productivity and quality of training. I have taken the liberty of including in my testimony a summary of the USPHS training program in our Department of Pharmacology at Columbia for the Ph. D. You will note some 25 Ph. D.'s have been conferred since 1960 with most of these supported by USPHS training programs. I am

sure that the fact that all of these individuals in pursuing a career in biomedical science indicates productivity. Similarly, the positions they hold indicate a high-quality person involved in our research laboratories and teaching.

As you know there is a program of combined study for the M.D.-Ph. D. degrees, the so-called medical scientist training program. This is an extremely arduous program of study which when completed produces an extremely high-quality individual to staff our academic medical centers both for basic and clinical research and teaching. Continued funding for this program is extremely important because of the excellence of the individuals that it attracts and also it provides a base from which trainees may enter a variety of disciplines.

Table 2 illustrates the productivity of this NIGMS program and how graduates of this program have made an impact in academic medicine since the inception of these programs a little over 10 years ago.

Mr. Chairman, I urge your committee to support biomedical training programs in your deliberations on the fiscal year 1976 budget. These programs are administered under the auspices of the National Institutes of General Medical Sciences. The amount of funds for training should be kept at the current level so that our programs are maintained during the study of manpower and training by the National Academy of Sciences and while we await their findings.

I would like to make two other points. First, that we must find some way to provide long-term funding in training of our biomedical scientist to stop the "roller coaster" effect of funds coming into and disappearing from programs. This is wasteful, nonproductive, shortsighted, and in the end, is destructive. School, institutional training programs should not be abandoned. They provide the best aspects of quality training for our future scientists as compared with other types of programs.

Thank you, Mr. Chairman and Mr. Michel.

[The attachments follow:]

TESTIMONY, May 15, 1975

TO: HOUSE, SUBCOMMITTEE ON LABOR-HEALTH, EDUCATION AND WELFARE

FROM: LOWELL M. GREENBAUM, PH.D.

POSITION: Professor, Pharmacology, College of Physicians & Surgeons at Columbia University
Career Scientist- Health Research Council of New York City

HOME: Roslyn Heights, New York

EDUCATION: B.S. City College of New York
Ph.D. Tufts University, Massachusetts

ACTIVITIES:

Director, Medical Scientist Training Program, Columbia University
Director, Graduate Training in Pharmacology, Columbia University
Chairman - Task Force for the Support of Training and Research; American Society for Pharmacology and Experimental Therapeutics (ASPET)
Chairman - Public Affairs Committee, ASPET
Member, Public Affairs Committee, Federation American Society for Experimental Biology
Past President, New York State Society for Medical Research

PUBLICATIONS:

The Current Status of Manpower and Training in Pharmacology in the United States (Task Force Report, April, 1975)

Politics and the Biomedical Perspective; Federation Proceedings, 32: 109, 1973

Author of some 50 scientific publications.

TABLE 1

Analysis of Ph.D. Graduates. 1960-1975
Dept. of Pharmacology, Columbia University

Total No. of degrees awarded	25
No. trained in neuroendocrinology	8
No. trained in neuropharmacology	6
No. trained in cardiovascular pharmacology	6
No. trained in biochemical pharmacology	3
No. trained in receptor pharmacology	1
No. trained in pulmonary pharmacology	1

No. now in pharmacology departments (U.S. Medical School)	11
No. now in pharmacology departments (foreign)	2
No. now in other medical school departments	2
No. now in government hospitals	1
No. now in pharmaceutical industry	5
No. now in postdoctoral training	3
No. now taking the M.D. degree	1
No. completed M.D. degree in addition to Ph.D.	2
No. in non-biomedical related areas	0

Current Trainees

First Year	3
Advanced	11
TOTAL	14

TABLE 2

MEDICAL SCIENTIST TRAINING PROGRAMS IN THE U.S.

No. of programs in U.S.A. since 1964	14*
No. of Students - Total	630
No. of students currently in training	414
No. of students who completed program	93

Current Status of those who completed the program

No. in Academic Positions	11
No. in Postdoctoral Research Positions	23
No. in Further Clinical Training (House Staff)	59

*3 programs were begun since 1973.

Current Positions of Those Completing MSTP Program

Position	Field	Medical Center
Asst. Professor	Medicine	Harvard
Asst. Professor	Pharmacology	Mt. Sinai (N.Y.)
Asst. Professor	Microbiology	University of San Francisco
Asst. Professor (2)	Pathology	Duke University
Asst. Professor	Biochemistry	University of Pennsylvania
Asst. Professor	Anatomy	University of Indiana
Asst. Professor	Biochemistry	Princeton University
Asst. Professor	Endocrinology	University of Tampa
Asst. Professor	Neurobiology	Weitzman Institute, Israel
Associate	Neurophysiology	University of Pennsylvania

THE CURRENT STATUS OF MANPOWER AND TRAINING IN PHARMACOLOGY IN THE UNITED STATES

A report by

THE TASK FORCE ON SUPPORT OF TRAINING AND RESEARCH (STAR)

of

THE AMERICAN SOCIETY
FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

(For further information contact
Dr. Ellsworth Cook, Executive Officer
ASPET
9650 Rockville Pike
Bethesda, Maryland 20014
Tel. 301-530-7060)

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LETTER OF TRANSMITTAL

April 1, 1975

Theodore M. Brody, Ph.D., President
American Society for Pharmacology
and Experimental Therapeutics
9650 Rockville Pike
Bethesda, Maryland 20014

Dear Dr. Brody,

I have the honor of submitting the following report to you. It is in response to a March 1973 directive by the Council of the American Society for Pharmacology and Experimental Therapeutics and its President, Dr. John Burns. The directive requested a special task force known as the Task Force on Support of Training and Research (STAR) to undertake a study of the current and future status of training and research in Pharmacology with particular respect to the impact of reduced federal support on these areas.

In this report the STAR Task Force presents the results of three surveys which taken in concert give a profile of the discipline of pharmacology both at present and to some extent in the future in terms of manpower training, research interests and funding. In addition, it gives the opinions of its members on newer aspects of teaching and education in pharmacology especially as it pertains to undergraduate studies.

I believe the report will prove of special significance to the Executive and Legislative branches of our government who must have factual knowledge to provide appropriate legislation and funding in the research and manpower training areas of Pharmacology, Clinical Pharmacology and Toxicology if the health and welfare of our nation is to be maintained. The responsibilities of pharmacology and its sub-disciplines in terms of the health of our nation are many especially with the ever-expanding use of single and multiple drugs for therapeutic purposes. There is need to better understand the actions of drugs and their toxicities on the systems of the body; there is need to find newer and safer drugs; there is need for finding better models and more sophisticated techniques for assessing the efficacy of chemical and natural agents as drugs for humans; there is need to find therapeutic solutions to the non-medical use of drugs as well as

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understanding the physiological implications of drug abuse; there is need for developing solutions to the problems of environmental pollutants.

I am certain you will agree that all of these require solutions which are dependent on research in pharmacology and the manpower trained to carry out this research. In addition, the demands of professional and undergraduate schools for teachers of pharmacology continue. This report focuses on the current resources of pharmacology, how they developed, and the apparent needs for the future.

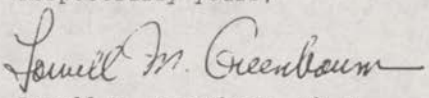
As Chairman of the Task Force, I had the pleasure of interacting with a remarkable group of professionals who devoted themselves with unceasing effort to find the appropriate directions and methods to make the activities of the Task Force a success. Out of these meetings came the concept of three Subcommittees or study groups which given various charges by the Executive Committee worked judiciously and imaginatively towards their respective goals. It was the Herculean efforts of the Chairmen of the Subcommittees and their ability to respond to the challenge with the members of their committees along with "local" personnel including computer center personnel which made a meaningful report possible. Dr. James Bain (Allocations), Dr. George Condouris (Manpower) and Dr. William West (Communications), not only supervised the respective committees but also wrote much of this report as pertained to their individual areas. My efforts were simply to edit and dovetail these reports. In no sense can I express enough thanks from the Task Force to them for their efforts and to the members of their committees who gave of their valuable time with enthusiasm.

The Subcommittee charges are presented in a separate place in the report and will serve as important guidelines for future studies of pharmacology just as the pioneering reports of Dr. Pelikan (1) did for the current study.

From the inception of the Task Force in March 1973 by then President John Burns, through the administration of H. George Mandel and yourself, the support of the Presidents and Council of the Society have been instrumental in the ability of the Task Force to complete this effort. Additional thanks must go to Dr. Ellsworth Cook and his staff as well as to the 2,000 pharmacologists who took the time to respond to the various surveys.

The time is past when science can proceed in the absence of government support and consequently its intervention. It is the scientist's obligation to keep our government representatives informed so that they can act in a knowledgeable and responsible fashion. I believe this report is an important step toward this end for the discipline of pharmacology.

Respectfully yours,



Lowell M. Greenbaum, Ph.D.
Chairman, STAR Task Force
Professor of Pharmacology
Columbia University
College of Physicians & Surgeons

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TASK FORCE ON SUPPORT OF TRAINING AND RESEARCH IN PHARMACOLOGY(STAR)

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INTRODUCTION

In March of 1973 Dr. John Burns, President of the American Society for Pharmacology and Experimental Therapeutics (ASPET), in response to the threat of drastic reductions in financial support of research and training in pharmacology, requested and obtained approval of the ASPET Council for the formation of a special task force to investigate the effects of this reduction as it related to the future of pharmacology and to the future health needs of the country. Dr. Lowell M. Greenbaum, Professor of Pharmacology at Columbia University, was appointed chairman of the task force subsequently known as the Support of Training and Research Task Force (STAR).

The members of STAR were chosen so that every standing committee of ASPET was represented as was academia, industry and government. The STAR Task Force accepted overall responsibilities to obtain data on the needs of pharmacology in terms of manpower for research and teaching and to provide the legislative and executive branches of the government with information concerning the present status and future of the discipline as it related to the need of federal support.

The Task Force met at frequent intervals early in its lifetime to define its charges (see addendum) and to set up a plan of action to obtain the necessary data. Three subcommittees

were formed:

a. Subcommittee on Manpower (Dr. George A. Condouris, Professor of Pharmacology, New Jersey College of Medicine, Chairman). The purpose of this committee was to identify current and future manpower needs in pharmacology, clinical pharmacology and toxicology.

b. Committee on Evaluation of Government Allocations for Bio-Medical Research and Development (Dr. James Bain, Director of Basic Health Sciences, Emory University, Chairman). The purpose of this committee was to evaluate the impact of changes in government allocation of funds on research and on training institutes such as medical schools and pharmacy schools.

c. Committee on Communications (Dr. William L. West, Professor of Pharmacology, Howard University, Chairman). The purpose of this committee is to seek ways to educate the public as to what a pharmacologist is and what the role of pharmacology is in meeting national health goals.

Each of the subcommittees conducted a survey by means of questionnaires (see addendum). The questionnaire of the Committee on Manpower was responded to by two thousand pharmacologists in academia, industry and government; the questionnaire from the Committee on Communications by a thousand pharmacologists. The responses were collated by computer centers at both the New

Jersey Medical College and at Howard University. The results of these collations form the body of the report and thus a profile of the discipline of pharmacology. Like all such data, some of it became dated almost immediately or during the preparation of the report. However, much of the data should prove useful not only for its intended use but as a guide to future questionnaires and investigations in biomedical disciplines.

SUMMARY AND HIGHLIGHTS

1. There are an estimated 4500 to 6000 professionals serving the roles of pharmacologists, clinical pharmacologists and toxicologists. They are engaged in research, teaching and administration in academia, government and industry. Most (75%) hold positions in non-profit institutions such as medical, dental, pharmacy, veterinary schools, government agencies and hospitals. Medical schools are the single largest employer. About 25% of the working pool are employed by pharmaceutical and chemical industry.

   The modal age of the group is 32 years while the median age is 40 years.

   The minority population of the working pool is 7%, while the population of females is 8%.

2. Almost all pharmacologists required lengthy periods of academic training since most hold one or two doctorate level degrees. (Ph.D.-75%; M.D.-18%; M.D.& Ph.D.-9%; D.V.M.& Ph.D.-2%; Masters only-3%)
   Many of the above have also taken post-doctoral training.

3. Over 40% of scientists carrying out pharmacology come from other disciplines. The unemployment level is below 0.1%.

   The need for pharmacologists is expanding beyond current parameters of research and graduate teaching. An increased responsibility for undergraduate teaching is now evident. Over 35 universities are carrying on programs in undergraduate pharmacology (excluding Pharmacy teaching).

4. Over 90% of the working pool are engaged in teaching and research as their primary activities. The largest number of pharmacologists are engaged in rank order in the following research areas: biochemical, cardiovascular, central nervous system, and autonomic pharmacology.

   About 12% of the working pool are involved in research teaching or administration of clinical pharmacology.

   About 10% of pharmacologists are engaged in toxicology.

5. Federal support has played a significant role in the development of the professional group. Half of the entire working pool has received some federal support for pre-doctoral training. Over 75% of those entering the working pool since

1969 have received such support.

Similarly, more than half of those undertaking post-doctoral training received some federal support.

6. In the absence of federal support for pre-doctoral training, new manpower in Pharmacology will drop to low levels in a short time. In the years 1970-73, an average of 8 trainees per department were in residence in 25 Departments of Pharmacology surveyed. In the absence of federal support (training programs) the number of departments involved in training will drop from 25 to 10; the number of trainees per department to 3. Extrapolations to the United States as a whole would indicate that by 1978 only 25-30 pharmacologists would be receiving degrees as contrasted to the current yearly average of 170. Since foreign students are included in these figures (for 1978), the number available to the U.S. would be even less.

7. The "profile" as summarized above indicates that pharmacology is a vital and expanding discipline. The need to fill positions with manpower from other disciplines, the lack of any unemployment, the continued demands by federal and state legislation for manpower to carry out research and development

in areas involving pharmacologists all attest to this expansion. Pharmacologists are unique in that their services are in demand by both academia and industry, thus adding to manpower needs.

It is known that about 170-180 pharmacologists are now being trained each year to fill these needs. The absence of federal support for pre-doctoral training programs in pharmacology will reduce the number of trained pharmacologists to levels which will probably be inadequate to meet the demands and responsibilities which the discipline must fulfill if the health needs, teaching needs, and research needs of this country are to be met.

TABLE 1

AGE DISTRIBUTION

Age	Frequency	%
20-24	1	0.1
25-29	82	4
30-34	414	22
35-39	371	19
40-44	342	18
45-49	287	15
50-54	214	11
55-59	89	5
60-64	70	4
65-69	31	2
70-74	22	1

Sample Size: 1923

Age distribution. (Table 1) The distribution of ages within the sample shows that with respect to the human resource, the discipline of Pharmacology is a "young" one; the modal age group is between 30 and 34 years (with this five year age span accounting for one-fifth of the sample). The modal age is 32 years with a frequency of 6% of the sample. The median age of the sample is 40 years.

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TABLE 2

DISTRIBUTION OF SEX IN WORKING POOL

Sex	Frequency	%
Male	1774	92
Female	145	8
Sample size:	1919	

Sex distribution. (Table 2) The distribution of the sexes in the sample is seen to show 8% females in the professional pool. In its survey of doctorates awarded in Pharmacology from 1920 to 1971, the National Research Council (6) reports that women accounted for 10% of the doctorates. Our figure of 8% is, therefore, in good agreement. This distribution can be related to the distribution among all life scientists which is reported to be 19%(7).

The Manpower Committee examined the data on sex distribution year by year to determine whether any trends were evident in the distribution pattern of sex in the pharmacology, clinical pharmacology and toxicology pool. There is evidence that in the past three years the percentage of females entering these disciplines is increasing (see Table 14).

TABLE 2

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TABLE 4

U. S. BUREAU OF THE CENSUS: 1970
ENROLLMENT OF U. S. GRADUATE STUDENTS (ALL SUBJECTS)

Group	%
American Indian	0.1
Blacks	3.1
Orientals	1.7
Spanish Surnamed	0.5
Total	5.4

The importance of data of this type is that it gives insight into the potential number of minority students that might be available for incorporation into the discipline. Note that the data collected in the current survey indicates a similar approximating figure for total minority group representation as in graduate school for all subjects. (Table 3)

TABLE 5

FREQUENCY DISTRIBUTION OF TYPES OF DEGREES

Degree	"Primary" Degree %	"Latest" Degree %
Ph.D.	75	76
M.D.	16	18
M.S.	6	3
D.V.M.	2	1
D.D.S.(DMD)	0.3	0.2
OTHER	1	3
Sample Size:	1880	1865
Ph.D. & M.D.		9.0
Ph.D. & D.V.M.		2.0

Types of advanced degrees held. (Table 5) Summarizes the responses to the question relating to "degree". Primary degree was determined from question #7 (Post Baccalaureate Degrees) the first answer was taken as the respondent's judgement of his primary degree. Question #8 (latest degree), however, yielded a second estimation of the degree distribution. Note that either question leads essentially to the same results, namely, that the majority of the respondents (75%) hold a Ph.D. degree. A certain number held more than one doctorate: 9% hold Ph.D. and M.D. degrees; 2% hold Ph.D. and D.V.M. degrees. Approximately 3% of the respondents hold the Master's degree as the "latest" degree.

TABLE 6

YEARS WITH DEGREE

Years	%
0-4	21
5-9	25
10-14	18
15-19	15
20-24	10
25-29	5
30-34	3
35-39	2
40 or greater	2

Sample Size: 1925

Years with the advanced degree. (Table 6) The table demonstrates that nearly one-half (45%) of the respondents have their primary degree(s) less than 10 years; and two-thirds have their degrees less than 15 years.

TABLE 7

DISTRIBUTION BY YEARS OF EMPLOYMENT

Years	Frequency	%
0-4	533	29
5-9	467	26
10-14	300	16
15-19	243	13
20-24	126	7
25-29	67	4
30-34	36	2
35-39	22	1
40-44	12	0.6
45-49	3	0.2
50 or greater	12	0.6
Sample Size:	1821	

Years of employment. (Table 7) The data reflect on the level of experience of the manpower pool. More than 50% have been employed professionally less than 10 years, with 84% being employed less than 20 years.

The data in Tables 1, 6, and 7, taken as a whole, indicate that the discipline has exhibited a significant growth rate within the past 10 to 15 years. Since virtually all of the respondents were employed at the time they completed their questionnaires, the results show that the needs for the discipline have truly expanded. Part of this expansion is undoubtedly attributable to the training programs initiated and supported

by the Federal government. These programs were started in 1958 to meet the national crisis which existed as a result of a shortage of scientific manpower in certain biomedical areas, among which was pharmacology. The question has been raised whether the "bulge" of younger pharmacologists is an artificial event, or whether it represents genuine, newly created opportunities for professional employment which are part of our nation's need. An analysis of the functions served by this pool of professionals which is given in Tables 10 and 11 clearly shows that the pool is fulfilling genuine needs.

TABLE 8

DISCIPLINE OF STUDY FOR Ph.D. or M.S.

Discipline	%
Pharmacology	55
Biochemistry	14
Physiology	10
Chemistry	5
Biology	4
Pharmaceut. Sci.	3
Psychology	2
Toxicology	2
Other	5

Sample Size: 1611

Mode of entry into the manpower pool. (Table 8) Whereas the figures in Table 5 show the types of degrees held by the present manpower pool, the results in Table 8 explain the disciplines in which the Ph.D. and M.S. respondents received their formal training.

It is interesting to note that only 60% of the pool was trained formally in pharmacology, toxicology and pharmaceutical science. To meet the professional needs of pharmacology, 40% of the pool were drawn from other disciplines. A year by year analysis of the proportion of Ph.D.'s with formal training in pharmacology failed to show any change in the proportions as seen in Table 8.

TABLE 9

PRIMARY EMPLOYER CATEGORY

Employer Category	%
Medical School	51
Pharmaceutical Industry	23
Pharmacy School	9
Federal Government	5
Non-profit Research Institute	3
Hospital	2
State Government	1
University	1
Other	1
Dental School	0.9
Other Industry	0.8
Veterinary School	0.7
Private Employment	0.6
Consulting Organization	0.6
Retired	0.5
Chemical Industry	0.4
Local Government	0.3
School of Public Health	0.3
Unemployed	0.1
Sample Size: 1916	

Place of employment. (Table 9) The respondents are employed by a wide variety of organizations as seen in the accompanying Table.

It is noteworthy that 75% of the respondents hold positions in academia, government or other non-profit institutions including hospitals. Medical schools are the single largest employer. 25% of the respondents are employed by pharmaceutical and related industry.

TABLE 10

PRIMARY EMPLOYMENT FUNCTION

Function	N	%
Research-Pharmacology	755	40
Teaching-Pharmacology	425	23
Research-Clinical Pharmacology	135	7
Research-Toxicology	129	7
Teaching-Clinical Pharmacology	79	4
Administration-Pharmacology	72	4
Teaching-Other	59	3
Research-Other	55	3
Patient Care	49	3
Administration-Other	42	2
Administration-Toxicology	41	2
Teaching-Toxicology	35	2
Administration-Clinical Pharmacology	14	1

Sample Size: 1890

Types of professional functions. (Table 10) Respondents were asked to rank their employment functions, listing their primary function under Rank 1. This question was designed to determine the type of professional activities subserved by the sample. Table 10 summarizes the primary functions (that is highest priority function) reported by 1,890 respondents. The functions are listed in order of decreasing percentages.

important function as judged by the respondents themselves. The data in Table 11 are based on a sample size of 1,890, but since many individuals serve more than one function the numerical discrepancy (grand total=5536) clearly leads to the conclusion that the respondents serve multiple functions, with an average rate of 2.9 functions per respondent.

TABLE 11

MULTIPLE EMPLOYMENT FUNCTIONS

	Priority Rank				
	1	2	3	4	Total
Pharmacology					
Teaching	425	395	152	66	1038
Research	755	424	113	58	1350
Administration	72	173	350	96	691
Clinical Pharmacology					
Teaching	79	84	71	42	276
Research	135	131	79	41	386
Administration	14	42	62	45	163
Toxicology					
Teaching	35	52	72	53	212
Research	129	116	87	49	381
Administration	41	52	39	18	150
Patient Care	49	32	65	123	269
Other					
Teaching	59	55	51	52	217
Research	55	69	58	38	220
Administration	42	25	60	56	183
				Total	5536

Multiple employment functions. (Table 11) In this table, the total combined functions of the respondents are reported together with the ranking of importance of these functions ascribed by each respondent. The respondents were asked to rank multiple functions from "1" to "4" with "1" being the most

TABLE 14

PH.D.'s CONFERRED IN PHARMACOLOGY

BY SEX 1968 THROUGH 1972*

	No.	%
Men	709	87
Women	104	13
Total	813	

*from "Doctorates Conferred in Fields of Primary Concern to N.I.H.; Fiscal Years 1962 to 1972."

Ph.D.'s conferred in Pharmacology by sex. (Table 14) This table indicates that in the years 1968 to 1972, 13% of the Ph.D. degrees conferred in Pharmacology were conferred on women.

TABLE 12

CLINICAL PHARMACOLOGY:

DEGREE VS PRIMARY FUNCTION

Function	M.D.	M.D.& Ph.D.	Ph.D.	Other	Totals
Teaching	38	12	18	2	70
Research & Development	57	27	39	4	127
Administration	9	2	1	0	12
Totals:	104	41	58	6	209

Clinical pharmacology: degree and function. (Table 12) Two-hundred and nine respondents with doctorates indicated clinical pharmacology as their primary function. Of these, 145 had M.D. degrees, hence, potentially could satisfy the criterion of patient care which is held by some as a pre-requisite for this category. On the other hand, the respondents themselves, made this judgment of function and it is conceivable that scientists with Ph.D. degrees alone could also be engaged primarily in this function. A further analysis of the 209 respondents showed that 16 were employed in pharmacy schools: and 43 in the pharmaceutical industry.

TABLE 16

FEDERAL SUPPORT, PRE- & POST-DOCTORAL TRAINING

	Percent		
Type	Yes	No	Not Sure
Pre-doctoral*	49	49	2
Post-doctoral**	47	52	2

*Sample size: 1908
**Sample size: 1748

Federal support of training. (Table 16) This table indicates the federal support of respondees for the entire working pool. It demonstrates that about half of the entire current working pool received some sort of federal training support during their Pre- and Post-doctoral years.

TABLE 18

TYPE OF FEDERAL SUPPORT

Type	Percent	
	Pre-doct.*	Post-doct.**
Training Grant	43	34
Fellowship	29	34
Research Grant	22	24
Other	7	8
*Sample size:	975	
**Sample size:	710	

Type of Federal support in the entire working pool. (Table 18) This table indicates the mechanism of the funding. It should be compared with the current mechanisms (year 1972) now employed for such support (Table 15). It may be seen that post-doctoral traineeships have been split between training grants and fellowships. Pre-doctoral training in 1972 was overwhelmingly supported by the training grant mechanism.

53-100 O - 75 - 22

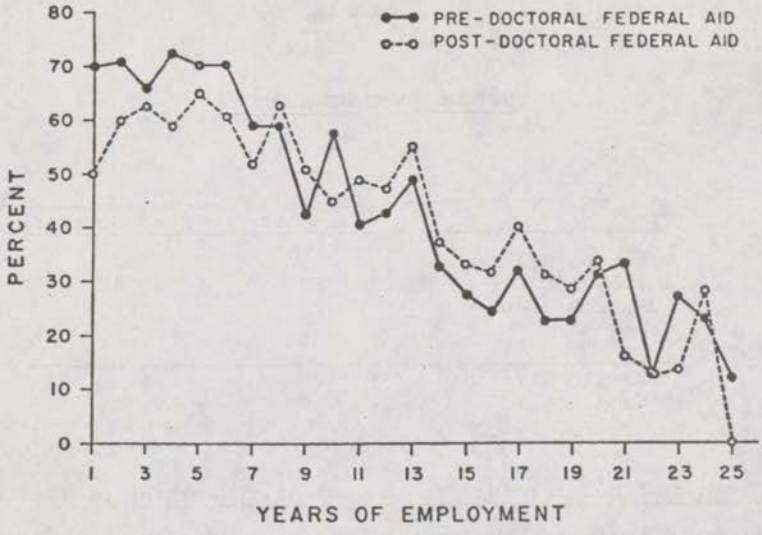


Figure 1. Summary of the proportion of federal pre- and post-doctoral support received as a function of the number of years the responder was in the working pool.

Figure 1 indicates the rise in the number of federal supported trainees entering the working pool over the last 25 years. This figure should be compared with figure 6 demonstrating the rapid drop in pre-doctoral trainees in the absence of federal support.

TABLE 21

MEMBERSHIP IN SOCIETIES

Society	Percent
Amer. Soc. for Pharmacol. & Exper. Therapeutics	40.0
American Chem. Soc.	12.0
Soc. of Toxicol.	7.0
Amer. Physiological Soc.	6.0
Soc. of Neurosciences	6.0
Acad. of Pharmaceut. Sci.	6.0
Amer. Soc. of Clin. Pharm. & Therap.	6.0
Amer. Soc. of Bio. Chem.	4.0
Amer. Coll. of Clin. Pharmacol.	3.0
Amer. Coll. of Neuropsychopharm.	2.0
Amer. Soc. for Clin. Invest.	2.0
Amer. Soc. of Anesthesiology	2.0
Amer. Acad. of Clinc. Toxicol.	1.0
Env. Mutagen Soc.	1.0
Amer. Psychol. Soc.	1.0
Soc. of Neuropharmacol.	0.2
Amer. Assoc. of Immunologists	0.1

Responders: 2256

Membership in societies. (Table 21) The table indicates that pharmacologists have varied interests aside from the parent discipline.

TABLE 23

UNDERGRADUATE TEACHING

Level of undergraduate teaching	Percent
High School	1.7
Community College	2.0
College	38.4
General Community	7.2

Responders: 1005

Undergraduate teaching. (Table 23) This Table indicates that a surprising number of pharmacologists engage in undergraduate teaching. Table 24 lists the schools (35) which currently have at least one undergraduate course in pharmacology.

Undergraduate courses in pharmacology are a relatively recent innovation. In order to determine if such courses are useful or necessary in the future, a poll was conducted to determine if pharmacologists believed there was need for an undergraduate program in pharmacology for students studying in the disciplines of science, education, social sciences and liberal arts. The results clearly indicate that most pharmacologists believe such courses are needed.

TABLE 25

SHOULD PHARMACOLOGY BE TAUGHT TO UNDERGRADUATES?

% in favor	for student majoring in:
88	Science
50	Education
48	Social Sciences
38	Liberal Arts

The decrease in actual research grant funding is matched by a dramatic increase in the amount of approved-but-not-funded grants per department (Figure 3). (These figures have not been corrected for released impounded funds.) The drop in total amount and numbers of departments reporting, especially in 1975-76 is, again, probably affected by the difficulties of forcasting several years in advance.

Contracts are evidently not a significant part of the operation of most departments, although the total amount of contract support reported in the early years of the survey is unexpectedly large (Figure 4). The amounts have stayed fairly constant up to the last few years of the period covered. The sharp drop then observed is no doubt the result of the short term nature of contract support where future prospects are not known nearly as far in advance as is the case with grant support.

Training grant funding follows much the same course as research grants except that the decline in amounts began about a year earlier (Figure 5). Of course, fewer departments are involved. The effect of the decline in training grant funding is most dramatically reflected in the numbers of predoctoral and postdoctoral trainees (Figure 6). The former will evidently drop from a high of about 220 in 1970-71 to less than 30 by 1975-76. Reduction in the number of postdoctoral trainees will be equally severe. In addition, over 50% of the departments surveyed could not continue training programs.

One of the more serious effects on a department of the loss of grant funding is the loss of support for faculty. This is also seen to be in a falling phase from 1974 through 1976 so far as the total amounts are concerned (Figure 7). The amount of salary support per department is shown as staying relatively constant, but the number of departments with such support decreases to less than one-half of the original number. Since educational institutions must give priority to their undergraduate and professional teaching responsibilities, graduate training and research will be the first activities to feel the effect of the loss of outside support.

Examination of the questionnaire itself will reveal that the non-Federal side of the ledger, far from increasing in order to compensate for the above described declines in Federal funding, is also decreasing.

With a few exceptions, no department reported major increases or decreases in teaching functions or other responsibilities. Those few departments that did report large increases were generally newly established and developing schools and the increase in responsibility was accompanied by an increase in local support. In a very few instances, changes in curriculum were reported as the explanation for major changes (usually decreases!) in teaching functions.

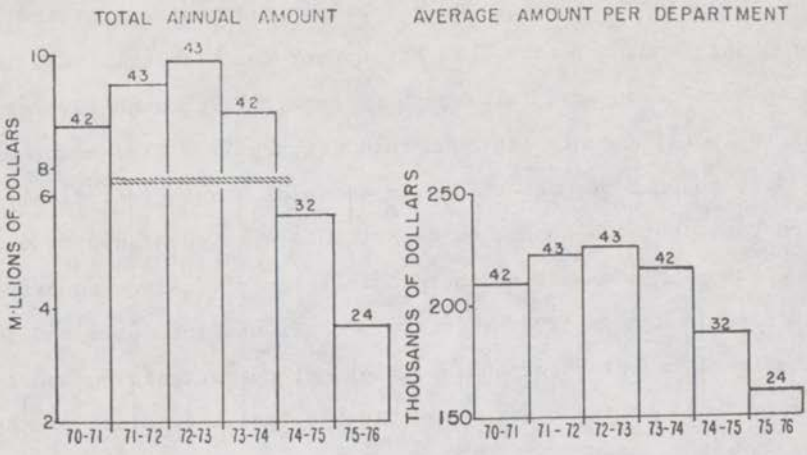


Figure 2. Research grant support in 50 departments of pharmacology, clinical pharmacology and toxicology. (The number on top of the bar refers to the number of departments responding out of the 50 surveyed.)

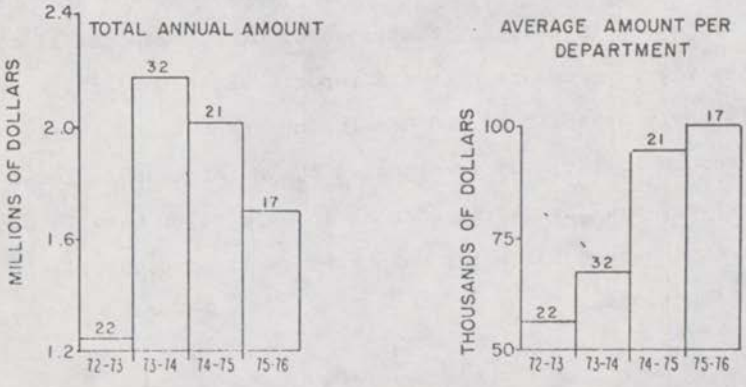


Figure 3. Research grants approved but not funded in 50 departments of pharmacology, clinical pharmacology and toxicology.

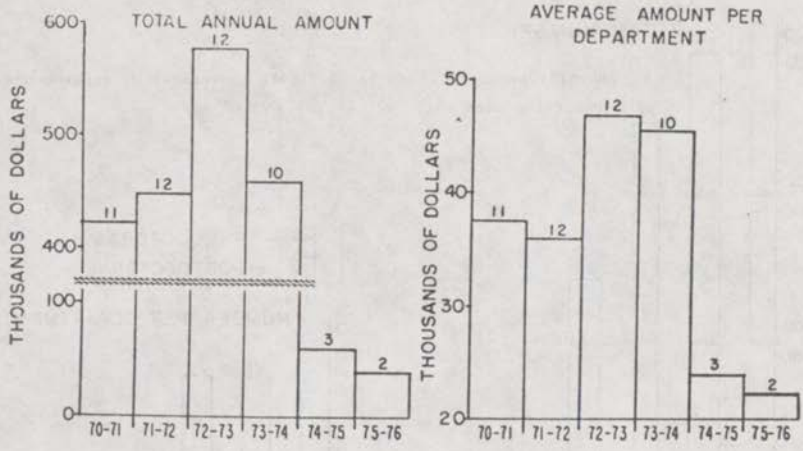


Figure 4. Contract support in 50 departments of pharmacology, clinical pharmacology and toxicology.

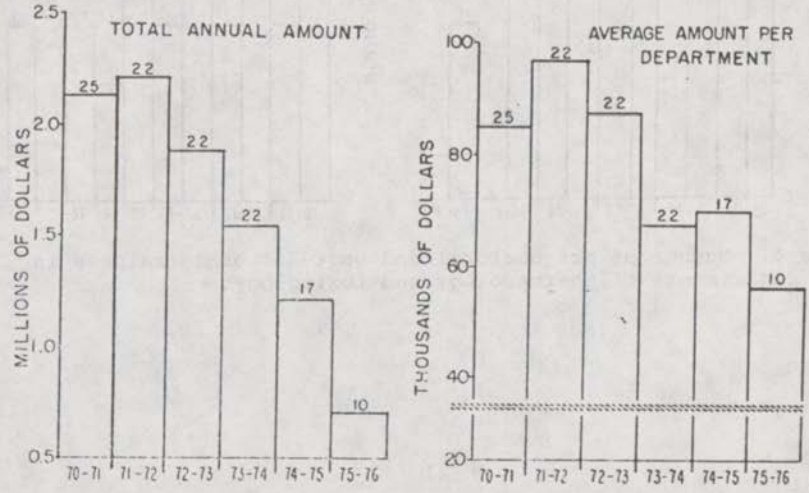


Figure 5. Training grant support in 50 departments of pharmacology, clinical pharmacology and toxicology.

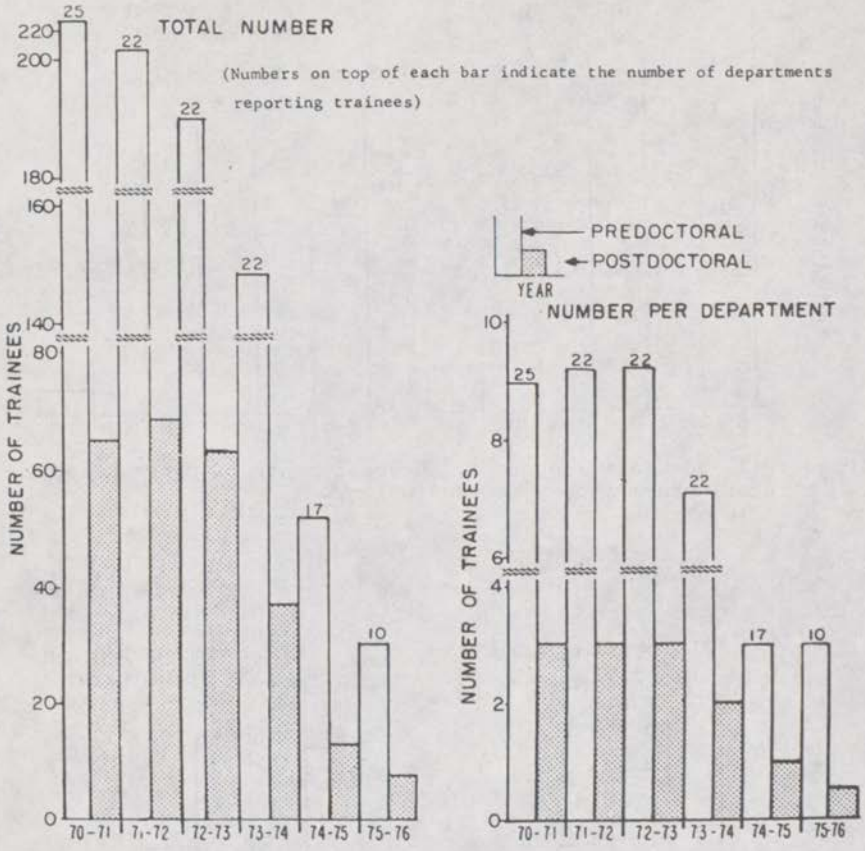


Figure 6. Number of pre-doctoral and post-doctoral trainees in 25 departments of pharmacology and toxicology.

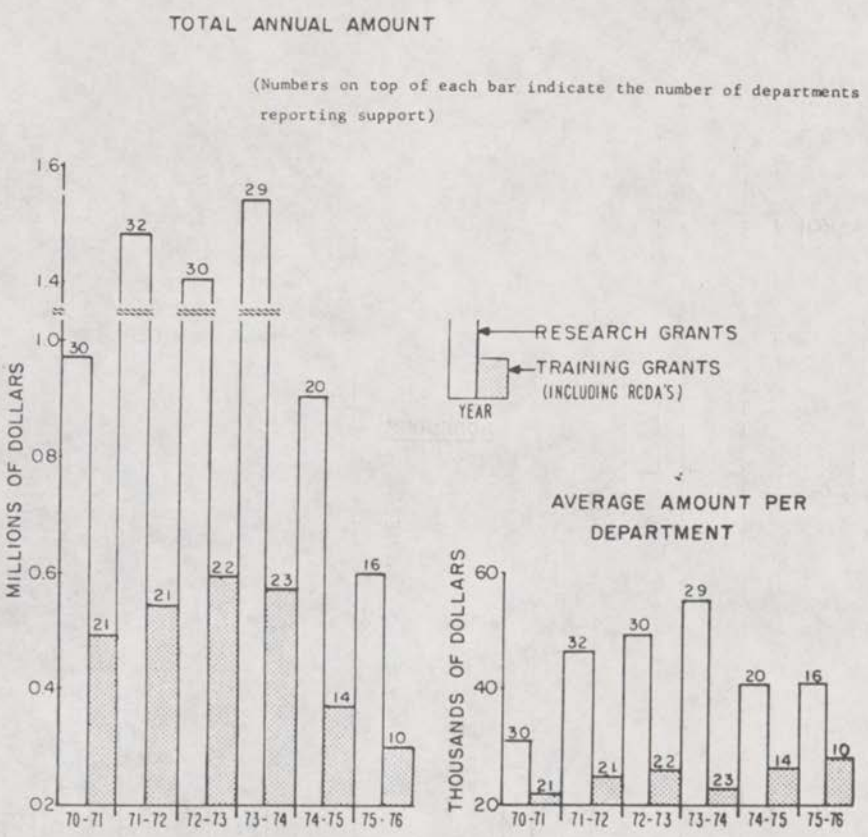


Figure 7. Faculty salary support from research and training grants in departments of pharmacology, clinical pharmacology and toxicology.

ADDENDUM

COMMITTEE CHARGES

COMMITTEE ON MANPOWER

The purpose of this committee is to identify current and future manpower needs in pharmacology, clinical pharmacology, and toxicology.

The committee is charged to seek out and identify manpower needs mandated by legislation involving environmental protection laws, consumer protection laws, requirements of the FDA in terms of drug bioavailability, safety and efficacy, the Pine Bluff toxicological operation, the Comprehensive Health Manpower Training Act of 1971 (PL-97157), drug abuse legislation and other appropriate legislation involving national health goals.

The committee is charged with determining the future needs of academia and industry. To aid in the academic survey, a questionnaire will be developed by the committee and used in conjunction with previously published surveys, e.g. from HEW and ASPET. To aid in the industrial survey, a group of industrial pharmacologists will be appointed to the committee. The function of the industrial group will be to study the demands on industry resulting from new Federal regulations and to learn how industry plans to find the skilled manpower to comply with those regulations.

The committee should determine if alternatives to phased-out programs can be developed to maintain necessary manpower in

academia, government and industry.

COMMITTEE ON EVALUATION OF GOVERNMENT ALLOCATIONS FOR BIOMEDICAL RESEARCH AND DEVELOPMENT (COMMITTEE ON GOVERNMENT ALLOCATIONS)

The purpose of this committee is to evaluate the impact of changes in government allocation of funds (1) on future research in pharmacology, clinical pharmacology and toxicology, (2) on training institutes such as medical schools and pharmacy schools.

The committee is requested to identify the role of the mission-oriented independent research grant by surveying its past accomplishments and indicating its future need especially in relationship to contract research.

The committee should identify changes in the character of medical and allied health schools as far as commitments of pharmacology departments are concerned.

The committee should find ways to demonstrate the medical economic value of research by pharmacologists and indicate how alterations in allocations of funds in research and training will affect the medical economics of the country.

COMMITTEE ON COMMUNICATIONS

This committee is charged with the long range goal of seeking ways to educate the public as to what a pharmacologist is and what the role of pharmacology is in meeting national health goals.

on the Support of Training and Research

Dear Colleague:

The American Society for Pharmacology and Experimental Therapeutics requires some hard facts to justify the continued support of training and research programs by the Federal Government. This mission is under the responsibility of the ASPET Task Force on the Support of Training and Research (STAR). These facts are needed since relevant Federal legislation explicitly mandates that they be supplied by N.I.H. or by responsible professional societies.

The Subcommittee on Manpower is charged with establishing the manpower needs in pharmacology, clinical pharmacology, and toxicology over the next decade. As part of this responsibility, the Subcommittee has designed the attached questionnaire to answer the question, "What are the characteristics of the present manpower pool in pharmacology, clinical pharmacology, and toxicology?" Its completion by you will greatly contribute to the development of the data base upon which projections can be made. Our goal is to identify the manpower pool through direct individual contact.

If you know of anyone who fits the descriptions below, please direct any extra questionnaire forms to that person or communicate with the addressee on page 4.

Definitions: (adapted from The Pharmacologist)

A Pharmacologist holds a doctoral degree in pharmacology or closely-allied health-oriented field, including the fields of medicine, dentistry, or veterinary medicine. He studies the actions of chemical agents which may or may not have immediate relevance to maintaining or restoring health. His experimental preparations are chosen as models of situations in which the agents might have therapeutic use.

A Clinical Pharmacologist holds a doctoral degree in medicine, dentistry, veterinary medicine, or pharmaceutical science. He studies agents which have immediate relevance to maintenance or restoration of health. His studies are carried out in man or animal species in which the agents may be used.

The Toxicologist has received training similar to the pharmacologist's and holds similar academic degrees. He studies chemical agents which present a hazard to life. His experimental preparations are usually those which permit establishing conditions of safe, or hazardous, exposure to the agents.

QUESTIONNAIRE

DIRECTIONS: After questions #1-3, enter all answers in right-hand column.

1. Name: _____
   (Please Print) Last First Middle

2. Social Security Number: _ _ _ _ _ _ _ _ _
   1 2 3 4 5 6 7 8 9

3. Business Address: _____

4. Year of birth ..... 19 __ __ (11 12)

5. Sex (please circle) ..... 1 (M) 2 (F) (13)

6. Are you in one of the following ethnic minority groups? ..... (14)

   1 American Asian
   2 American Black
   3 American Indian
   4 Mainland Puerto Rican
   5 Mexican-American
   6 No

7. Degree(s) (Post-baccalaureate): (15)

   1 PhD
   2 MD
   3 DDS or DMD
   4 DVM
   5 MS
   6 Other (please specify): _____ (16) (17)

8. a. Latest Degree (use code from #7) ..... (18)

   b. Year of award of latest degree ..... 19 __ __ (19 20)

   c. University awarding latest degree: _____ (21 22)

   d. College or Division in University: _____ (23 24)

9. If holder of an MS or Ph.D., please specify discipline of highest degree ..... (25)

   1 Biochemistry
   2 Biology
   3 Chemistry (other than biochemistry)
   4 Pharmaceutical Sciences
   5 Pharmacology
   6 Physiology
   7 Psychology
   8 Toxicology
   9 Other (please specify): _____

10. Year of first full-time employment in Pharmacology or Toxicology following receipt of your last degree: ..... 19 __ __ (26 27)

53-100 O - 75 - 23

11. Present primary employer category (check one only) 28 29

Academic		Other	
01	Medical School	11	Non-profit Research Institute
02	Dental School	12	Pharmaceutical Industry
03	Pharmacy School	13	Chemistry Industry
04	Veterinary School	14	Consultant Organization
05	School of Public Health	15	Other industry (please specify) _____
06	University (non-health related)	16	Private Employment
07	Other _____	17	Hospital or patient-care facility
Government		18	Retired
08	Federal	19	Unemployed
09	State		
10	Local		

12. Which of the following functions best categorize your current primary work activities? (Rank from 1 up to 4, with 1 as highest priority).

	Pharmacol.	Clin. Pharmacol.	Toxicol.	Other	Rank
Teaching:	01	02	03	04	(1) 30 31
Research & Development:	05	06	07	08	(2) 32 33
Administration:	09	10	11	12	(3) 34 35
Patient Care:	13				(4) 36 37

13. Have you had formal post-doctoral training in:

1 Pharmacology
2 Clinical Pharmacology
3 Toxicology
4 Other
5 No formal post-doctoral training

38
39
40

14. In which of the following selected areas do you have special competence in Research? in Teaching? (indicate up to 3).

01	Biochemical Pharmacology	08	Immunopharmacology
02	Cancer Chemotherapy	09	Neuropharmacology
03	Cardio-vascular Pharmacology	10	Pharmacogenetics
04	Developmental Pharmacology	11	Pharmacokinetics
05	Drug Abuse	12	Psychopharmacology
06	Endocrine Pharmacology	13	None
07	Environmental Pharmacology		

Research
41 42
43 44
45 46
Teaching
47 48
49 50
51 52

15. In which of the selected areas in question # 14 are you directly contributing to the training of graduate students? (indicate up to 3).

53 54
55 56
57 58

16. Did you receive any Federal stipend or tuition support during your pre-doctoral training? (Other than G.I. Bill) .....

1 Yes
2 No
3 Don't Know

59

17. Did you receive any Federal stipend or tuition support during your post-doctoral training? (Other than G.I. Bill) .....

1 Yes
2 No
3 Don't Know

60

18. If your answers to items 16 and/or 17 are yes, please indicate source(s) of Federal Support:

1 Special Fellowship
2 Research Grant
3 Training Grant
4 Other (Please specify): _____

Pre-doctoral

61 62
63 64

Post-doctoral

65 66
67 68

19. Please check membership in following professional societies: (indicate up to 3).

01 Acad. of Pharmaceut. Sci.
02 Amer. Acad. of Clin. Toxicol.
03 Amer. Assoc. of Immunologists
04 Amer. Coll. of Clin. Pharmacol.
05 Amer. Coll. of Neuropsychopharmacol.
06 Amer. Physiological Soc.
07 Amer. Soc. for Clin. Invest.
08 Amer. Soc. for Pharmacol. & Experimental Therapeutics
09 Amer. Soc. of Anesthesiology
10 Amer. Soc. of Bio. Chem.
11 Amer. Soc. of Clin. Pharmacol. & Therap.
12 Amer. Psychol. Sor.
13 Environmental Mutagen Soc.
14 Amer. Chem. Soc.
15 Soc. for Neurosciences
16 Soc. of Neuropharmacol.
17 Soc. of Toxicology
18 None
19 Other (please specify): _____

69 70
71 72
73 74

PLEASE RETURN THIS QUESTIONNAIRE TO:

George A. Condouris, Ph.D.
Chairman, Department of Pharmacology
College of Medicine & Dentistry of N.J.
New Jersey Medical School
100 Bergen Street
Newark, New Jersey 07103

COMMITTEE MEMBERS:

Dr. Sidney Archer
Dr. Amir Askari
Dr. Daniel L. Azarnoff
Dr. Karl Beyer
Dr. Eugene Greenblatt
Dr. Tom S. Miya
Dr. Walter F. Riker
Dr. Frank Standaert
Dr. Irving Tabachnick
Dr. Marion E. Webster

PART I – QUESTIONNAIRE

Pharmacology is one of the branches of science of which the meaning and scope is not well understood by the average citizen. Although the use and abuse of drugs has become a prevalent occupation, widely publicized, and everyone is aware of the socio-economic impact of such behavior, the scientist who understands most about drugs is himself not clearly known by name. For example, many citizens (non-scientist) believe that the term pharmacist and pharmacologist are one and the same. This lack of communicationbetween pharmacology and the public has lately led to the various financial difficulties in academia, and to misconceptions in the public and Congress. Therefore, it is planned to compile a computerized collection of all data available about scientist who work in any branch of pharmacology. This data could provide the right manpower when needed for requests by high schools and community colleges for speeches pertinent to pharmacology or for short structured courses, respectively. When Congress needs information, the computerized data could provide the necessary manpower information. When a science writer wants to verify information or a concept and needs clarification for his publication, the data could be consulted.

We hope that this central collection will be housed by the ASPET offices at 9650 Rockville Pike, Bethesda, Maryland 20014. Most important, we hope that this central collection will provide the missing link between our science and the layman.

We need your cooperation and help in completing the attached questionnaire carefully and as complete as possible. In addition, we do need your suggestions on how it might be used.

SUBCOMMITTEE ON COMMUNICATIONS:

Dr. Victor H. Cohn
George Washington University School of Medicine

Dr. Gertrude D. Maengwyn-Davies
Georgetown University School of Medicine

Dr. Nguyen Thoa
National Institutes of Health

Dr. Fred E. Hahn
Walter Reed Army Medical Center

Dr. William L. West, Chairman
Howard University College of Medicine

Name _____

Address _____

City _____ State _____ Zip Code _____

Place of Employment _____

USE OF CODE NUMBERS TO ANSWER QUESTIONS WHERE INDICATED:

1. Place of employment (use code) ☐☐☐
2. Title of position _____
3. Geographic location of employment (use zip code) ☐☐☐☐☐
4. Degrees earned (use code) ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐
5. Members in national scientific societies (write in 3)

_____

_____

_____

6. Areas of competence – Teaching (write in 3 from the code list)

☐☐☐ ☐☐☐ ☐☐☐

7. Areas of competence – Research (write in 3 from the code list)

☐☐☐ ☐☐☐ ☐☐☐

8. Indicate if your research is disease oriented.

☐ 1 – YES; 2 – NO

_____

_____

_____

_____

_____

INDICATE MAJOR AREAS OF RESPONSIBILITY

		1 – YES	2 – NO
9.	Teaching	☐	
10.	Basic research	☐	
11.	Applied research	☐	
12.	Clinical	☐	
13.	Administration	☐	

14. Suggest additional uses for a registry:

_____

_____

_____

_____

_____

LIST OF CODES

PLACE OF EMPLOYMENT

100 Dental School
101 Government
102 Hospital
103 Industry
104 Medical School
105 Osteopathic School
106 Pharmacy School
107 Research Institute
108 Veterinary School
109 Other _____

DEGREES EARNED

110 B.A. or B.S. degree
111 B.S. degree in Pharmacy
112 D.V.Sc. degree
113 M.S. or M.A. degree
114 M.D. degree
115 Pharm. D. degree
116 Ph.D. degree
117 Other _____

TEACHING AND RESEARCH (Areas of Competence)

200 Adrenergics
201 Analgesics, Narcotics
202 Analgesics, Non-narcotics
203 Anesthetics (general)
204 Anesthetics (local)
205 Anorexigenics
206 Antihypertensives
207 Anti-inflammatory
208 Autonomics
209 Antifertility
210 Behavioral Pharmacology
211 Biochemical Pharmacology
212 Biotransformations
213 Blood
214 Cancer
215 Cardiovascular Pharmacology
216 CNS Pharmacology
217 Chemical Mediators
218 Chemotherapy
219 Cholinergics
220 Developmental Pharmacology
221 Drug Abuse
222 Drug Interactions
223 Endocrinology
224 Environmental Pharmacology
225 Forensics
226 Gastrointestinal
227 Hypertension
228 Immunopharmacology
229 Inflammation
230 Lipids
231 Medicinal Chemistry
232 Neurochemistry
233 Neuromuscular
234 Pharmaceutical Chemistry
235 Pharmacokinetics
236 Placental Pharmacology
237 Polypeptide Pharmacology
238 Psychopharmacology
239 Pulmonary-Respiratory
240 Renal Pharmacology
241 Reproductive Pharmacology
242 Toxicology
243 OTHER (Write in)

_____

_____

_____

_____

(over)

PART II -- QUESTIONNAIRE

Although drugs have almost become a part of daily existence for many, there is little opportunity to learn reliably about these substances or the principles governing their activities. Some universities have introduced an undergraduate course to provide such information about drug abuse, antifertility drugs, psychotherapeutic agents, environmental chemicals, antibiotics, over-the-counter drug preparations (OTC preparations), or to introduce the basic tenets of pharmacology.

DIRECTIONS: Answer the following questions with (1) YES; or (2) NO.

1. Are you currently teaching pharmacology at the:
   - ☐ a. high school level
   - ☐ b. community college level
   - ☐ c. college level
   - ☐ d. general community level
2. Do you think there is a need for an undergraduate course in Pharmacology and/or Toxicology for majors in:
   - ☐ a. science
   - ☐ b. education
   - ☐ c. social science
   - ☐ d. liberal arts
3. Would you participate in organizing and teaching such an undergraduate course? ☐

MAIL COMPLETED QUESTIONNAIRE TO:

Dr. William L. West
Department of Pharmacology
Howard University College of Medicine
Washington, D. C. 20001

Space for additional information:

PART III – QUESTIONNAIRE

Some universities are now considering an extension of undergraduate teaching of pharmacology to a Bachelor of Science (B.Sc.) in Pharmacology. Students graduating from such a major could be prime candidates for graduate studies in pharmacology. They could serve as skilled and knowledgeable research assistants in industry or other research laboratories. They might be involved as drug education specialist in public schools or community colleges.

DIRECTIONS: Answer the following questings with (1) YES; (2) NO.

1. Do you think there is a need for a Bachelor's degree with a major in pharmacology or toxicology? ☐
2. Would you aid in the teaching of courses related to this Bachelor of Science degree? ☐
3. Do you currently have a B.S. degree Program in Pharmacology or Toxicology? ☐
4. Please give a brief description of your B.S. degree Program.

_____

_____

_____

_____

_____

_____

SURVEY OF THE STATUS OF SUPPORT FOR TRAINING AND RESEARCH IN PHARMACOLOGY, CLINICAL PHARMACOLOGY, AND TOXICOLOGY

A questionnaire on behalf of the Committee on Government Allocations, Task Force in Support of Training and Research, American Society for Pharmacology and Experimental Therapeutics.

The intent of this questionnaire is to obtain data on the three major divisions shown in the title. Please indicate the one(s) to which your answers apply:

Pharmacology _____ Clinical Pharmacology _____ Toxicology _____

If you do not have administrative jurisdiction over all three divisions we would appreciate your xeroxing the requisite number of copies of the questionnaire and turning it (them) over to the appropriate individual(s) in your institution with the request that they fill in a questionnaire and return it to the Committee.

1. What was the level of research grant support[1] in your department or division for the following periods[2]?

Federal		Non-Federal	
1970-71:	$_____	1970-71:	$_____
1971-72:	$_____	1971-72:	$_____
1972-73:	$_____	1972-73:	$_____

2. What is the level of research grant support committed to your department or division for the following periods:

Federal		Non-Federal	
1973-74:	$_____	1973-74:	$_____
1974-75:	$_____	1974-75:	$_____
1975-76:	$_____	1975-76:	$_____

[1]Include both direct and indirect costs.

[2]Most institution's fiscal year begins on July 1 or September 1. If yours should happen to fall on January 1, insert the figures for the year 1970 in the blank for 1969-70, for the year 1971 in the blank for 1970-71, etc.

3. What was the level of research contract support in your department or division for the following periods?

Federal		Non-Federal	
1970-71:	$_____	1970-71:	$_____
1971-72:	$_____	1971-72:	$_____
1972-73:	$_____	1972-73:	$_____

4. What is the level of research contract support committed to your department or division for the following periods?

Federal		Non-Federal	
1973-74:	$_____	1973-74:	$_____
1974-75:	$_____	1974-75:	$_____
1975-76:	$_____	1975-76:	$_____

5. What was the level of research grant support pending in your department or division as of July 1, 1973?

Federal		Non-Federal	
1973-74:	$_____	1973-74:	$_____
1974-75:	$_____	1974-75:	$_____
1975-76:	$_____	1975-76:	$_____

6. What is the level of research grant support approved, but not funded in your department or division since July 1, 1972?

Federal		Non-Federal	
1972-73:	$_____	1972-73:	$_____
1973-74:	$_____	1973-74:	$_____
1974-75:	$_____	1974-75:	$_____
1975-76:	$_____	1975-76:	$_____

7. What was the level of federal training grant support in your department or division for the following periods?

	Dollars	No. Predoctorals	No. Postdoctorals
1970-71:	$_____	_____	_____
1971-72:	$_____	_____	_____
1972-73:	$_____	_____	_____

8. What is the level of federal training grant support committed to your department or division for the following periods?

	Dollars	No. Predoctorals	No. Postdoctorals
1973-74:	$_____	_____	_____
1974-75:	$_____	_____	_____
1975-76:	$_____	_____	_____

9. What was the level of faculty salary[3] support in your department or division derived from federal training (include RCDA's) or research grant support for the following periods:

	Dollars	No. Positions	Fraction[4]
1970-71:	$_____	_____	_____
1971-72:	$_____	_____	_____
1972-73:	$_____	_____	_____

10. What is the level of faculty salary support committed to your department or division from federal training (include RCDA's) or research grant support for the following periods?

	Dollars	No. Positions	Fraction[4]
1973-74:	$_____	_____	_____
1974-75:	$_____	_____	_____
1975-76:	$_____	_____	_____

[3] Include fringe benefits paid by the institution.

[4] This item requests the fraction of faculty salary support derived from these grant sources *vis-a-vis* total faculty salary support (i.e., dollars from the grants/total dollars).

11. Please give us any other information you think would be of help to the Committee in assessing the impact of changes in government allocation of funds on training and research in your department or division (use additional sheets if necessary).

_____

_____

_____

12. What increases or decreases have occurred in your institution's support of your department or division for the following periods? [Indicate a decrease by putting the figures in parentheses].

	Dollars	No. Faculty Positions	Space	Other (Specify)
1970-71:	____%	____%	____%	____% _____
1971-72:	____%	____%	____%	____% _____
1972-73:	____%	____%	____%	____% _____

13. What increases or decreases in responsibilities were required from your department or division with respect to the changes in support shown in 12?

	Teaching Load						
	No. of Students	No. of Courses	No. of Hours	Research	Service	Other (Specify)	
1970-71	____%	____%	____%	____%	____%	____%	_____
1971-72	____%	____%	____%	____%	____%	____%	_____
1972-73:	____%	____%	____%	____%	____%	____%	_____

14. What increases or decreases in your institutions' support of your department or division are firmly committed for the following periods?

	Dollars	No. Faculty Positions	Space	Other (Specify
1973-74	____%	____%	____%	____% _____
1974-75:	____%	____%	____%	____% _____
1975-76:	____%	____%	____%	____% _____

15. What increases or decreases in responsibilities will be required from your department or division with respec to the changes in support shown in 14?

	Teaching Load					
	No. of Students	No. of Courses	No. of Hours	Research	Service	Other (Specify)
1973-74	___ %	___ %	___ %	___ %	___ %	___ % ___
1974-75	___ %	___ %	___ %	___ %	___ %	___ % ___
1975-76:	___ %	___ %	___ %	___ %	___ %	___ % ___

16. What increases or decreases in responsiblities for your department or division have occurred during the following periods unaccompanied by changes in support?

	Teaching Load					
	No. of Students	No. of Courses	No. of Hours	Research	Service	Other (Specify)
1970-71:	___ %	___ %	___ %	___ %	___ %	___ % ___
1971-72:	___ %	___ %	___ %	___ %	___ %	___ % ___
1972-73:	___ %	___ %	___ %	___ %	___ %	___ % ___

17. What increases or decreases in responsibilities for your department or division will surely occur during the following periods unaccompanied by changes in support:

	Teaching Load					
	No. of STudents	No. of Courses	No. of Hours	Research	Service	Other (Specify)
1973-74:	___ %	___ %	___ %	___ %	___ %	___ % ___
1974-75:	___ %	___ %	___ %	___ %	___ %	___ % ___
1975-76:	___ %	___ %	___ %	___ %	___ %	___ % ___

18. Please give us any other information you think would be of help to the Committee in assessing the changes in the character of your institution as far as commitments to your department or division are concerned (use additional sheets if necessary)

If you do not have time or the inclination to complete items 19 and 20 at once, please remove the last page of the questionnaire for future use and return the first 18 items immediately to: Dr. James A. Bain, Division of Basic Health Sciences, Emory University, Atlanta, Georgia 30322

Respondent (optional): Name: _____ title: _____

Institution: _____

Address: _____

_____

This is a continuation of a questionnaire surveying the status of support for training and research in pharmacology, clinical pharmacology, and toxicology on behalf of the Committee on Government Allocations of the Task Force in Support of Training and Research, American Society for Pharmacology and Experimental Therapeutics.

Do not delay the return of the first 18 items of the questionnaire in order to finish items 19 and 20.

19. What information or ideas do you have which would be of help to the Committee in identifying the past accomplishments of the mission-oriented, independent research grant and in determining the need for future support through this mechanism? How does this type of support compare to contract support?

20. How can we demonstrate specifically the medical economic value of research by pharmacologists and toxicologists? Do you have specific, documented figures in this regard? How would alterations in the allocations of funds to research and training affect the medical economics of the country? Again, do you have any ideas as to how such effects could be documented?

Please utilize your own format in replying to the above and send your replies to:

Dr. James A. Bain
Division of Basic Health Sciences
Emory University
Atlanta, Georgia 30322

Respondent (Optional): Name: _____

Title: _____

Institution: _____

Address: _____

_____

REFERENCES

(1) Pelikan, E. W. (1972) Projections of Manpower Needs and Resources in Pharmacology. The Pharmacologist, 14: 38.

(2) Doctorates Conferred in Fields of Primary Concern to N.I.H.: Fiscal Years 1962-1972.

(3) U. S. Senate Report 93-381; Committee on Labor and Public Welfare, 1973.

(4) Report of the Subcommittee on Communications STAR Task Force, American Society for Pharmacology and Experimental Therapeutics. 1974.

(5) Report of the Subcommittee on Manpower STAR Task Force, American Society for Pharmacology and Experimental Therapeutics, 1974.

(6) Doctorates Awarded from 1920-1971 by Subfield of Doctorates, Sex and Decade; Report of the National Research Council. National Academy of Sciences, March, 1973.

(7) 1970 Experiences, Civilian Labor Force; Bureau of Census, National Science Foundation.

Mr. FLOOD. Thank you, Doctor.

Dr. CURTIS. Mr. Flood and members of the committee: It is a privilege to appear before this distinguished committee. Although I am a member of the American Physiological Society and a faculty member of the University of Illinois, my role today is that of a citizen witness. I would like to speak specifically about the general research support grant program.

Before I do I would like to second the suggestion that the research training programs are very important.

Mr. Michael mentioned the brick and mortar aspect of the Peoria School of Medicine. We also have a rather significant problem in terms of attracting and bringing to Peoria a faculty of people who are highly trained, both in medicine and in research, and most of them have come out in the past of programs just like this.

His legislative assistant earlier asked me, "Why don't you build more medical schools." One of the reasons is that there isn't that huge number of faculty to staff them.

This program has had a long and fruitful history and has had a very significant influence on the achievements of biomedical science in this country. There is no allocation for this program in the President's 1976 budget. In testimony before this committee, Dr. Thomas Bowery, Director of Research Resources, NIH, testified "the primary objectives of the program had been obtained." I submit the objectives of this program are just as important today as they were when the enabling legislation was passed in 1960. I would like to urge you to reinstate this program as you did last year.

I will try to sketch out for you a few of the multitude of uses these funds have served over the years and why these flexible funds are very vital. It also seems appropriate to contrast this program to the categorical research grant program, and I hope to convince you that they are both necessary and complimentary. The use of GRS funds has varied from institution to institution, and I would like to describe some major use and patterns.

These funds are often turned over to a faculty committee for use as "start-up" funds for young investigators. As you are very well aware, the competition for categorical research grant funds has become much more severe in recent years, with the highest percentage of rejections going to young scientists. There are obviously many reasons for this but the lack of preliminary results on the proposed project is, no doubt, partially responsible. I, personally, have always been fortunate enough to be about 10 percent into a problem before I wrote the grant proposal.

It is a little easier if you get a little peak under the curtain as to what might happen to write a good proposal. Hence, in many institutions GRS funds enable young investigators to get the start they need to write grant proposals which are funded. At the two institutions of which I have close knowledge, Tufts University and the University of Illinois, about 80 percent of the recipients of 1 or 2 years of GRS funds went on to successfully compete for other grant funds.

B. These funds are also used to purchase large, multiuser instruments and facilities that would be hard to justify on the basis of one or two grant proposals or from educational funds. The existence of these facilities, such as electron microscopes and nuclear magnetic residence

devices, usually lead to multiple successful grant applications. Indeed, funding is often contingent on the availability of these facilities.

C. The flexibility of these funds allows their use to purchase research time for beginning investigators to keep the momentum of their training going. Many beginning investigators have to learn how to juggle the multitude of teaching, committee, counseling, and patient care responsibilities as well as research activities. The reduction of the former for a couple of years often pays large dividends in establishing a fruitiful research career. This purchase of research time has its counterpart in the partial salary support in the regular grant programs.

D. These funds also have the flexibility to allow grant supported investigators to follow up new leads which are really outside the scope of their research grants. The history of science overflows with examples of very significant discoveries coming as outgrowths of totally unrelated research. If these ideas had to be put aside to enable the full grant to be written, much time and momentum and interest would be lost.

As a previous member of a finance committee on a much smaller scale than this one, I am well aware of a possible hesitation on your part in giving unrestricted funds, but from my observations GRS funds have been very wisely used in the past. GRS funds add another dimension to the NIH research support program, which continues to be extremely important.

Thank you very much for this opportunity to testify.

Mr. FLOOD. Thank you.

Dr. CURTIS. Thank you.

HEW BUDGET FOR 1976

WITNESS

HON. CHARLES A. VANIK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. FLOOD. We now have the high honor and the great privilege of hearing from our distinguished colleague from the great State of Ohio, Mr. Charles Vanik.

Thank you, Mr. Vanik.

Mr. VANIK. Thank you, Mr. Chairman.

I am sorry I was delayed with a vote in committee and I appreciate your giving me this opportunity to testify.

Dear Mr. Chairman, members of the committee, I appreciate this opportunity to comment on the fiscal 1976 appropriation for the Department of Health, Education, and Welfare.

First, as you know, the Ways and Means Committee has now created a number of subcommittees, and I am recently chairing its Oversight Subcommittee. We are just getting staffed up. Much of our attention will be directed toward the Internal Revenue Service. But after consultations with the committee's Public Assistance and Health Subcommittee chairmen, it has been decided that we will begin to look at a number of medicare and welfare problems. I am hopeful that our studies will be helpful to the Appropriations Committee.

I want to say that I would like to work with your committee, Mr. Chairman. We will certainly endeavor to consult with you and keep you advised of inquiries into social security, medicare, and welfare areas. I hope that if you have ideas or proposals for Oversight that you would like us to undertake, that you will let us know. For too long, the Ways and Means Committee has legislated in broad areas of HEW without attempting to determine whether the programs were effective or what appropriations concerns you were encountering. I hope that in the future we can work together better.

I would like to make a number of comments concerning problems which the Oversight Subcommittee has encountered.

INCORRECT SOCIAL SECURITY NUMBERS

First, we have asked the IRS how they could get tax refunds back to people more quickly and thus hold down expenses for interest payments for late refunds. We have found that one of the major problems is that before a refund can go out, the social security number is cross-checked with Social Security. According to testimony by IRS officials, there are some 3 million incorrect social security numbers in SSA's files. Given present staffing, this amounts to a 5-year backlog in corrections. I am attempting to determine from SSA what they are doing to reduce this backlog more quickly. Not only would this insure better crediting of accounts, but it would enable the IRS to refund checks more quickly and thus hold down interest costs which in fiscal year 1976 will amount to $391 million. Additional computer personnel positions might be cost efficient.

COMPUTER EQUIPMENT

In another computer area, I am very worried about the Social Security Administration's automatic data processing capabilities. For example, the tax bill was signed into law on March 29. On May 8, the first of some 62 million rebate checks was mailed out by the IRS. The formula for this rebate was not simple. Yet when you ask Social Security how much leadtime they need to pass on a benefit increase, they insist they need 2 to 3 months to prepare their computers. As you know, there has been a GAO report indicating that the SSA is not making the best programing use of its advanced third generation computers. In essence, while SSA led in the use of computers in the Federal Government in the 1950's, it is now feeding first generation programs into third generation hardware. The result is an increasing hardening of the arteries at Social Security. They are unable to respond quickly. We are rapidly coming up to the day when we will need to overhaul their computer operations. We need to give them more attention, particularly since with sudden emergencies in our economic status it may become very, very necessary at any given moment to put some infusions in our system, and I think we should have the machinery to do it if that contingency should occur.

MEDICARE AND MEDICAID

In the area of medicare and medicaid it is commonly estimated that up to $3 billion is wasted annually through frauds and over-

billings. I would like to enter in the hearing record two letters which I have received from the Social Security Commissioner and the Social and Rehabilitation Service Administrator concerning their anti-fraud efforts.

First, in the area of medicare, I would hope that your committee would join in urging that tougher action be taken against health providers who abuse the program. For example, I asked Commissioner Cardwell if any actions had been taken under a provision of the 1972 Social Security amendments to terminate a provider or supplier of services if it is found that they have been making unnecessary or overly expensive billings. Despite the fact that this amendment was added to the law 2.5 years ago, the regulations are still not issued and are "currently under review by the Department of Health, Education, and Welfare's Office of the General Council." It is obvious that we in the Congress will have to be more demanding if these frauds and overbillings are ever to be reduced.

The letter also describes the Social Security Administration's present system of cost control and audit procedures—unfortunately, during the past 2 years, the cost of the program has been increasing at a higher percentage than the growth in the field investigative force over the past 2 years:

> The program integrity investigative resources in terms of personnel involved in actual inspection/investigation activties are as follows:
>
> | | |
> |---|---|
> | Fiscal year 1973 | 43 |
> | Fiscal year 1974 | 57 |
> | Fiscal year 1975 | 60 |
>
> Approximately 64 positions have been allocated for our investigative needs in fiscal year 1976.

I would certainly hope that the Social Security Administration's request for additional inspection and investigation activities would be supported by your committee. Indeed, I believe that millions could be saved by mandating an even larger effort against medicare frauds and overbillings.

While medicaid is no longer under Ways and Means jurisdiction, it is under yours—and I would like to mention my support for HEW's efforts to increase the level of medicaid auditors.

First, it is incredible that for the past 10 years, there has been almost no Federal staff to investigate fraud and abuse in the medicaid program. As Mr. Dwight states:

> We have been limited to one person on a part-time basis in our central office in Washington, D.C.

The situation is improving—but is still woefully inadequate. As Dwight reports:

> However, Congress has recently authorized Medical Services Administration 90 new positions; of those positions, the Commissioner of MSA has designated 11 positions with which to form a Fraud and Abuse Surveillance Branch in the Division of Program Monitoring.
>
> Our Department is resquesting in its fiscal year 1976 budget 108 positions to be filled in the 10 regional offices to organize a RO fraud unit for the surveillance and the detection of fraud and abuse in the medicaid program.

This is a minimum request, Mr. Chairman, since it would still provide only one Federal auditor and investigator per $100 million in a program which has been plagued by scandal and abuse. It would

be my hope that the Congress would support this expansion of investigative staff and even provide for additional personnel. I believe that this investment in auditors will more than pay for itself in the reduction of fraudulent and unnecessary charges to the medicaid program.

In another area, I see from the administration's budget for Assistance to Families with Dependent Children (AFDC), that the administration has submitted a budget request of nearly $4.6 billion, up a quarter billion dollars from the present fiscal year. It is to be expected that the budget would grow during a major recession. In fact, however, I believe that the budget request has been held down through unrealistic reliance on a so-called quality control program. This program, which after much postponement, comes into effect on July 1st, requires no more than a 3 percent error rate in ineligibilities and no more than a 5 percent error rate in overpayments and underpayments to eligible AFDC recipients. After July 1, 1976, the Federal Government will not pay for any welfare payments above the error rate.

Mr. Chairman, obviously we are all for eliminating errors and frauds in the welfare program. In the past, the error rate has been running at an incredible 40 percent—but it should be remembered that half these errors are the fault of the welfare agencies—not the beneficiaries.

It is also obvious that it is impossible for the States to meet the standards set by HEW. If HEW is budgeting AFDC payments on the basis of quality control goals, then those goals will not be met and they will be back asking for more money. In addition, since the goals are unrealistic, after July 1976, the burden will be thrown on the States, many of which may have to cut already low-benefit levels.

I believe that the impossibility of achieving the quality control goals—figures which seem to have been pulled out of thin air—can be seen by a careful reading of an HEW study released this March entitled, "Quality Control in AFDC."

In short, the administration's budget figures for AFDC are unrealistic. In many ways, HEW is saying that they were unable to develop adequate staff control at the Federal level, therefore they are going to put the monkey on the back of the States and penalize them for failing to do the impossible. As is so often the case, it is the poor who will suffer. I certainly hope your committee will address itself to that.

SOCIAL SECURITY DISABILITY BACKLOGS

I would also like to comment on the problem of backlogs in Social Security disability. The problem of unconscionable delays in disability determinations is one of the major "case work" problems in my Cleveland district office. At any one time my Cleveland staff is dealing with 20 or 30 cases of constituents who have been waiting for half a year or even a year or more to have their appeals heard. These are particularly difficult cases, because they involve people who are disabled, people who have no income, people who are exhausting their life's savings. It throws them temporarily on relief rolls.

I understand the Social Security Administration has asked you for an additional 76 staff positions to help reduce the disability and Social Security claims backlog. I strongly urge that you support this request.

53-100 O - 75 - 24

Frankly, however, I think that additional hearing examiners and administrative law judges are needed. For example, while the disability claims backlog has declined from 248,000 appeals as of June 30, 1974 to 196,000 at the end of this March, the Bureau of Hearings and Appeals has seen an increase in the number of backlog cases. As of June 30, 1974, they had 77,000 cases pending. At the beginning of March, 1975, there were 110,000 cases pending. The Social Security Administration says that the "rate of increase" in backlogs is declining—but I believe it is imperative that we eliminate any backlog.

Obviously, Mr. Chairman, we not only need more personnel—we need a better system of appeals. Despite the addition of black lung and SSI, there is something wrong with a system which at the end of fiscal year 1970 had 14,000 hearing requests pending but as of March 1, 1975, had a backlog of 110,418.

As you know, the Ways and Means Committee is making a major study of the entire disability appeals system. I would hope that we can enact legislation to simplify the process and cut down on these backlogs.

I want to point out, Mr. Chairman, that what I ask for and what I think would be essential to serve the people that are involved here would be to get a quick adjudication one way or another of their disability cases so that they know how to move.

In addition to a major reform of the entire system, I believe that there are steps which the Social Security Administration could take today to help reduce backlogs in certain areas of the country. For example, there are only six administrative law judges covering the Cleveland Bureau of Hearings and Appeals office. This works out to one judge for every 1 million people! For the whole State of Ohio, I understand we have only 14 law judges. The Chicago region of the Social Security Administration has approximately 65 ALJ's serving some 35 million people. Several of the judges from my area have come to me and pointed out that the Atlanta region, which serves 31 million people, has 95 administrative law judges. In short, there is a discrepancy which leads to inefficiency and economic ruin for hundreds of people in my area of the country. I would hope that your committee could order the Bureau of Hearings and Appeals to conduct a study of its workload and apportion judges on a more equitable basis, thus reducing the type of backlogs which are ruining the lives of so many of my constituents.

Again, Mr. Chairman, the Oversight Subcommittee will look forward to working with you. I hope that some of the comments I have made today will be helpful to your committee in its work.

Thank you very much.

Mr. FLOOD. Thank you.

As always, you are very helpful, of course.

Thank you very much.

Mr. VANIK. Thank you.

WITNESSES

DR. JAMES J. GALLAGHER, DIRECTOR, FRANK PORTER GRAHAM CHILD DEVELOPMENT CENTER, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, N.C.

DR. RICHARD SCHIEFELBUSCH, DIRECTOR, BUREAU OF CHILD RESEARCH; DIRECTOR, CENTER FOR RESEARCH IN HUMAN DEVELOPMENT, UNIVERSITY OF KANSAS, LAWRENCE, KANS.

Mr. FLOOD. Dr. Gallagher, University of North Carolina.

Dr. GALLAGHER. Thank you very much, Mr. Chairman.

I am accompanied today by Dr. Richard Schiefelbusch, who is the Director of the Center for Research in Human Development at the University of Kansas.

I am also pleased to note that in the hearing room are Mr. Paul Marchand, who is representing the National Association for Retarded Citizens, who recognizes the importance and value of long-range research and training, and Mr. Robert MacNeill, who represents the University of Affiliated Facilities for Mental Retardation.

Mr. Chairman, I have submitted a statement for the record but what I would like to do would be informally raise a couple of issues with the help of Dr. Schiefelbusch that are of particular importance to us.

We are particularly concerned with the NICHHD appropriation request for fiscal 1976. I know the chairman is very familiar with the problems of mental retardation and the long history of support that this committee has given to these efforts so I am not going to go into that.

I would point out that there is a new event occurring in the country today which is of major consequence.

That is the resort to the courts of parents of retarded children, so that there are over 20 States in the country, including Pennsylvania and Illinois, that are either under lawsuits or threatened with lawsuits regarding equal educational opportunity for mentally retarded children.

This has brought forth a nationwide swing to normalize the life of the mentally retarded child, the mentally retarded adult.

What that means is bringing the adult out of the institutions and into the community. It means bringing the retarded children out of the special class programs and into the regular class with only some support backup for the regular teacher.

We are embarked, in short, on a major social change with regard to the life span of the retarded child and retarded adult. At the same time that we are engaged in this and the great increase in resources that are being required for the States, one measure of this effort is Senator Mathias last year proposed over a half billion dollars should

go to the States to support them in providing these additional resources.

At the same time, the support programs that can provide and assure quality programs for these children and adults are being reduced or cut. If you think about the program for mentally retarded youngsters in two parts, one is a direct service, the service given by the teacher, pediatrician, the nurse, and so forth.

Then there is the other part and that is the part that guarantees quality service, that is, research programs to find new techniques and methods for solving the problem, training programs to make sure that better trained people get out there, demonstration programs to make sure that exemplary practices get well broadcast so that we can have improvements.

Then we have, on one hand, the direct service program; on the other hand, the support program. While there is great pressure to expand and elaborate on the direct service programs, the programs for the support, the research, the training, and the demonstrations are not being funded as well and, as a matter of fact, in some cases are being cut back. That is what we want to talk to you about today.

The mental retardation centers are a unique organization in the sense that they bring together a wide variety of specialties and specialists to deal with this complex problem.

A mentally retarded individual to the biochemist looks like a problem in biochemical system. To the neurologist it looks like a problem of the central nervous system. To the psychologist it looks like a problem in learning. To the sociologist it looks like a problem of adapting to the community, the individual problem of adapting to the community.

They are all like the blind man trying to find out about the elephant. Unless they communicate with one another, unless they work together with one another, the total portrait of what this person really is all about is never going to be understood or known.

It is the virtue of the mental retardation centers that they bring together staff from all of these kinds of disciplines to work together on this specific problem and, further, to do it in a collaborative research project so that six or seven projects are done on a common issue and common problem, and I would like Dr. Schiefelbusch to just comment on one of the areas at the University of Kansas that Mr. Shriver is quite familiar with.

Dr. SCHIEFELBUSCH. We, of course, have a program there that corresponds to one of the centers. We have located our work, however, at the medical school at the university and at one of our resident locations, residence then for retarded children.

What we are trying to do is to identify the areas that we think will be particularly difficult for society to manage in accommodating this flood of new people from the institutions or from resident centers in community locations and to provide a way to actually do this job better. This, I think, is a new sort of venture for some kinds of research specialists. It is a new venture for a university and a medical school to assume such kinds of responsibility, but I think this is what we must do because otherwise we are going to lose confidence at the community level or in the heart of society to do this job.

We have the national point of view, the philosophy. Society is demonstrating a lot of idealism about it, but the scientists and the specialists have really got to demonstrate it can be done, and the danger is that we will give up on it before we get it done.

So I think what Jim is proposing is literally that the center should at this point take a new lease on their effort and expand into this kind of an area to identify and develop methodology.

I think it can be done. We have the technology moving in this direction, but there must be funds to enable some new projects to be submitted in the coming year or two.

The danger is right now the support agency doesn't have the moneys to fund or to welcome these additional applications.

Dr. GALLAGHER. One of the things we are working on at the University of North Carolina is, can we prevent mental retardation that is caused by environmental condition. To do that we have a team of pediatricians, experimental psychologists, family specialists, and educators, and they are all working on the same group of children whom we are trying, in effect, to work with during their preschool years so that we can keep the forces which drive these youngsters and their families into these unfortunate developmental positions from happening.

The pediatrician looks at the effect of chronic illness on the development of intelligence. The family specialist is interested in the early motivation for learning of young children. The educator is building special learning sequences for a youngster so he can develop more effectively.

The psychologist is interested in how do you stimulate language development at an early age. All of these people are working together with one group of children so that all of the results then can be coordinated and they will understand a great deal more about this total elephant that we call mental retardation.

We have other centers and we have a long list of the cooperative and coordinated research efforts which are going on at the other centers. Our problem is that the proposed funding for 1976 as revealed to us by NICHHD that would be spent on research programs of this sort will be dropped from $14.5 million to slightly over $13 million in fiscal 1976. That together with the effects of inflation will curtail effectively the kind of collaborative research program that we are describing. It will be unlikely that they can even start any new programs, while the staff of the agency itself in our own knowledge about the center suggest that as many as six of these collaborative program projects would be scientific approvable and could make a substantial impact on these complex problems.

Mr. FLOOD. Thank you, Doctor.

Dr. GALLAGHER. What we are asking for is an increase of $3.5 million over fiscal 1975. That is a very small sum of money but we think that it would result in major benefits to the field of mental retardation.

Mr. FLOOD. Thank you.

Dr. GALLAGHER. Thank you.

[The statement follows:]

TESTIMONY OF DR. JAMES J. GALLAGHER, DIRECTOR OF THE FRANK PORTER GRAHAM CHILD DEVELOPMENT CENTER OF THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, N.C., AND DR. RICHARD SCHIEFELBUSCH, DIRECTOR, BUREAU OF CHILD RESEARCH AND DIRECTOR, CENTER FOR RESEARCH IN HUMAN DEVELOPMENT, UNIVERSITY OF KANSES, LAWRENCE, KANS., REPRESENTING THE MENTAL RETARDATION CENTER DIRECTORS GROUP

I am most grateful to have the opportunity to appear before the Subcommittee on Appropriations as a representative and chairman of the Mental Retardation Centers Group and present the case for increased support of NICHHD's child health program and, in particular, the mental retardation program. It is also encouraging to have the support of consumer organizations such as the National Association for Retarded Citizens who know the long-range value of research and training. There are 12 major mental retardation centers across the country that were activated in 1965–70 by a national effort started by Congress in 1963 in passing Public Law 88–164 to meet the problems of the mentally retarded. It was one of the first, and remains one of the best efforts, to focus attention and resources on a major social problem in this country. It has been effective because of the consistent support that Congress has provided over a decade of ebbs and flows of other priorities.

Mental retardation is not a disorder. It affects two to three out of every 100 persons in the United States or, by a conservative estimate, over 4 million of our citizens. In the past 2 or 3 years a dramatic change has taken place in our approach and judgment as to what is best for mentally retarded children and adults. There has been a nationwide swing to attempt to "normalize" the lives of mentally retarded individuals. This means bringing retarded adults out of the institutions into the community, bringing retarded children out of the special education classrooms and into the regular classroom program with special support help. Unless these major social changes are accompanied by or guided by accumulated wisdom applied by well-trained persons, then we will have once again embarked on a hasty and poorly conceived effort that is sure to result in less than what we would wish.

There is an old Pennsylvania Dutch slogan, "We get too soon old and too late smart," but one wonders how many times we must embark on these hasty, frantic, and ill-conceived efforts at reform before we understand what is necessary for effective change.

It is useful to consider programs resources for mental retardation, or any other problem areas, to be divided into two major parts. The first part involves support for the direct delivery of services to those in need, through the teacher, pediatrician, therapist, nurse, et cetera. The second part includes these support services that make likely high quality of service delivery. These activities would be research programs such as carried out in the mental retardation centers, or the multidisciplinary training program carrying on under the university affiliated facilities in the maternal and child health programs, or it could be the teacher training efforts and demonstrations programs funded by the Bureau of Education for the Handicapped in the U.S. Office of Education.

These support services, although crucial to the quality of services, are often poorly funded because they have neither the glamor nor the immediate urgency as does the direct services. In problem area after problem area, we have found it relatively easy to obtain service money because it so obviously fills an urgent need, but we have found it very difficult to fund those support efforts that can make the service delivery worthwhile.

The States now invest over $1 billion a year on special education programs for retarded children and a like sum of money is invested in medical and social service care, but when the mental retardation centers ask for $3 million more or the university affiliated facilities ask for more training money, or the Bureau of Education for the Handicapped asks for more demonstration programs for preschool handicapped children, we find these relatively small amounts much harder to obtain. This is true even when, as pointed out, there are major reforms and significant changes taking place in the service delivery program.

One of the reasons for this, of course, is that these various support programs are funded by different agencies with different leadership and different priorities, and it is difficult for one problem area to have sufficient priority in all of these agencies to get the necessary resources to do a quality job.

The mental retardation centers provide a unique set of laboratories and supporting facilities to bring to bear the knowledge and skills of many different

professional disciplines on the complex causes and treatment of this condition. The mentally retarded child's problems are multiple and extend beyond the skills or knowledge of any individual professional or profession.

The mentally retarded individual looked at from one standpoint is a complex biochemical systems problems, from another, a breakdown of central nervous system operation, from still another the inability to master cognitive learning, and from yet another, the inability to adapt to one's social surroundings and environment. In each of these situations, the scientists are akin to the blind men feeling the elephant; they each grasp a portion of the truth, but unless they collaborate and share their knowledge with one another, they will have an incomplete picture of the mentally retarded child and adult.

One great advantage of the mental retardation centers is that they allow a community of scholars and scientists from wide backgrounds to share their knowledge to draw a better picture of this elephant, this puzzling condition of mental retardation.

One important strategy used by the mental retardation centers is the collaborative research effort that allows a variety of scientists to work on a similar problem area but from different perspectives and gain greater understanding and insight, than if each were to work on the problems separately.

One example of such collaborative research is being carried out at the University of North Carolina. In this study, six separate research projects are being conducted on the same population of potentially retarded infants and preschool children. Included in the research team are pediatricians, experimental psychologists, family specialists, and educators. For the pediatrician, it is an opportunity to study the effect of physical illness on learning, and thus link biological and psychological development.

For the family specialist, it is the early emergence of motivation for learning, and the factors that relate to that, that is important. For the educator it is a chance to encourage the early vocalization of the youngsters as part of stimulation of language. All of these results will be richer as a collection of studies rather than an individual study because the results of all will be shared with the team. In this way we expect to get a much more effective study of the whole elephant of mental retardation.

At the Joseph P. Kennedy, Jr., Mental Retardation Center at the University of Chicago a group of investigator have found that abnormal metabolism of carbohydrate substances, acid mucopolysaccharides, is linked to severe mental retardation. These discoveries have led to better diagnosic techniques, including the use of amniocentesis, the device of drawing fluid from the uterus of a pregnant woman to test for possible genetic problems. This has led to a more effective genetic counseling, and for clinical scientists to develop treatment programs for such cases. The interaction of biochemists, geneticists, and pediatric specialists through this program project is generating new insights and solutions to problems that would be unlikely in the single research project approach.

A team of researchers at the University of Kansas is exploring the transmission of essential substances from the mother to the embryo. We are aware that many substances within the mother pass to the embryo, sometimes with tragic consequences ending in mental retardation. It is especially important when the mother is under drug therapy for other disorders to know what is transmitted and what is not. We need to understand the nature of the transmission, the axoplasmic transport, and the result of the failure to deliver these substances at the right place and at the right time. To answer these difficult questions a team of biochemists working with specialists in histology and electromicroscopy are collaborating with clinicians to find answers to these basic issues of communication across the nervous system.

A team of social scientists at the John F. Kennedy Center at George Peabody College are continuing to investigate ways in which mental retardation caused by environmental conditions can be modified or eliminated. A team of scientists have developed and evaluated a parent training program that has been found to be most effective and is applied in the home of the child. An encouraging part of this work is that help can be delivered by less than professionally trained persons, home visitors, under supervision and that the effects of parent training carry over to siblings as well as the children directly concerned.

Teams of scientists at the mental retardation center at the Neuropsychiatric Institute at the University of California at Los Angeles have screened, through blood samples, large populations of citizens in southern California. The team approach allows them to analyze, diagnose, and give genetic counseling, if ap-

propriate in those citizens who show characteristics that could lead to genetically caused disabilities.

It is because we are committed to this collaborative multidisciplinary research effort that we are most disturbed to find from NICHHD that the projected funds to be spent in the mental retardation program will drop from $14.5 million to $13.1 million in fiscal 1976. This will result in severe curtailment in precisely the type of collaborative program projects that is one of the unique contributions of the mental retardation centers. With only the funds that the administration currently plans to spend in this area there will be little if any money available for new starts, for new program projects to come into being. The staff of the agency estimates that some six program projects, likely to be scientifically approvable, could be estimated to emerge from the mental retardation centers program this year if any knd of encouragement and support were available. It is a great irony that in this field so much could be purchased for so little.

Last year the Congress urged NICHHD to invest $16 million in approved research and program project efforts in the mental retardation program. The agency responded by spending $14.5 million. We urge the Congress to once again insist on the expenditure of $18 million that we have been assured would be spent productively on mental retardation research. That would represent an increase of $3.5 million over fiscal 1975 and $5 million over the administration request. Such a request will still not fully realize the potential of these centers, particularly with the special problems of inflation, but it represents a responsible request in view of the current economic scene.

Public Health Care

WITNESSES

DR. HAZEL BLAKENEY, AMERICAN NURSES' ASSOCIATION
MISS CONSTANCE HOLLERAN, DEPUTY EXECUTIVE DIRECTOR, AMERICAN NURSES' ASSOCIATION

Mr. Flood. We now have Miss Constance Holleran, deputy executive director, and Dr. Hazel Blakeney, American Nurses' Association.

Dr. Blakeney. I am Hazel Blakeney from the Commission on Nursing Education for the American Nurses' Association.

Mr. Chairman and Mr. Michel, in the brief time allowed us today we want to speak of our concerns about recent changes that we have observed in the interpretation of the HEW health programs once funds have been appropriated.

First, let me speak with appreciation for the nursing student, researchers, schools, and health agencies that have benefited from your most recent actions on the budget rescissions and deferrals and for the restitution of nursing research funds by this committee in the second supplemental appropriations bill.

Your support is greatly appreciated by these groups.

It is difficult for nursing not to become paranoid as a result of the constant attempts of the executive branch to wipe out support for this request both by budget methods and by administrative maneuvering.

However, we know we are not alone. The dental division also faces constant attempts to dissipate its program. The NIMCH, maternal and child health, and other important health programs also face constant efforts to cut them.

Our full statement submitted for the record speaks to our specific concerns in relation to the funding of health programs for 1976.

Today, we specifically want to draw your attention to what has happened to program operations since the direct operating funds were

allowed to be moved from the program operation level. For example, positions, travel funds, contract money, and so on, once clearly specified for each major program, now are appropriated in response to administration requests in a lump sum under the direct control of the agency director.

As a result, positions for MCH, as an example, are not filled for MCH work. Staff responsible for projects and contract consultation are not available as needed and those experts who are available have no say in what program travel will be done, who will attend important meetings, and similar matters.

We think that it is now very difficult for the Congress to get accurate reports on programs they have funded and that the accountability factor is one that needs to be quickly investigated and strengthened.

Regional offices have moved health professionals from programs for which they were hired and assigned them totally different responsibilities. Nurses, for instance, are being moved from civil service job classification of nurse consultant to those of generalists. This means that if a nurse leaves, the position can be filled by someone with no background in the field.

The same is true for social workers, nutritionists, and others.

More than a year ago in response to a question by one Member of Congress, the Secretary of HEW replied that some of these moves were being made but that they were only temporary until qualified persons could be recruited. We contend that this process is continuing and that qualified people are being moved to generalist slots rather than vice versa.

Maternal and child experts in regional offices have been assigned to many non-MCH responsibilities. We want to know what programs are paying those salaries, and if it is the MCH program, is that legal?

Recently, an internal HEW group has made yet another set of recommendations to reorganize the health manpower of HRA.

If enacted it would remove all health professional control of funds for the various health manpower programs. For example, the Divisions of Nursing, Dentistry, and so forth could be replaced by small advisory offices of six professionals for each group, while all program activities would be consolidated along functional lines.

We think this might be a very wise move for those attempting to kill off those support programs in spite of congressional approval. Already nursing schools are complaining about the lack of expert assistance from the regional and central office levels.

The budget submitted to this committee for fiscal 1976 allows for only 52 positions for the Division of Nursing as compared with 135 in 1972. If the Congress agrees with us that the funding of these health programs has a profound impact on the future of the health professions and the health system of this country, we do hope that you will agree that program guidance is an important aspect of the HEW role.

Knowledgeable consultants respected by their peers have been the strength of many Federal health programs. Effective use of the funds appropriated is greatly dependent on the caliber of the PHS program staff.

Our point is that the program experts are a fast dying breed in today's HEW and we think Congress should do something about it. Otherwise the objectives to be achieved by the various pieces of health legislation haven't a hope of being achieved.

In these tight money days we feel that only good projects or contracts, well developed and properly supervised by competent HEW staff, should be funded. If that is to happen there needs to be some revival of the health staff in PHS.

So we ask that you promptly alter the system of appropriating direct operating funds and that you investigate the actual operations under the current appropriations. We think you will be upset with your findings.

In closing, let me mention that the Nurse Training Act has now passed both House and Senate by overwhelming majorities. We are hopeful that the conference report will be passed prior to the markup of the HEW appropriation bill. We do hope that for fiscal 1976, nursing schools will be able to count on an actual appropriation.

We thank you very much for the opportunity of appearing today.

[The statement follows:]

TESTIMONY OF THE AMERICAN NURSES' ASSOCIATION, PRESENTED BY HAZEL BLAKENEY

Mr. Chairman and members of the subcommittee, the American Nurses' Association appreciates this opportunity to appear before this committee to express its views on the health budget needs being considered by the committee for programs within the Department of Health, Education, and Welfare. As you well know the ANA has a long and continuing concern about the health care available to the public at large.

The administration budget for health is seriously deficient if we are going to meet the health needs of the American people. The proposed budget of $4.43 billion is $940 million less than the current appropriations of $5.47 billion and dramatically points to serious underestimations made by the President and his advisers. The administration's budget request, in addition to the rescissions and deferrals sent to Congress for the current year, is a lucid example of the kind of priority being placed on health care. Health programs amount to only 1.2 percent of the administration's overall spending program.

The 20-percent cutback in Federal spending for the direct delivery of services, as well as the severe cutbacks in manpower programs, will retard any efforts the Federal Government has made in providing health care to all those who need it. In recent years progress has been made in bringing health care to those in need regardless of where they live or their ability to pay. Obviously we have not done all we could do, but considering the funding available, giant steps have been taken. ANA looks forward to the day when a national health insurance program will guarantee health care for all individuals regardless of location or financial situation. Until that time, however, existing programs in direct delivery of health care and programs to educate and provide health professionals must continue to be adequately funded. This must take into account the rate of inflation and the population increases. Also we ask that you include funds for congressionally approved new and expanded programs.

The President's budget reduces Federal spending from the present appropriated levels for many programs. If the President's budget is accepted, community health center programs will be reduced from $200.4 million to $155.1 million, material and child health care from $266.9 million to $193.9 million, migrant health care from $23.7 million to $19.2 million, family planning from $100.6 million to $79.4 million, drug abuse training from $14 million to $3 million, alcoholism from $145.9 million to $114.1 million, and sudden infant death syndrome from $2 million to no funding at all. Mr. Ford has asked the States to take up where Federal spending is reduced; yet to date there is every indication that the States do not have the financial resource to do so. As time passes the Federal contributions run out, needed health services previously provided will have to be cut drastically. This is particularly disturbing in light of the estimated number of new individuals entering the health care system. The cutback of almost $300 million in Federal spending on programs that provide direct medical services will be disastrous to the American people, especially the poor.

In areas such as disease control the budget calls for heavy cuts despite compelling evidence that increased funding is absolutely necessary. Health experts

have determined that increased Federal funding for immunization and venereal disease control program is necessary because States have already failed to meet their share of responsibility. Despite this, the administration has cut this part of the budget from $34.2 million to $24.8 million. This figure appears even more dramatic when we consider that only 60 percent of the young children in this country have been immunized against polio, which is a 3-percent decrease in immunizations from 1972. Also, funds for venereal disease, a disease which health planners call epidemic in the United States, were cut from $22 million to $20 million.

The budget tells us that Federal spending on all health research will increase by $88 million, but spending for research by the National Institutes of Health will decrease by $35 million. The explanation for the NIH decrease is said to be because of the expenditures this year by the release of illegally impounded or recycled money.

Spending for alcoholism, drug abuse, and mental health programs would decrease from $653 million to $531.5 million. Most severely affected would be community mental health centers and mental health training programs which would be phased out. Despite recent attempts to provide outpatient care for more individuals, a method proven to be less costly yet equally effective in health care delivery, these aforementioned budget cuts are curtailing needed health and medical health services.

In the area of manpower legislation, the President's reduction of capitation and student assistance will not only reduce the ability of nursing schools to educate enough nurses to meet the already existing shortages and keep up with the growing demand for more nurses and trained specialists but will have a serious effect on the quality of education. Schools will be unable to hire needed faculties and students will be forced to work and go to school at the same time and therefore decrease the time which can be devoted to studies.

Presently, there are approximately 758,000 registered nurses in practice in the United States. The ANA estimates that we are about 143,000 nurses short of meeting today's needs and well behind in meeting the projected number of 1,100,000 needed by 1980. These projections are based on potential needs without reference to what nursing manpower would be necessary for a national health insurance program. Largely because of the Federal assistance in recent years, enrollment in the Nation's nursing schools has increased significantly. In 1971 nursing school enrollments were 187,500, in 1972 it was 213,100, in 1973 it was 232,500 and in 1974 it was 244,400.

On May 7 of this year the Congress passed the Nurse Training Act of 1975, H.R. 4115. We hope this committee will again provide the funding needed to make this particular piece of legislation work as effectively as the Congress has intended. In January, as I'm sure you know, the President pocket vetoed the Nurse Training Act of 1974 and dismissed its importance in providing health care by not recognizing the shortages that exist now and the urgent need for more nurses.

The passage and implementation of the Nurse Training Act has had an enormously beneficial effect on nursing schools and their ability to educate more nurses.

Last year, for example, because of the Nurse Training Act and the funds provided for nursing school construction, 49 schools were able to use the $36.6 million and increase and improve their facilities so that 2,934 more first year students were studying nursing than the year before. There were, however, more than 100 applications requesting over $100 million in construction aid.

Twenty million dollars in special project money in 1975 enabled 307 special projects to be completed and another 275 to begin. These funds are the most significant of all the nurse training programs in terms of effectiveness in improving education nationwide. They are designed to improve, strengthen, or expand nursing educational programs.

The new Nurse Training Act provides for funds in a separate section for nurse practitioner programs. In 1972 there were funds provided under special projects which began 32 3-year contracts to train nurses to be nurse practitioners. More than 600 nurses have already been trained in this specialty and an estimated 2,400 nurses will receive additional training.

Because of the Nurse Training Act, 60 nursing schools last year were able to meet their budgetary obligations because financial distress money was available from the Federal Government.

Likewise, in 1975 about 1,000 nursing schools received $34.3 million in capitation money to help meet their rising costs.

Last year, $13.7 million was awarded for 3,600 students under the traineeship provisions of the Nurse Training Act. Also, because of the Nurse Training Act, about 1,200 nursing schools were able to aid almost 28,000 students by awarding $22.8 million in student loans. Unfortunately, though, schools had requests for loans of $47.2 million more which they could not fill. Similarly, 1,225 schools were able to award $19.4 million in scholarships to about 20,500 nursing students.

As you can see Mr. Chairman, these figures are most encouraging. The NTA enables schools to expand and develop their nursing education programs as well as help students who wish to become nurses. Only through continued Federal assistance can we maintain and expand these programs.

The Nurse Training Act, Mr. Chairman, is needed more than ever. While education costs have risen so dramatically other support which nursing schools have counted on in the past is no longer available. Just last week, for example, the Board of Directors of New York City's Health and Hospital Corporation voted to end the subsidies it has been giving to nursing schools.

H.R. 4115 provides authorizations close to the figures appropriated by this committee. In every sense of the word, it is a realistic bill in terms of needed authorizations.

Similarly, the health manpower legislation that will eventually emerge from this Congress will require this committee's leadership in seeing that there is adequate funding to assure that the intent of the Congress and the needs of the Nation are not casualties of the administration's misguided priorities and miscalculations.

The $260 million health professions budget reflects substantial proposed cuts in institutional and construction assistance. Student aid is also reduced. Institutional capitation assistance, which is being phased out over 4 years, has been reduced from the fiscal year 1975 figure of $150 million to $101 million for fiscal year 1976.

Student loans are reduced to $20 million from the $36 million in the continuing resolution and scholarship aid is reduced from $14.6 million to $3.5 million.

The administration has explained on several occasions that these cuts are part of a continuing effort to change the role of the Federal Government in funding the education of health professions.

The nursing budget proposal is $34.5 million. This is a reduction of last year's Presidential request of $46.6 million and a reduction of a $140 million authorization in the continuing resolution. Absent from the President's request were grants to schools for construction, institutional support such as capitation, financial distress, and student assistance in the form of traineeships. Money requested by the administration was markedly less than was authorized in the House last week.

[In millions of dollars]

	President's budget request	H.R. 4115 passed the House May 7, 1975		
		1976	1977	1978
Construction:				
Grants		20	20	20
Interest subsidies	1.0	1	1	1
Subtotal	1.0	21	21	21
Institutional support:				
Capitation		50	55	60
Financial distress		5	5	5
Special projects	16.0	15	15	15
Advanced training	1.0	15	20	25
Nurse practitioner		15	20	25
Start-up grants				
Subtotal	17.0	100	115	130
Student assistance:				
Traineeships		15	20	25
Student loans	9.0	25	30	35
Scholarships	4.0			
Repayment	2.5			
R. & D	1.0			
Total	34.5	161	186	211

As you can see, the omissions from the budget, along with the reductions in other areas, points to the inadequacies of the $34.5 million Presidential requests as compared to the $161 million authorization for 1976 approved last week by the House. Last year $140 million was appropriated for nursing education.

The budget requests no funds for nursing capitation grants for fiscal 1976. The Congress appropriated $36 million for these grants to schools of nursing in 1974. Capitation grants have become a necessity to nursing schools that wish to hire faculty, expand programs, and increase enrollments. Schools must be able to plan on Federal support if they are to be able to teach more and more students each year. The administration suggests that in order for schools to make up for the loss of capitation money they should increase tuition. However, tuition costs have increased already in many schools by 10 percent. Any additional rise in tuition along with the proposed reduction in financial assistance will prove unbearable for most low- and middle-income students.

The following are examples of the dramatic rise in cost of tuition at several nursing schools.

	September 1974	September 1975	Increase
Catholic University:			
Undergraduate nursing	$2,450	$2,650	$300
Graduate nursing	2,600	2,800	200
Boston University:			
Undergraduate nursing	2,890	3,280	390
Graduate nursing	2,890	3,280	390
Cornell University: Undergraduate nursing	2,050	2,500	450
Georgetown University: Undergraduate nursing	2,600	2,900	300

The rising costs of education are not confined solely to increasing tuition costs. A recent survey conducted by the college scholarship service of the college entrance examination board revealed that yearly costs of attending a 4-year college in the fall of 1975 will have increased approximately 50 percent over the fall of 1970. The increase will be a startling 86 percent in 2-year colleges.

The budget also does not request funds for construction grants. Last year the Congress appropriated $20 million. It is our contention that if nurses are to be evenly geographically distributed there must be a way for local people to provide institutions of learning within their communities. We now know that without these grants, new nursing school construction or renovation will be seriously curtailed if not halted completely. Even though the President's budget provides for interest subsidies and loan guarantees for construction, most schools cannot avail themselves to these funds because they lack the ability to repay the principal amount of the loans.

The budget requests no funds for nurse traineeships. Last year Congress appropriated $13.7 million. Priority need in the nursing profession is for educators, clinical specialists, and administrators. The severe shortage of nurses prepared to teach, administer, research, and practice more independently in ghetto and rural areas continues to grow, and this trend will not be reversed unless adequate aid to graduate students is increased in the budget. These traineeships have provided financial aid to almost 50 percent of registered nurses enrolled in graduate degree programs. These funds are given to the student to pay tuition fees and provide a stipend of approximately $200 a month. The traineeships represent the only type of assistance available to graduate students. Current full-time enrollment in masters programs has increased from 3,529 in 1970–71 to 4,324 in 1972–73. It should be noted that in 1974 there were about 3,600 students receiving traineeships.

The budget requests no new funds for student nursing loans. Last year Congress appropriated $24 million. The only funds available for loans in the President's budget are to meet existing commitments. This means that new nursing students will not be eligible to receive student loans. Presently there are about 22,500 nursing students who receive loans.

The budget requests no new funds for nursing scholarships. Last year Congress appropriated almost $21 million.

As you can see, the administration budget proposes a complete phaseout of student support. The efforts to again eliminate direct student loans and scholarships will be particularly catastrophic to those students who have an established

need for financial assistance. Last year, nursing schools requested from HEW almost $72 million for loans and scholarships, but HEW dispersed only $18 million. One school, or example, reports that nearly one-half, 130 of 300, of the applicants for admission stated that they will require financial aid in order to attend nursing school.

The administration tells us that student assistance in the form of traineeships, loans, and scholarships is not necessary for nurses because they can take advantage of guaranteed loans or basic opportunity grants. Our answer to this is that nurses find it very difficult to pay back guaranteed loans. The average pay for nurses working in a hospital is extremely low. The U.S. Department of Labor reported that in August 1972, staff nurses earned the following weekly salaries:

Miami, Fla	$180.00
Houston, Tex	167.50
Boston, Mass	185.00
Washington, D.C	182.50
Denver, Colo	170.50
Atlanta, Ga	171.50
Seattle, Wash	177.00
St. Louis, Mo	173.00
Philadelphia, Pa	172.50

It appears evident to everyone except the administration that with salaries as low as these it is impossible for students to repay loans and still have enough money left for the necessities of life.

The second alternative which the administration presents to nursing loans and scholarships is even more unrealistic than the use of guaranteed loans. If a student comes from a family of four which has an annual income of $10,000, he or she would be eligible for a basic opportunity grant of about $220 a year.

This grant would barely make a dent in the tuition costs in some schools, let alone provide living expenses. Sadly, tuition costs and living expenses are rising while student financial assistance is diminishing.

Also of concern to nurses is the administration's request for the funding for the BOG's. The education budget proposes to eliminate supplemental opportunity grants and new capital payment into the National Defense Student Loan Fund. Will the President's budget have funds available for nurses after these two programs are eliminated?

To demonstrate further the undesirability and the unworkable nature of the BOG's we point to recent irregularities in the handling of student loan programs in Texas and adjoining States. The temporary closing of an office of education regional office was ordered because payoffs and strongarm tactics by U.S. aides were alleged. Admittedly, this is an isolated incident, but nevertheless, it points to the desirability of maintaining a proven successful student assistance program over one which leaves many questions unanswered.

Psychiatric nursing traineeships

Presently there are about 37,000 psychiatric or mental health nurses now in practice. It is estimated that by 1980, 58,000 more psychiatric mental health nurses will be needed. This is a total of 95,000 or an increase of 250 percent in just 4 short years. Traineeships and school programs support will have to substantially increase if we are to meet these needs.

Of the 37,000 nurses with preparation in psychiatric mental health practice, 3,700 have graduate degrees in this specialty. There is an urgent need now for 5,000 more nurses with this specialty preparation and at least 50,000 by 1985.

In fiscal year 1975 there were 113 undergraduate psychiatric nursing programs receiving assistance from NIMH and 59 graduate psychiatric programs. These figures represent a reduction in the number of psychiatric nursing programs from fiscal year 1972, 134 and 52 respectively. In total, the number of psychiatric programs receiving assistance, including undergraduate, graduate, child psychiatry, teacher, career service stipend, research training, short term special areas, pilot and special projects have been reduced from 208 in fiscal year 1972 to 190 in 1975.

While support to institutions has declined student assistance has also decreased. Traineeships in psychiatric nursing have decreased over the past several years too. In 1968 for example, there were 1,681 NIMH traineeships, 1,316 graduate and 365 undergraduate. In 1975 there were 1,272 traineeships, 989 graduate and 283 undergraduate. The President's budget for 1976 could only fund 930

graduate and 189 undergraduate traineeships for a total of 1,119. This would be 152 less traineeships than what is now being funded.

Graduate-level students in nursing depend heavily on Federal assistance finance their education. More than 50 percent of all graduate students received Federal assistance in masters-level nursing programs. We expect, because of rising tuition costs and increases in the cost of living, many more students will need assistance if they are to go on to graduate programs.

The Federal Government estimates that there are about 9 million alcoholic men and women in the country, more than 725,000 active narcotic users, 12.1 million people using stimulants and sedatives for nonmedical purposes, and 20 million Americans affected by emotional disturbances. How can the President tell us that these staggering statistics don't require more than the 37,000 nurses now in psychiatric mental health practice?

Similarly, the President's veto of last year of the Health Revenue Sharing and Health Services Act of 1974 demonstrates the administration's lack of awareness of the mental health needs of the country. A health services bill has been reported out of committee again and House action is expected shortly. Title II of this bill authorizes spending for community mental health centers. Necessary funds for planning, initial operation, education and consultation services, conversion grants, distress grants, and facilities assistance are essential if we are to provide the kind of mental health services required in today's society.

Maternal child health care

The Health Services Administration has requested $721 million in new budget authority and trust funds. This request is $236 million less than the comparable fiscal year 1975 level. The 1976 request is based on the assumption that increased cost sharing on the part of the States, local governments, other agencies, and increased third-party reimbursements will enable services to continue at the 1975 level. Hardest hit by these budget slashes was a 28-percent reduction for services in maternal child health and a 25-percent reduction for MCH research and training. The President requested $212 million in 1976, which is less than his $265 million request in 1975. Congress, in 1975, appropriated $294.8 million.

Some of the most exciting developments in the field of health are the more dramatic utilization of well-prepared nurses in maternal and child health programs. Nurse-midwives in Mississippi, for example, have clearly demonstrated their ability to dramatically lower the infant mortality rate. Since nurse-midwives have been involved in Mississippi the infant mortality rate in one county has dropped from 39.1 percent to 21.3 percent. This is just one example of the type of program which will be cut or abandoned if the President's budget request is adopted.

What is particularly shocking is that the infant mortality rate in the United States still ranks 15th among the countries of the world and that infant death for nonwhites continues to run considerably higher than for whites. Still more alarming is the fact that incidence of premature births is the same as it was in 1950.

In 1974 the number of women who died in childbirth was 20.8 per 100,000 live births. Here again, though, maternal death rates for nonwhites are considerably higher than for whites—about three times as high. Is this Congress going to permit the President to neglect the obvious needs of poor nonwhite Americans and cut MCH services?

States and local communities caught in the same inflationary squeeze as the Federal Government have a more limited base of taxation and cannot make up the difference left by the Federal withdrawal. Consequently services and programs will be altered at the expense of those who need this type of care most.

In 1974 the conferees on the second supplemental appropriation bill included language in their report to bring a halt to the administration's efforts to reduce staff of MCH professional employees in both the central and regional offices. Those that were to be terminated included registered nurses, social workers, nutritionists, and other experts. Unfortunately there is evidence that the expressed intentions of the Congress are not being carried out and some regional offices are not staff with registered nurses. Maternal child health programs have always had strong regional programs and if they are to continue this committee must continue its vigorous oversight of this important program.

Research, research training, and biomedical research

Since 1955, Federal funds have been made available for the support of nursing research projects dealing with all aspects of patient care, nursing as an occupa-

tion, nursing education, expanded or extended roles for nurse practitioners and for the communication of research findings.

Nursing research project funds are authorized in the Health Resource Administration budget with an indefinite appropriation. Since fiscal year 1974 however, the President's budget has requested no money for new nursing research projects. The administration has been telling us since 1974 that the deletion of a departmental request for nursing research funds was "an error."

Thanks to the members of this committee funding in the sum of $1.2 million for new nursing research projects was included in this year's second supplemental. We are most appreciative of this committee's efforts to begin to restore funds for needed nursing research, and we hope the committee will continue to fund needed research projects.

In the area of research training grants and fellowships $1.3 million has been provided. However, a technical problem arose when the Congress enacted the Research Service Awards Act and took the administration of this program away from the Division of Nursing. To date, there is much confusion as to the status of research grants and fellowships. One reason is that Congress has specified NIH and ADAMHA as the administrative agencies for the program. The Division of Nursing, formerly a part of NIH and now a part of the Health Resources Administration, has always administered nursing research programs. It was not the intention of Congress to move that program to NIH. The Division of Nursing has the staff experts and appropriate review committees to effectively administer the program. The nursing research program is unique and must be treated as such. Within a short period of time we hope the Congress will correct this technical error and funding for this vital program can go on. Research training grants and fellowships enable graduate nursing students to acquire the skills necessary for conducting important and necessary research. A recent study of how doctoral candidates nurses have financed their studies shows that only 7 percent are able to do so completely without outside assistance. Of those who received some financial assistance, 79 percent reported that it came from the Federal support program.

We strongly endorse the efforts of the National Institutes of Health and their programs of biomedical research. The limitations the President's budget places on the National Cancer Institute, National Heart and Lung Institute, the National Institute of Arthritis, Metabolism and Digestive Diseases and the National Institute of Child Health and Human Development are just a few examples of why this committee cannot sit idly by and permit the undoing of research programs.

Community health centers

Earlier we spoke briefly of the Health Revenue and Health Services bill as it related to the mental health community centers. However, neighborhood health centers where nurses and other health professionals have made a strong contribution in providing medical and health care in underserved and inner-city locales will be hindered by the decrease in funds. The President has requested $155.1 million as compared to the $280 million authorized last year. This money is used to bring quick medical treatment to individuals with various kinds of medical problems and accidents. With the proposed reduction many neighborhood health centers would be forced to close and others would have to drastically reduce their services. The working poor, whose income level disqualifies them from public assistance but is too low to enable them to afford private medical care, would bear the brunt of these reductions.

Similarly, migrant workers, who traditionally have no State health programs would be hard hit by the President's budget. These people have no representatives in Congress or State and local governments to turn for assistance. When the Federal Government reduces funding for migrant health from $23.7 million to $19.2 million we have to stop, take notice and reverse the direction in which we are moving.

Also of great importance to the nursing profession and to a large and growing segment of health care recipients is the home health care provisions of the Health Services bill.

Authorizations for demonstration projects for home health care services was again included in H.R. 4925. This is an important project because the future of health care services for the elderly might very well rest on the success of this program.

Recent publicity about understaffing in nursing homes and the lack of trained personnel underscores the need to find an alternative way of delivering health care to the elderly.

Likewise, the funding of demonstration grants for the training of health professionals and paraprofessional personnel is vital if we are going to make a significant impact on the delivery of home health care services.

Direct operations and staffing

One of the areas which provides most concern to us is the need for the Congress to know if its legislative intentions are being carried out. In previous years, funds for nursing programs were clearly identified. This year there was no line item in the budget submission to the Congress for direct operations. In the past, in addition to line items for institutional assistance, student assistance, and construction assistance there have been separate line items for educational assistance and direct operations. The absence of these statistics makes it difficult if not impossible for the Congress to determine if its legislative intentions are being carried out.

If this type of budget reporting continues Congress will have no way of knowing what the level of support is for component programs and divisions. Congress will not be able to determine how many staff positions remain filled or unfilled, how much travel is allowed and who will travel and all other relevant information necessary to know how these programs and divisions are administered.

Because the administration has been able to keep these figures from the Congress we have seen a dramatic decrease in the number of full-time permanent positions in the division of nursing in the past 4 years (135 in 1972 to 52 in 1976).

We were shocked to learn at a recent Senate subcommittee hearing that the 83 positions lost of the division of nursing have been given to other divisions within HRA. We have also discovered that due to the heavy workload on the relatively few full-time positions, expert consultation to the schools have been greatly limited. Clearly, this is not the intention of the Congress.

We urge this committee to require the President to detail the items for the direct operations of all the divisions for salaries, staff, travel, consultation, committees, and other essential expenses.

Particularly due to the failure of the President to adequately report the operating budget of divisions and programs, shifts in staffing at regional levels have reduced the effectiveness of health programs. Positions which require a particular expertise are being filled with lesser qualified individuals causing programs and services to suffer. Often regional officers are assigned to a position in which they have had no previous experience and are unable to administer the programs as Congress intended. This holds true for many programs including NIMH and MCH.

Our system of government created three coequal branches and each must respect the constitutional perogative of the other. The Congress makes the laws and the Executive carries them out. Congress must hold the President accountable for the way his administration carries out their intentions.

We are at a point in American history when we are preparing for a national health insurance program. In the past the Federal Government has played a major role in filling the gap where human needs exceed individual abilities. Health and medical care is no longer a luxury that only the rich can afford. It is now recognized as a basic human right. There is too much at stake for the Federal Government to abandon or reduce its role in the delivery of health and medical care, manpower development and needed research.

As members of the coalition for health funding we support the minimum budget put forth by the coalition. We would like to stress again, however, that these figures are only minimums and higher funding would contribute greatly to the kind and quality of health care Americans expect and deserve. The President's budget is seriously deficient in providing continued support for services, training and research, and we urge your careful consideration of the views presented this week.

In light of the more encouraging financial news, especially that of Secretary Simon that tax income exceeds expectations so that the deficit for this year will be considerably less than that being touted only a few weeks ago, we do hope that this committee will assure a more adequate health budget than the one submitted to you. You have in the past and we feel confident that once again you

will make your recommendations based on the real needs, the potential breakthrough and an assessment of resources needed to provide safe, adequate health care to the public.

NURSE TRAINING ACT

WITNESS

MS. ANNA COLES, DEAN, HOWARD UNIVERSITY COLLEGE OF NURSING, AND SECRETARY, AMERICAN ASSOCIATION OF COLLEGES OF NURSING

Mr. FLOOD. Dean Anna Coles of the American Association of Colleges of Nursing.

Ms. COLES. Mr. Chairman, the American Association of Colleges of Nursing is an organization representing the 4-year colleges of nursing in the United States. There are approximately 170 schools in the association. I am Anna Coles, dean of the Howard University College of Nursing and secretary of the American Association of Colleges of Nursing.

Today, I wish to speak to two acts which authorize nurse training: the Nurse Training Act, and the mental health training authority. The Nurse Training Act has been passed by both the House and Senate and will soon be in conference. As the previous witness has explained, we expect enactment shortly and before passage of an appropriations bill in the House; we therefore are seeking appropriation for the Nurse Training Act in these hearings.

The House bill, H.R. 4115, authorizes $50 million for capitation grants for fiscal year 1976. This level is a reasonable one and represents only a 30 percent increase over the actual appropriation in fiscal year 1973, 3 years ago. We believe that the program should be fully funded at the $50 million level. This amount will enable schools to keep pace with the inflation in costs of operation which have occurred during the past 3 years and allow for some new programs. Capitation grants support the operation of nurse training programs and are critical to the continued operation of nursing schools. As indicated in the House Committee Report on H.R. 4115, a concerted effort must be made to expand the supply of domestically trained nurses. The Public Health Service has estimated that 1 million nurses will be required in the United States by 1975. Current estimates of supply fall short of this mark by 50,000. In addition, in 1972, 17 percent of our supply of nurses were foreign-trained and the Interstate and Foreign Commerce Committee in its report on H.R. 4115 said that: "This committee is concerned by the growing reliance of this Nation on foreign-trained health manpower, and would hope that increases in domestic supplies of health professionals would serve to obviate our present dependence on foreign graduates." The expansion of capitation grants recommended is essential to meet the demand for nurses projected and to alleviate the overreliance on foreign-trained nurses.

We would also recommend funding of advanced traineeships at the level of $15 million for fiscal year 1976 which is the authorization level. This represents an increase of only $1.3 million over the fiscal year 1974 appropriation. We would further recommend a level of $25 million for the scholarship program which represents about a 22-percent

increase over fiscal year 1974. These two programs of traineeships and scholarship aid also need to be expanded as recommended to meet the increased demand for domestically trained nurses.

Finally, we would like to emphasize the funding of two new programs in the 1975 act: the advanced nurse training program and the nurse practitioner program. These two programs are important to the development of manpower with the requisite skills and specialties needed by our health delivery system. Specially trained personnel for specialized care units such as coronary care, burn therapy, and renal dialysis, was emphasized in the House committee report discussion of the advanced training program. Advanced training programs are also necessary to prepare nurses for administrative and supervisory positions. The development of such specialists and supervisors will make the health care system more accessible and will make it more efficient in the long run. The nurse practitioner program is intended to expand the number of nurses who provide primary health care. In particular, such nurses can expand the provision of services in rural and similar underserved areas, thereby making health care more accessible to the American public. As the Interstate and Foreign Commerce Committee stated in its report on H.R. 4115:

> Significantly greater numbers of professional nurses prepared at levels for independent and collaborative health care delivery as nurse midwives, pediatric, family and geriatric nurse practitioners are needed.

We recommend that the authorization level of $15 million be appropriated for each of these programs in order to sufficiently develop these programs.

With regard to mental health training, we fully support the position of the Coalition for Mental Health Manpower to fund such training at a level of $125 million. The demand for mental health services is growing, particularly with a recession rampant. Also, mental health services are preventive and intended to keep people from acute care and institutionalization. In this respect, there is also a growing demand for services. To meet such a growth in demand, specially trained personnel are needed and a training level of $125 million is barely sufficient to meet this demand.

I appreciate your consideration of our testimony.

Mr. FLOOD. Thank you.

Ms. COLES. Thank you.

THE NATIONAL HEART AND LUNG INSTITUTE

WITNESS

DR. JOSEPH ROSS, CHAIRMAN, GOVERNMENT LIAISON COMMITTEE, AMERICAN COLLEGE OF CHEST PHYSICIANS; PROFESSOR AND CHAIRMAN, DEPARTMENT OF MEDICINE, UNIVERSITY OF SOUTH CAROLINA, SCHOOL OF MEDICINE

Mr. FLOOD. Dr. Joseph Ross, chairman of the government liaison committee, American College of Chest Physicians.

Mr. Chairman and members of the committee, I am Dr. Joseph Ross, chairman of the American College of Chest Physicians' committee on government liaison. I am also professor and chairman, depart-

ment of medicine, University of South Carolina, School of Medicine. I appear today on behalf of the American College of Chest Physicans (ACCP).

As you may know the ACCP is a professional medical specialty society of more than 9,500 physicians, medical professors, and scientists who specialize in diseases of the heart, lungs, and circulatory system.

Speaking for the membership of the college, may I say that we very much appreciate this opportunity to offer our views to this important committee in order to share our thoughts concerning the fiscal year 1976 appropriations for the National Heart and Lung Institute and the National Library of Medicine. As you will note in the statement to follow, we have suggested specific dollar amounts for most of the line items related to these vital segments of the National Institutes of Health.

In the main, we agree with our professional brothers of the American College of Cardiology regarding the dollar amounts recommended for the NHLI and the NLM. We do suggest, however, some further additions to the budget for certain areas we think should be emphasized. Moreover, because we agree with the American College of Cardiology, for the most part, on those items within the NHLI budget relating to the heart programs of NHLI, we intend to focus our statement on the lung programs of the Institute.

While we have expressed our recommendations in specific dollar amounts, we would like this committee to know that our statements reflects our thoughts concerning priorities, general funding levels, and general directions for both the NHLI and the NLM. Reasonable men can and do differ on specific amounts for many of the programs in both of these important institutions. We hope, however, that our philosophy and priorities will be of help to you in deciding upon those specifics.

THE NATIONAL HEART AND LUNG INSTITUTE

(1) Budget

For your convenience, we have attached a table (table I) which summarizes our financial recommendations for the National Heart and Lung Institute. We hope you will find this mode of presentation helpful.

We completely agree that in times of limited resources, the emphasis of the Institute's program should be on the support of people rather than the purchasing of capital goods such as construction. On the other hand, it is our judgment that the individuals supported by the Institute's budget will need a great deal more space in which to work than is now available.

The budget which we have recommended will allow the continuation of present programs with some minimal expansion and allowance for inflationary increases. Now only about 45 percent of approved research grants can be funded. The amount of $238 million which we have recommended will allow funding of 60 percent of approved research grants, which is a much more reasonable figure.

(2) Staff positions at the NHLI

Mr. Chairman and members of the committee, we believe that this subcommittee has shown extreme sensitivity, interest in, and knowledge of the National Heart and Lung Institute over the years. As evi-

dence of our conclusion in this regard, we would cite the report on the HEW budget issued by this committee which accompanied H.R. 8877—the fiscal year 1974 budget.

We regret to say, however, that some of the directions issued by this committee to accompany the 1974 budget have not been implemented by HEW. The most serious of these omissions concerns the staff level at the Institute.

On page 42 of the report of this committee which accompanied H.R. 8877 (Senate Report 93–414), this Committee said "In addition, the Committee *directs* that a portion of the increase be used to staff the NHLI to meet the intent of the 1972 (Heart and Lung) Act. The Committee believes that approximately *800 positions* would be required to staff the expanded program *and has included funds for this level of staffing*." (Emphasis supplied.)

In spite of the above-cited very clear directive from this committee, the number of positions made available to NHLI by the Office of Management and Budget in fiscal year 1974 was less than 700. We regret to report that even to date NHLI has substantially less than 700. We draw the committee's attention to this lack of responsiveness on the part of the Office of Management and Budget in the hope that this committee can take the necessary corrective action.

(3) *Pulmonary programs of the Institute:*

Mr. Chairman, our college presents thousands of physicians and scientists of this country who are dedicated to the prevention and treatment of diseases of the lungs. We hope in the following statement to convey our concerns about the mounting impact of these diseases on the public's health.

As you may know, it is only within the past few years that a concerted strategy began to evolve to meet this serious health problem. It is gratifying to be able to report that the National Heart and Lung Institute and the biomedical community have worked together quickly and effectively in developing plans that are now represented in the national heart, blood vessel, lung and blood program.

Each year in this country about 260 million persons are afflicted as a consequence of respiratory diseases. About 40 million of these people have chronic pulmonary diseases which can at this time only be alleviated but not cured. Respiratory diseases affect all ages but they are most devastating among the very young and very old.

The causes of respiratory diseases are multiple. Some, like cystic fibrosis, are hereditary. Most, however, develop as a consequence of exposure to environmental factors—especially infectious agents, or ganic and inorganic dusts, and gases. Some of these latter agents affect the airways of the lungs (for example, asthma—an allergic disease) while others cause proliferation of the lung tissue cells (for example, the fibrotic lung diseases).

Of particular interest is emphysema. This disease, though clearly associated with environmental factors (especially cigarette smoking), is more likely to occur in individuals who inherit a deficiency of a specific substance (alpha-1-antitrypsin), which blocks the dissolution of lung proteins.

It is also important to mention acute respiratory failure in the adult which can result from causes as diverse as burns or others types of trauma, infectious diseases like pneumonia, or acute phases of chronic

diseases such as emphysema and chronic bronchitis. A conservative estimate is that there are about 150,000 cases a year with an average mortality of 40 percent.

While these examples provide some sense of the dimension of the problem, they scarcely do justice to the subject as they fail to include many respiratory diseases that contribute to the national disease toll.

In facing the problems of mounting a national program against these diseases, it is now clear that the attack must be three pronged:

(1) For those already afflicted, we must find ways of diagnosing the disease early enough so that it is still amenable to treatment. We must also develop more effective modes of therapy.

(2) For those at risk—whether because of hereditary predisposition or exposure to environmental factors—we must find more effective ways of preventing development of the disease or effectively modifying its course.

(3) Perhaps most important to ultimate success in our long-range goal of prevention is the development of basic knowledge about the biochemical, immunologic, and physiologic changes that underly respiratory diseases. Hopefully, these changes will then be susceptible to the type of intervention that will serve to prevent or arrest the disease process.

Recently the National Heart and Lung Institute has had a new dimension added to its activities which is almost certain to have a significant impact on upgrading pulmonary health care beyond the major health centers. Two types of programs (demonstration and education) are being actively developed to insure the rapid translation of research findings into patient care. Therapeutic procedures or techniques that are suitable for use beyond a research institution are to be supported as demonstration projects to test the feasibility of their use in community settings. Support is also being provided for development of more effective educational techniques for informing community physicians, nurses, allied health personnel, and the lay public about advances in the pulmonary field that are relevant to their activities. The newly initiated National Research and Demonstration Centers program will be a primary focus (but not the only one) for these new facets.

In this regard, only one of these National Research and Demonstration Centers in lung disease has been developed in spite of the authorization for 15 in lung diseases. We believe that it is important to develop more of these centers, at least two or three within the coming year, so that there are enough of the centers that they can be fairly evaluated in their effects.

Over the years in an effort to set its own priorities, the National Heart and Lung Institute has engaged in a major planning exercise that has involved close working relationships between the institutes staff and the biomedical community. For lung diseases, this planning effort began in 1971 with the Task Force on Research in Respiratory Diseases. The deliberations of this task force involved over 200 biomedical scientists and physicians. In 1972, a 12-member lung disease panel and 4 task groups, building upon the report of the earlier task force and adding areas not covered by the earlier group, developed a national plan for lung diseases. This is now part of the national heart, blood vessel, lung, and blood program of NHLI. These

resource documents have served the Division of Lung Disease, the Pulmonary Diseases Advisory Committee, and the National Advisory Heart and Lung Council with the background material for its planning. They have also been widely used in the pulmonary community and in research and medical institutions.

Drawing upon these planning documents and utilizing a variety of supportive mechanisms, the Institute's lung program is presently emphasizing the following:

(1) Pediatric pulmonary diseases, especially early diagnosis and treatment of hyaline membrane disease; fundamental studies of changes in cystic fibrosis; and the long-term effects of childhood bronchiolitis.

(2) Emphysema and chronic bronchitis, with particular attention to epidemiologic study of genetic and environmental risk factors, and studies of methods of early detection.

(3) Fibrotic, and immunologic diseases, especially the biochemistry of collagen and elastin, and epidemiologic studies of hypersensitivity diseases.

(4) Respiratory failure, with particular attention to therapeutic devices, and development of noninvasive monitoring techniques.

(5) Pulmonary vascular diseases, especially pulmonary hypertension, pulmonary edema, and cor pulmonale.

(6) Inhalation diseases, with particular interest in epidemiologic studies in occupational environments.

(7) Structure and functions of the lung, which provides the underpinning for studies of all of the above diseases.

Because of the importance of adequate professional resources to undertake these many programs, the Institute fosters fellowship support, particularly of scientists in basic disciplines who have in the past not been adequately involved in lung-related problems.

To upgrade teaching in medical institutions so that medical students will be attracted to the pulmonary field, pulmonary academic awards provide support for physicians who are dedicated to such an effort.

To provide young scientists with the opportunity to pursue a pulmonary-related research project, the Institute supports the Young Investigator Pulmonary Research Grant.

This large effort, developed in just a few years, holds great promise. The more so because each program is being carefully evaluated on a continuing basis and will be pursued only if its value is clearly demonstrable.

There is still a shortage of physicians in this field. At last count there were over 200 vacancies in medical schools which are funded but cannot be filled with educators in this field.

The administration's budget for the National Heart and Lung Institute for fiscal year 1976 is $293 million. The 1972 Heart Act, Public Law 92–423, requires that at least 15 percent be spent on lung programs.

We believe the bottom line figure put forth by the administration is much too low. As you note from the attached table I, we think the total appropriations ought to be in the range of $400 million. Obviously, 15 percent of this latter total will provide for a significantly expanded effort in the battle against lung diseases.

I want to make a correction in the table. The amount which we intented to recommend for manpower programs should have been $32 million rather than $23 million.

NATIONAL LIBRARY OF MEDICINE

We respectfully recommend an operating budget for the National Library of Medicine of about $30 million, which is about 10 percent higher than that for fiscal year 1975, and accounts only for inflation. We do not think the administration's fiscal year 1976 budget request for National Library of Medicine is adequate to meet National Library of Medicine's growing responsibilities.

The National Library of Medicine is the sole national institution charged with the task of accumulating and organizing the world's biomedical literature and disseminating necessary information to the health sciences community. For the past several years, the cost of acquiring materials has been increasing at an annual rate of about 12 to 15 percent. Furthermore, while demand for National Library of Medicine services from the biomedical community has grown enormously over the past few years, the National Library of Medicine's authorized manpower levels have declined about 14 percent since fiscal year 1968. A reduction in funds compounded by no additional increases in personnel levels in fiscal year 1976 most certainly will lead to an erosion of essential library services.

For the above reasons, moreover, we strongly recommend an increase in the number of positions allowed for National Library of Medicine from less than 460 to about 500. In essence, we are seeking a 10-percent increase in the number of positions. We believe that the staff at National Library of Medicine is effectively used at present. We also believe that with increasing demands on its services, National Library of Medicine will absolutely need an increase in its staff allotment.

Finally, we wish to recommend to this committee that sufficient additional funds be included in National Library of Medicine's budget to permit the construction of the Lister Hill National Center for Biomedical Communications. We understand the figure is about $20 million. We are also told that had HEW gone ahead with the construction of this center in fiscal year 1968, the cost to the Government would only have been about $12 million. Therefore, we urge this committee to see that construction of the Lister Hill Center is recommended as soon as possible before inflation takes an even greater toll.

CONCLUSION

Mr. Chairman, on behalf of the American College of Chest Physicians, and its more than 9,500 members, I wish to convey our deepest appreciation for your having afforded us this opportunity to share our views and judgments with you. As we have noted throughout this testimony, our recommendations in the heart area conform rather closely to those of our fellow society, the American College of Cardiology. Therefore, we have emphasized the lung aspects of the National Heart and Lung Institute.

Within the lung programs, moreover, we have tried to recommend certain priorities among the almost infinite array of possibilities.

We realize there are limited resources and we further realize that these limited resources ought to be allocated according to the best possible information.

Finally, we have chosen to comment briefly on the National Library of Medicine. We believe that the National Library of Medicine is a national resource without parallel. We hope you will agree on this matter and provide the National Library with the resources it needs to get the job done.

Again may I thank you for this opportunity to appear before this important committee.

[The table follows:]

TABLE I.—NATIONAL HEART AND LUNG INSTITUTE BUDGET

[In thousands]

	Fiscal year—		
	1975 expenditures	1976 President's budget	1976 ACCP recommendations
(1) Research grants	183,214	165,735	238,000
(2) Manpower programs	19,932	20,954	32,000
(3) Research contracts	81,713	63,828	91,000
(4) Intramural research	24,638	24,699	27,000
(5) Research management and program services	17,860	17,578	20,000
Total NHLI	327,357	292,794	408,000

Mr. FLOOD. Thank you.

AFTERNOON SESSION

REHABILITATION SERVICES ADMINISTRATION

WITNESS

DR. RAYMOND FINLEY, ASSOCIATE PROFESSOR OF MEDICINE, TEMPLE UNIVERSITY MEDICAL SCHOOL, AND ASSOCIATE DIRECTOR OF THE REHABILITATION RESEARCH CENTER OF THE MOSS HOSPITAL AND TEMPLE UNIVERSITY MEDICAL SCHOOL

Mr. NATCHER. The committee will come to order.

We take up at this time the American Congress of Rehabilitation Medicine and American Academy of Physical Medicine and Rehabilitation, and we have before the committee Dr. Finley.

Doctor, we are glad to have you before the committee and we will be pleased to hear from you.

Dr. FINLEY. Thank you very much.

Since you have introduced me I won't go into that, but I will repeat that I am here on behalf of the American Academy of Physical Medicine and Rehabilitation, the board-certified and scientific body for physicians specializing in physical medicine and rehabilitation, and the American Congress of Rehabilitation Medicine, a multidisciplinary health professionals association.

My only focus today will be on the rehabilitation research item in the budget of the Rehabilitation Services Administration (RSA).

That program was once funded at the level of $32 million. That was in fiscal year 1972, 4 years ago. The current request for funding is at $20,000, which obviously represents a significant 35-percent decrease from that earlier level.

In order to present to you the problems and the issues as I see them and as my colleagues see them, I would like to take you on a little bit of a journey if I may and the way I would like to start this is to simply ask you to look at that beautiful color in that book and these plates.

What you are looking at is really the muscle cells taken from a preparation on a laboratory slide. Now, this kind of work could not be done except in the last few years because it has been possible as a result of the transistor which was developed in 1948 and for which Princeton University faculty persons received the Nobel Prize.

Now, what is the significance of that? The transistor permitted us to build an electrode microscope which was suitable to get into a building and would permit scientists and physicians and medical people to look at slides prepared in this manner.

Before the day of the transistor, engineering technology could not produce an electron microscope that could be gotten into a building where people could use it because you and I remember the days of vacuum tubes that used to be in radios and it is the transistor which has replaced the vacuum tube, and on a small chip about the size of that we can get enough circuitry designed and in place to power the magnification that presents these kinds of slides which we could not get more than 20 years ago.

This book is brand new. The transistor was developed in 1948, We have this information now within recent years. In the last 10 years there has been more information produced in neurophysiology than there has been ever since there has been such a field.

This has been our problem in rehabilitation. We have not had this information before the last 10 years to provide the scientific base for therapy and for engineering design to aid the people who have functional losses as a result of chronic disease and permanent disability resulting from catastrophic and traumatic injury.

The RSA program was initiated in 1954. This is the research program and it was started as a research and demonstration program. We did not have this kind of information when that program was started. There are about 1,000 R. & D. projects that have been produced in the first 10 years in which this program was alive and then that program was cut.

Now, we move from this as a basis to the design of laboratories which were created by the Federal Government and established as a part of this program in 1954 for RSA.

These laboratories now are not the kind that you are most familiar with and have seen in the popularity of motion pictures and television and you see a row of microscopes and slides and mice in cages.

The research that we do, having been established by RSA, is people research. The subjects are people. The subjects are disabled people. Now, the Senate has just passed a medical devices bill in the expectation that there will be a number of devices produced for improving the function of disabled people.

Where will the information content come from by which to evaluate these devices? How will they be evaluated? I know that your expectation is that this will be a function of the Federal Drug Administration. The Federal Drug Administration historically has used those people in medical schools, universities, to determine the efficacy, the safety, and the beneficial treatment of pills.

Now we are talking about medical devices, these kinds of things to aid the function of patients. These are people who are permanently physically disabled. They will never be restored. They will always be crippled and have the limitation as a result of their disability.

The National Institutes of Health provides money for research in the care and prevention of diseases. With that money which has been provided the National Institutes of Health has kept children alive today who 17 years ago would have died.

These are children we call spina bifida. There are gaping holes in their spines. None of them had ever lived before. Now they are adolescents and no one knows how to handle these adolescents because there has never been any before.

These are the kinds of issues we have, and we have learned on the basis of this neurophysiological information that the only way you can interact with the central nervous system and provide functions important for these people is through electronic engineering devices that will get into the central nervous system in a way that physical therapy and occupational therapy cannot do.

This is a device which has been developed to retrain a stroke patient in the walking patterns that are required after brain damage.

This is a device which introduced plastics into rehabilitative care.

These two things together, electronics and plastics, are the greatest advantages that are turning our economy and our national life around.

Now, there are 26 million Americans who are disabled as a result of physical disability alone. These people have no advocates within their own group because they are so physically limited. They are paralytics. They cannot speak for themselves. They cannot marshal the resources available to take care of themselves.

And they must have spokesmen for them. Neither do these 26 million Americans vote as a voting block so they have no political clout. They have no one to talk for them. Their only hope is the morality of the issue and the integrity that we have in realizing the full expression for all people in our society and return them to productive work and productive income so that they can care for themselves.

I might say, as a final kind of a statement, the medical care for these people is a level of about $30 billion because these are catastrophic injuries we are talking about and there have been no funds available to learn how to handle these kinds of people and retraining them for useful function.

The dollars have gone for the prevention and the care of the acute disease. When these people reach rehabilitation they have exhausted all of their financial resources for care and they have none. So that we need greater resources of the Federal budget in this field in order to move toward the problems which are being created by the continuing industrialization where accidents are mounting.

The improved medical care is keeping people alive who otherwise would have died, and we keep them alive to function in bodies that

are so severely restricted that they are forever dependent on the rest of us who are productive in society.

Thank you, sir.

[The statement follows:]

Mr. Chairman: My name is Raymond Finley, and I am an associate professor of medicine at Temple University Medical School, and associate director of the rehabilitation research center of the Moss Hospital and Temple University Medical School. I am testifying on behalf of the American Academy of Physical Medicine and Rehabilitation, the board-certified and scientific body for physicians specializing in physical medicine and rehabilitation, and the American Congress of Rehabilitation Medicine, a multidisciplinary health professionals association.

My only focus today will be on the rehabilitation research item in the budget of the Rehabilitation Services Administration (RSA). We fully support the position of the coalition for health funding on other elements in the rehabilitation budget. We support the position of the State directors program and the counselor educators regarding training. But, we are compelled to address our remarks solely to research because of the dire straits in which we find the rehabilitation research program. That program was once funded at the level of $32 million—in fiscal year 1972, 4 years ago. Since then, not only has the program failed to keep up with the inflated costs of operating research projects, it has been reduced by about 35 percent to $20 million. The result has been disastrous. Existing research and training centers—one major focus of the program—have had their funding substantially reduced. No new centers have been started for 4 years despite major new emphases and demands for research in rehabilitation. The bio-engineering centers program has hardly gotten off the ground because it has received only about $4 to $5 million in total. International research has not been financed at all. Spinal cord research has received little funding.

Yet, the 1973 Rehabilitation Act represented a turning point for the entire program including research. The 1973 amendments set forth in law for the first time major research priorities. Both the House and Senate reports called for an expanded research program. The important priorities emphasized were the research and training center program, the Rehabilitation Engineering Research Centers program, a spinal cord research program, a program for projects and demonstrations regarding end stage renal research, and program of international rehabilitation research. All of these priorities plus projects dealing with the homebound, and projects related to architectural barriers, are set forth in section 202 of the act. In addition, the act itself calls for a priority in services to those with the most severe handicaps. It is that population—the quadrapalegics, parapalegics, double amputees, blind, the severe stroke victims—about whom we know least in terms of developing effective medical rehabilitation techniques to restore such individuals to productive lives.

In light of these basic changes in the law which are also reflected in the Senate and House reports on the 1973 amendments regarding the importance of research, the administration's request of $20 million is anemic.

We believe that rehabilitation research clearly deserves funding at the target level of $32 million set forth in the 1974 amendments. Clearly, the House Committee on Education and Labor believed a $32 million level was reasonable for it specified such a level, not as a ceiling, but as a target. We believe such a funding level to be justified; perhaps justified more than increases for any other types of health research. Rehabilitation research is not ivory tower research—it is not removed from patient needs or patient care. It is directly derived from patient needs. Research and training centers are directly related to care. Research carried out in such centers translates into improved treatment techniques such as methods to intervene more quickly with regard to spinal cord injuries and prevent deterioration, or methods to strengthen the lungs of those with lung diseases to enable them to carry out ordinary physical tasks, or special braces for multiple amputees or even the patient with a hemicorporectomy. New electronic devices are being developed to give the blind a limited sense of vision.

We would urge you to support a restoration of the rehabilitation research program to its fiscal year 1972 level of $32 million. This some recommendation has been made by the Coalition for Health Funding and has been developed and endorsed by a number of groups concerned with rehabilitation including the National Rehabilitation Association, representing consumers and providers of care, the State Directors of Vocational Rehabilitation, the State Directors of

Mental Health, and the National Easter Seal Society for Crippled Children and Adults. Their support clearly indicates that we are not speaking for an academic, irrelevant research program, but one related to program needs and patients.

Mr. NATCHER. Doctor, we appreciate your appearing before our committee at this time.

Thank you very much.

Dr. FINLEY. Thank you.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

WITNESSES

DR. JAMES C. HUNT, PRESIDENT, NATIONAL KIDNEY FOUNDATION; CHAIRMAN, DEPARTMENT OF MEDICINE, MAYO CLINIC

DR. JAY Y. GILLENWATER, PROFESSOR OF UROLOGY, UNIVERSITY OF VIRGINIA

Mr. NATCHER. Our next witness is Dr. Hunt, president of the National Kidney Foundation, chairman of the department of medicine at Mayo Clinic.

Doctor, we are glad to have you appear before the committee at this time. We will be glad to hear from you. You have another gentleman there with you.

Dr. HUNT. That is Dr. Gillenwater, Mr. Chairman, who is professor of urology at the University of Virginia.

Mr. Chairman, we appreciate the privilege of appearing before this committee again. It was just a year ago that we were last here and at that time presented to the committee a detailed review and presentation concerning the problems in the kidney and genitourinary field.

With the permission of the chairman rather than reading a long and detailed statement, I would request that we be permitted to introduce this into the record, sir.

Mr. NATCHER. Fine. It will be inserted in the record in its entirety and we will be glad to hear from you.

Dr. HUNT. With that, Dr. Gillenwater, who is a practicing urologist at the University of Virginia and myself as Dr. James Hunt, the president of the National Kidney Foundation, and practicing physician also, Mr. Chairman, would like to very informally point out, I think, a few practical aspects of the kidney disease problem as it exists in the country today and make several recommendations to the committee.

I guess my own personal feeling would be that I am perhaps like a minister in church speaking at the wrong place. Those people who are in church and attending church are usually those who are motivated and headed in the right direction.

I personally feel, Mr. Natcher, that perhaps were it not for the Congress we would be in much greater trouble in the health care and medical care field in this country than we are today.

We are in trouble. We are in particular trouble in the kidney and genitourinary field, for although we do have the palliative means of treating people who are or would be dying from uremic poisoning, by use of the artificial kidney transplantation, these people aren't well. They are being palliated rather than cured.

The treatment that we can offer is a result of H.R. 1, Public Law 92–603, which provides medicare coverage for people who are or would be dying from kidney failure. This is an enormous cost which you are very familiar with.

I would guess, personally, that we are underestimating what is actually being spent by the BHI in this area today. I would guess, when the record is really in, that we are going to be spending $400 million to $500 million providing transplantation and artificial kidney care for people who would otherwise die.

Mr. Natcher, we don't advocate stepping backward on this. Of course, we have to take care of these people because many of them are being put back to work. But we also have to more effectively address the problems which are causing uremic poisoning, causing kidney failure, and these problems simply aren't being addressed from two standpoints, one from a treatment standpoint and, second, and especially, from a research standpoint.

I am speaking about problems such as prostate trouble, and kidney stones, and urinary tract infection, and high blood pressure, among many others, that can be effectively treated. I guess our greater concern is, in the long run, that we don't have a stable program or stable policy even by the executive branch of the Government in this country at the present time.

At the present time the OMB has directed that the moneys which were appropriated for the current Research Training Program Act cannnot be used to support institutional training grants. Only individual fellowships can be supported, and these require a detailed spelling out, and writing out, by each individual doctor early in the stage of his career, oftentimes before he has had any research training as to what he is going to do.

The same is true in terms of the support for research. We have gone more and more to targeted research, which is appropriate, except that we have gone away from, and failed to support, the individual investigator who has already been trained at great expense, and to that end in our recommendations as spelled out in the document which we submitted to you for the record, we feel the priority should be, one, to support the investigator who is starting his research program, who is initiating a research program.

The second thing is that we believe we should support research training and train the young doctor. We are not advocating training to many investigators but rather to train them well, those that we do rain. We are not advocating an increased spiral of training but rather to have a stable program.

Third, we think that these disease areas which are causing kidney failure, uremic poisoning, that research should be done in them. There is an excellent model that has been established in several of the institutes.

In the National Heart and Lung Institute they are called specialized centers of research, where people from multiple specialties and multiple disciplines get together, make application to the NIH for a specialized center of research, and through very careful review, very appropriate peer review—I know, Mr. Chairman, because I sit on one of those committees for the Heart Institute. They have specialized centers for atherosclerosis, high blood pressure, hypertension.

We advocate to the committee that the NIAMDD also develop such programs, fully aware that these are tight fiscal problem times. We think, in all fairness, when there is $500 million, probably $1 billion in 5 years, being spent to treat those people dying of kidney failure, that there should be an increase of money in the kidney field, especially in NIAMDD and to that end we ask that this committee support 10 new centers, 10 specialized centers of research, 10 SCOR's as they are known at the NIH, in neurology and nephrology to do multispecialty and multidiscipline research in this area.

We think that these, in the long run, will be the ultimate physical responsibility because we think that we not only would provide better health care and medical care but would prevent a lot of suffering.

Thank you, Mr. Chairman.

[Dr. Hunt's statement follows:]

Mr. Chairman and members of the subcommittee: It is a pleasure to, once again, appear before your committee. I speak on behalf of the National Kidney Foundation whose consumer and provider membership constitute the leading volunteer health organization in the United States concerned with kidney and genitourinary diseases.

I am James C. Hunt, president of the National Kidney Foundation and professor and chairman of medicine, Mayo Clinic and Mayo Medical School, Rochester, Minn. Accompanying me is Jay Y. Gillenwater, professor of urology at the University of Virginia, who has assisted in the development of our presentation. The lay and professional members of the National Kidney Foundation continue to work closely with the Federal and State Government in the fight against renal and genitourinary diseases. Last year we expanded our efforts in the support of public education, professional education, and basic and applied research. The resources we committed were in the millions but, alas, not sufficient to address any one facet of the multiple needs.

May this committee be assured that we will do more this year and will expand our efforts in the years ahead. Our voluntary manpower has and will continue to offer their services to patients, public and private institutions, Government agencies, and the Congress.

I. Current Status of Health Care, Research and Education in Kidney and Genitourinary Diseases

Mr. Chairman, section 299I of Public Law 92–603, provides medical coverage for more than 90 percent of citizens with end-stage renal disease (ERSD) and will have been in effect for 2 years on July 1, 1975. Although long-term regulations have not yet been published, under this statute, financial assistance is given to patients through the disability provisions of medicare. This enlightened legislation addresses itself to the immediate problem of assisting permanent kidney failure patients by helping pay the enormous cost of renal dialysis and transplantation. However, the essential problem remains. We must yet find means of preventing a variety of kidney diseases which ultimately result in permanent kidney failure.

Support for research and research training in nephrology, urology, and related basic disciplines through the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) and through the National Heart and Lung Institute (NHLI) has been inadequate during recent years. The administration's priorities for suggested funding do not propose an increase but, in fact, delineate a regressive policy. For fiscal year 1975 the Congress approved for the NIAMDD an appropriation of $173,121,000 and for fiscal year 1976 the administration is requesting only $148,409,000. We believe the proposed policy for research support by the administrative branch to be shortsighted. The Congress has continued to strongly support research and research training. However, a potential crisis is in the making with respect to research training. During the past several years we have had no less than three simultaneous federally supported research training programs, the last of which was effected

by the National Research Service Award Act (NRSA) of 1974. The first review of experience under the NRSA will not be effected until June 1975; yet, the Office of Management and Budget (OMB) has directed that no new institutional research training grants be awarded for fiscal year 1976. Indeed, only 25 percent of fiscal year 1975 moneys may be utilized for institutional grants in accordance with OMB directives to the NIH. Institutions and young trainees have had short notice with respect to time for making of applications and describing programs. Judgments cannot be made by the NIH until the last moment and on May 15, 1975, we yet do not know what moneys will be available for institutional or individual fellowship grant support for July 1, 1975. Consequently, many highly qualified young scientists and physicians who cannot tolerate such uncertainty are moving to other activities and programs, thus research and education programs experience a great loss.

Mr. Chairman, last year we presented to this committee a well balanced, comprehensive program describing in detail the needs and justification for research and research training in the field of renal and genitourinary diseases. The Congress is fully informed concerning these needs which are as applicable now as they were a year ago. Accordingly, I will not reduplicate our testimony of May 8, 1974. Rather, might I suggest that the lay and professional volunteers of the National Kidney Foundation and other concerned consumer-provider groups are of the judgment that no effective action will occur unless this committee and the Congress directs the executive branch to permit the Department of Health, Education, and Welfare to take appropriate action to describe and effect a stable policy and program in biomedical research and research training.

Today, I am here to again urge that this committee continue its recognition of the dire need in kidney and genitourinary disease for increased Federal funding (1) to support basic investigation, (2) to expand health manpower development and (3) to extend detection and prevention programs.

Mr. Chairman, Senator Magnuson in his book "How Much For Health," appropriately observed:

"Congress has now voted to include coverage of end-stage kidney disease under the social security program. But this program will be extraordinarily expensive unless there are research breakthroughs. My view is that Government would be remiss not to invest in suitable investigations of the causes and ultimately the cures of kidney disease."

II. Needs and Priorities in Research and Training in Renal and Genitourinary Diseases

A. Background. 1. Prevalence studies. Urinary tract infections occur in approximately 1.5 percent of children and 4 to 5 percent of adults. Urinary tract infection ranks third to the common cold and menstrual disorders in women as a cause of loss of worktime. At least one-third of the individuals with end-stage renal disease (ESRD) who require kidney dialysis or transplantation experience such as a result of obstructive lesions of the urinary tract or renal infection or most commonly both.

Hypertension is estimated by the NHLI to occur in more than 30 million Americans and is probably the most common cause of kidney failure—especially in black Americans. In most instances, available treatment is not curative.

Benign obstructive disease of the prostate occurs in 80 percent of males 60 years of age or older and more than 50 percent of males in this bracket will develop cancer of the prostate. The probability that a man 40 years of age will live sufficiently long to require prostatic surgery is greater than 10 percent. We have only a rudimentary knowledge of the cause of prostatic disease.

Approximately 1.5 percent of hospital admissions in the United States result from stones of the kidney and genitourinary system (urolithiasis). It is estimated that at least $50 million yearly is spent on medical care for urinary stone disease, much of which must be accomplished in the hospital environment and involves surgical management.

Diseases of the urethra, bladder, and ureters are exceedingly common. For example, it is estimated that 10 percent of the 10 million diabetics in the United States have some degree of neurogenic bladder dysfunction. Infection of the urinary tract and loss of kidney function are extremely common complications.

Cancer of the kidney ranks fourth in order of occurrence in children under 15 years of age. In males 15 to 34 years of age cancer of the testis is the fourth most common and in males 55 to 74 years of age, cancer of the prostate ranks third only to cancer of the lung and cancer of the colon as a cause of death.

Glomerulonephritis and a broad variety of diseases of the renal filtering system and blood vessels of the kidney are especially common in children and with great frequency are progressive in nature resulting in permanent renal failure necessitating renal dialysis or transplantation. Similarly, a variety of congenital disorders of the kidney and genitourinary system, such as polycystic renal disease and bladder malfunction, with undue frequency lead to renal failure in children and young adults.

It has been estimated that as a result of a variety of disorders kidney and genitourinary disease rank fourth in frequency as a cause of death in the United States each year.

2. Support for health care in catastrophic illness. Public Law 92-603, section 299I, which amended the Social Security Legislation to permit medicare coverage for individuals with ESRD has permitted professionals in nephrology and urology to accomplish renal dialysis or transplantation for a large majority of individuals needing such treatment. This care carries an enormous price tag which, within 5 years, may exceed $1 billion annually. Certainly, the delivery of high quality care to the unfortunate individuals stricken with such catastrophic illness cannot be curtailed.

Close inspections of expenditures of funds associated with the program indicates that the costs of renal dialysis and transplantation are directly related to the extensive technologies and large medical teams required to deliver this medical care. Restrictive regulations appear to be a grossly inadequate approach to the problem because in the modern medical center, management is characterized as a "tight ship." Despite the enormous financial expenditure, these individuals are less than normally healthy and active and, in the main, must anticipate markedly reduced life expectancy. The solution then lies in a far more fundamental approach. The approach lies in understanding and preventing the disease processes which result in ESRD.

3. Fiscal year 1975 support for research and training in kidney and genitourinary diseases. During 1975 approximately $21 million are available through the NIAMDD for clinical and basic investigations related to renal and genitorurinary diseases. The entire research training budget of the NIAMDD is approximately $3 million, of which less than one-fourth is committed to research training for physicians and scientists in nephrology, urology, and related fields. Moneys committed to research to a major extent are problem oriented, particularly to chronic renal failure, uremia, dialysis, and transplantation, and research in this area has been productive during recent years. As a result of these investigatory findings, the private sector has been able to develop and perfect major improvements in technology, especially for renal dialysis. Support for additional studies and developments should certain in part come from industry.

B. Research and training priorities and direction. In the long run, Mr. Chairman, the failure of the executive branch to invest in basic research in the kidney and genitourinary disease fields will prove pennywise and pound foolish. Just where should these investments in research and training be made:

1. Project grants. The first and most fundamental approach to the development of new knowledge is the support of investigator initiated research. The well-trained investigator who pursues his own research interests has traditionally been recognized as the major contributor to new knowledge and new science. Research of this type requires project description, peer review, and individualized support. Support for individual project grants duing the past seveal years has diminished profoundly as "mission oriented" research through contractual mechanisms has inceased. As a first and foremost priority, we strongly advise increased support for investigator initiated projects in the broad field of renal and genitourinary diseases.

2. Research training. The training of young and new investigators, in our judgment, ranks second in priority only to the continued support of those individuals already fully trained, competent, and productive as clinical and basic scientists. The investigator who is deeply immersed in the scientific field is not only in an idea position to evaluate the areas of continued probing that are most likely to be productive, but also provides an ideal environment for the "rearing of children" who might subsequently assume an independent role as the next generation of investigators and teachers.

Two mechanisms of research training traditionally have been supported and these include the "institutional" research training program and the individual pre- and postdoctoral fellowships. It has become increasingly important to develop multidisciplinary research endeavors and programs with teams composed of a variety of individual investigators. The interdependence of research scien-

tists make it all the more important that institutional research training grants not only be continued, but expanded in contradistinction to the recent directive of the OMB which has required that all training program moneys be utilized for individual postdoctoral fellowships for fiscal year 1976. The concept as proposed by the executive branch defies logic in our estimation.

Institutional training grants permit judgment decisions by the faculty and training program directors on the basis of merit in the individual trainee instance. Review is accomplished at a local level without necessitating an overwhelming burden of individual trainee peer review by the study sections and research committees of the NIH. Accordingly, institutional research training program peer review is accomplished through program review and is based on institutional and trainee productivity. This mechanism has been and remains an extremely effective one which, to our knowledge, has not been challenged by the professional and scientific community.

In fiscal year 1972 and fiscal year 1973, $178 million and $195 million were budgeted by the Congress for research training purposes for the NIH and ADAMHA.

In fiscal year 1974 funding had decreased to approximately $150 million; however, the Congress increased the appropriation to $176 million for fiscal year 1975 funding and soundly rejected an administration attempted recision at a much lower level. Nonetheless, the requested budget for fiscal year 1976 has been markedly reduced to approximately $136 million. Many institutes in the NIH, including the NHLI and NIAMDD, have identified specific and striking needs for a profoundly increased number of faculty positions and traineeship stipend support as a result of the regressive policy of the administration in support of research training during the past 3 years.

The relatively recent development of Nephrology as a discipline renders the need in this field for expanded training programs all the more urgent. For, indeed, we have assumed a major clinical responsibility in the provision of palliative care of the sick with ESRD through renal dialysis and transplantation. Not only are our patient care responsibilities markedly increased, but we also have a profound shortage of junior and senior faculty needed to train clinical practitioner manpower to effect this mission. In no area of biomedical research and training is there greater need for the establishment of a stable policy and support program than in Nephrology and Urology.

3. Multidisciplinary research programs. As in other ventures, it is necessary in the biological and medical sciences to effect a "critical mess" in order to maximally address certain complex problems. This is especially true in immunology, biochemistry, cell biology, membrane transport and other complex and relatively new disciplines. To that end, individual investigators have for a number of years pooled talents and facilities under the umbrella of program project grants. Greater freedom in following new leads in accordance with individual and group productivity has resulted. Appropriate utilization of resources and time has been monitored by the peer review meachnism at the local and national level.

The demonstrated excellence and productivity of the program project grant approach has resulted in strong support for expansion of this concept through the development of specialized centers of research (SCOR) as is the instance of the SCOR's in atherosclerosis, hypertension and other disciplines by the NHLI. This vehicle has differed from the traditional program project grant largely in that there is more direction of program and closer supervision by the intramural staff of the NIH and the monitoring peer review body as part of the SCOR approach. The success of the SCOR program through the initial 5-year venture in the NHLI has lead the institute to continue and, hopefully, expand the SCOR program during fiscal year 1976. As a personal participant in the research review committee of the hypertension SCOR program of the NHLI, I can assure the Congress that even close and more demanding peer review is effected in these programs.

The concept of SCOR's as developed by the NHLI is most appropriate one for other institutes in our estimation. The enormously complex problem of investigating the diverse causes of progressive renal disease and the high prevalence of ESRD and the enormous financial burden of providing appropriate medical care and health care for the population with ESRD justifies a "mission oriented" multidisciplinary research effort in renal and genitourinary diseases in our estimation. To that end, we would place a high priority on the establishment of at least 10 SCOR's in nephrology and urology (conjoined programs) throughout the United States during fiscal year 1976. In our estimation, an effective SCOR can be accomplished with the funding of $750,000 to $1 million neces-

sitating an approximate support of $9 to $10 million annually for the recommended 10 SCOR's.

4. Renal and genitourinary research centers. The National Cancer Institute (NCI) and the NHLI have adopted the research center concept for targeted research, professional education, public education and demonstration purposes. The experience to date is too brief to document the effectiveness of this approach. Some members of the academic community and a number of the professional and volunteer health organizations strongly support the concept. Under ideal circumstances, particularly in a more favorable fiscal environment, we too would advocate the research center approach because of the desperate need for new knowledge and an increased number of academic faculty in the renal and genitourinary field. The accomplishment of necessary momentum in the training programs to develop young investigators would better be fulfilled if it were possible to mount a major thrust in a number of institutions. The center concept through current programs has involved expenditures of $3 to $5 million or more in the few centers so supported at the present time. Even if funding in the magnitude of $30 to 50 million were available, there are few academic institutions with sufficient manpower and know-how in nephrology and urology to effectively and appropriately utilize moneys of this magnitude. Indeed, it is doubtful that several academic institutions could in a conjoined manner develop programs which would justify expenditure of the taxpayers money in this fashion at the present time and under current circumstances.

For the reasons cited above and because of our judgment that first and second order priority should be given to investigator-initiated research projects and to research training programs for young investigators, and, especially, because of the need to increase the capabilities in research and develop new academic faculty for many of the health science centers, we urge that serious consideration not be given to the establishment of research centers in nephrology and urology at the present time. Rather, we urge that the experience in the established research centers be closely monitored while additional capability and expertise is developed in urology and nephrology and in the related basic sciences as is described above.

III. Detection and demonstration programs

In nephrology and urology, experience to date with detection and demonstration programs has not been encouraging save for the conjoined experience with multiple other disciplines participating in hypertension detection and management. In the latter instance a major national drive has been effected by a number of professional and volunteer health agencies and the NHLI as part of the national high blood pressure education program. The appropriate role of the National Institutes of Health, the Center for Disease Control, the Bureau of Health Resources, and the private sector should and must be determined.

Patient compliance is a major problem in many disease states in nephrology and urology. In order to accomplish improved compliance with treatment regimens, behavioral research strongly deserves research support through the NIH and ADAMHA. Detection and demonstration programs might appropriately be located in association with such behavioral research activities and should be a part of broad spectrum research activities such as in the proposed nephrology and urology SCOR's.

Summary

Mr. Chairman, as always it is an honor and pleasure to appear before you and your colleagues. We in the National Kidney Foundation are most appreciative of your past and present interest in helping to alleviate the massive national problem of kidney and genitourinary diseases.

We would be less than honest if we wid not say we are disappointed with the fiscal policies of the executive branch as applied to kidney and genitourinary diseases and to the overall problem of research and research training support.

We, too, are painfully aware of the current budget constrictions and the need for prudent spending. It is especially with this in mind that we have suggested a plan of action for kidney research which we feel makes good medical and fiscal sense. We have suggested a three-fold plan aimed at prevention and cure which is outlined as follows:

1. Increase the present funding levels to permit expanded (a) investigator initiated project grants, (b) research training to include individual fellowships, institutional training programs, and career development awards, and (c) encourage program project grants and contracts in kidney and genitourinary

diseases with a funding increase from $21 to $24 million. We urge the National Institute of Arthritis, Metabolism, and Digestive Diseases to place special emphasis on renal immunology, microbiology, epidemiology, biochemical and mineral research in urolithiasis, and to expand clinical and basic research in the causes of prostatic and other genitourinary diseases. We believe that the NIH should provide additional direction and support to studies of the role of kidney in hypertension. We believe that increased investigation in renal disease and hypertension is urgently needed since hypertension is probably the single most common cause of ESRD. Effective management of hypertension in the black citizen so as to prevent ESRD would not only relieve much suffering but would be "pound wise." Support of research in hypertension and kidney disease should be effected both in SCOR's in nephrology and urology in the NIAMDD and in the hypertension SCOR program in the NHLI. Training support should be allied with productive research programs.

2. Provide funding for specialized centers of research (SCOR's) in nephrology and urology (and the related basic sciences) which should be developed in at least 10 academic institutions. In SCOR's, multidisciplinary groups of scientists and academicians will be gathered in an effective manner to concentrate on high priority research in a variety of renal and genitourinary problems. After appropriate peer review each nephrology-urology SCOR should have a supporting budget of up to $1 million annually. We believe that an investment of $10 million annual in SCOR's in nephrology and urology over the next several years will provide better health care and, in the long run, in a major savings of the taxpayer dollar currently being utilized by the hundreds of millions for palliative care of the end-stage renal disease patient by renal dialysis and transplantation.

3. Detection and demonstration programs in renal and genitourinary disease warrant further investigation and strong support, especially for behavioral research in compliance studies. Such programs will require integration with community health centers wheer health care research might include evaluation of the role of new health manpower in compliance studies. Revenue sharing moneys as proposed for community health center hypertension clinics, would provide appropriate models for evaluation purposes.

We, therefore, recommend that this committee, through increased appropriations, direct the National Institute of Arthritis, Metabolism, and Digestive Diseases to increase their funding in basic and applied research for kidney and genitourinary diseases from $21 to $34 million with increased funding of investigator initiated project grants, research training programs and 10 nephrology and urology specialized centers of research. This would require a total funding level for the institute of $185.9 million as compared with the level Congress appropriated for fiscal year 1975 of $172.9 million.

Mr. NATCHER. Doctor, we appreciate your appearing before our committee.

Doctor, would you care to say a few words?

Dr. GILLENWATER. I would; Mr. Natcher, I appreciate the opportuni of appearing before your committee. I would like to just briefly talk about some of the urologic diseases and the research needs in these fields.

Urology has 11 percent of the hospital admissions and actually a very small amount of the research effort goes into this field and it carries significant morbidity and mortality. Kidney stones occur each year in 1 in 1,000 Americans. One out of each 1,000 Americans a year have kidney stones.

One and a half percent of hospital admissions are from kidney stones. The estimated hospital cost is $47 million. There are 260,000 workdays lost from kidney stones. There is a very small amount of research going on to prevent these stones. Benign prostatic enlargement in the male occurs in about 80 percent of us if we live to be 70 to 80 years old. Ten percent of these people with enlargement of the prostate or prostate difficulties require surgical intervention. There is minimal research going on to try to understand why the

male develops continuous enlargement of his prostate and what could be done to prevent it.

There is a significant problem in the United States of bladder disfunction, that is, incontinence of urine. It doesn't cause much death but certainly creates social problems. Ninety percent of the multiple sclerotic patient have some leakage of urine. Ninety percent of the spinal cord injuries leak urine.

Forty-three percent of people with Parkinson disease have urinary leakage. Ten percent of the diabetics, which are 10 million people in the United States, have bladder disfunction.

From urinary tract infections about 1 percent of children have it, 5 percent of the adult population.

Urinary tract infections in the young female cause more work

Urinary tract infections in the young female cause more work loss except for menstrual cramps and for upper respiratory infection, the common cold; systitis causes more work loss than any other single entity.

I would just like to say that the urologic genitourinary kidney diseases are very frequent and common disorders resulting in mortality and morbidity, and we would ask you to support research in these areas and to support, more importantly, training of capable investigators to focus on some of these very common problems.

I thank you.

Mr. NATCHER. Thank you very much, Dr. Gillenwater.

We appreciate your appearing before our committee and again, Dr. Hunt, we want to thank you.

Thank you very much, gentlemen.

Dr. GILLENWATER. Thank you.

DEPARTMENT OF LABOR BUDGET

WITNESS

THOMAS S. WATSON, JR., PRESIDENT OF THE BOARD OF GOVERNORS, FRIENDLY INN SETTLEMENT HOUSE; MEMBER, GREATER CLEVELAND NEIGHBORHOOD CENTERS ASSOCIATION

Mr. NATCHER. Next we have before the committee Mrs. Wills. Mrs. Guy Wills? What about Mr. Thomas Watson?

Mr. Watson?

Mr. WATSON. Right, here, Congressman.

Mr. NATCHER. All right, Mr. Watson.

We are glad to have you before the committee, Greater Cleveland Neighborhood Centers Association, Cuyahoga County. We are glad to have you, Mr. Watson. We will be glad to hear from you.

Mr. WATSON. Thank you, Congressman.

I am Thomas S. Watson, Jr., the president of the board of governors of the Friendly Inn Settlement House.

As a result of having been elected president of the board of governors of a settlement house I was automatically made a member of the board of the Greater Cleveland Neighborhood Centers Association which I represent here today.

Prior to my election as president I served as treasurer of Friendly Inn and a member of the Greater Cleveland Neighborhood Centers Association Budget Committee. In those positions I concerned myself with the delivery of social services to the disadvantaged of Greater Cleveland and primarily the accountability for the dollars involved in purchase of those social services.

I am a certified public accountant and serve as a principal in a Cleveland-based CPA firm. I received numerous awards, including the Outstanding Young Citizen for 1973 by the Cleveland JC's.

I would like to address the audit and monitoring function employed by the Department of Labor as it pertains primarily to the change between the categorical grant programs that have existed and the block grant system that is now in effect as a result of the Concentrated Employment and Training Act.

The audit function of the Department of Labor has long been one recognized as both necessary and helpful. DOL was employing auditors to perform program as well as fiscal audits long before the Government Accounting Office audit standards of 1972 were published.

However, there has been a recent shift in DOL. The move from categorical grants under the Emergency Employment Acts and the Manpower Training Acts to the block grants of the Concentrated Employment and Training Act have provided the Department of Labor and Congress with a new opportunity.

Categorical grants were audited at least once a year. The audit performed on behalf of the Department of Labor was structured to evaluate the categorical grant conditions and basic DOL and equal employment opportunity guidelines.

This audit was inevitable. As a result compliance with grant conditions was necessary on the part of all sponsors. If the grantee was found in noncompliance by the auditor his subsequent funding was in jeopardy. It was a considerable clout, a considerable way of evaluating the performance of grantees with some recognizable consequence for not performing according to the grant conditions and guidelines.

That emphasis has apparently now changed a little bit. The audit function has moved from the control of the regional auidtors of the 10 regions to the control of local officials in many cases. There are now two audit requirements with the new CETA program, one being the audit of the prime sponsor, which is an audit that is to function very much as the audits of the categorical grant programs.

The other part of that is an audit of the service delivery units, which are controlled by the prime sponsor. Those service delivery units can be audited by the State auditor, the city auditor, an independent public accounting firm hired by the city, and any number of kinds of people.

That presents a unique quality control problem for the regional audit office. The regional audit office is expected to monitor the audit function itself and the resulting report to insure compliance with specific audit guide regulations and specific functions within the audit performance.

With the control of the auditor moving from the regional office to the political subunit, the governmental unit, and leaving the responsibility of quality control with the regional office, we have moved things

apart a little bit and we have maybe created an unwieldy kind of animal or an unwieldy kind of system.

My understanding is that the audit requirements, the procedures that are available or that are to be followed in the audit function, can still be changed. They are not rigid. They are not even being used at this point. The first audit that is to come up under the CETA program will come up affecting a period ending June 30, 1975, so we are looking at new procedures and requirements that can be dealt with.

We feel that one of the things that could be very effective is an emphasis by the Department of Labor and by the Regional Manpower Administration to cause the grantees, the prime sponsors, to employ audit firms or people of audit capacity that are familiar with the Department of Labor guidelines and that are familiar with the processes that are involved in the older programs, in the categorical grant programs.

We understand that there is a problem of budget in this kind of an audit function, that title I and title II have in their program budget dollars for the audit function. However, the other titles of the new act have not yet been put into budget dollars for audit services.

Our main thrust is to request that this committee encourage the Department of Labor to cause the regional audit offices and the prime sponsors under the CETA program to employ auditors in both a planning and an evaluation process.

Auditors that are familiar with the Department of Labor guidelines and that are familiar with the kinds of controls that are necessary to deliver real services for real dollars should be involved in the process of planning so that when the proposal is submitted for the initial funding there is a workable plan and a method for implementing that plan in a realistic manner.

There is a method of evaluating the performance against the plan in a realistic manner. Indices and data can be accumulated and developed that will allow real measurement of delivery of social services for the dollars that Congress has appropriated to purchase those services.

If that kind of thing happened on a more broad basis and the audit function were to evaluate the performance against the budget, we may develop more delivery of social service for the dollars that we are expending.

That is our primary thrust.

Mr. NATCHER. Mr. Watson, thank you very much for appearing before our committee at this time.

Mr. WATSON. Thank you.

[The statement follows:]

BIOGRAPHICAL SKETCH—THOMAS S. WATSON, JR., PRESIDENT OF THE BOARD OF GOVERNORS, FRIENDLY INN SETTLEMENT HOUSE

Thomas S. Watson, Jr. was elected president of the board of the Friendly Inn Settlement House to serve the 2-year term that expires August 31, 1976. He by virtue of his election serves as a member of the board of the Greater Cleveland Neighborhood Centers Association. Prior to his election as president Mr. Watson served as the treasurer of Friendly Inn and a member of the Greater Cleveland Neighborhood Centers Association budget committee.

In the above positions he has concerned himself with the delivery of social services to the disadvantaged of Greater Cleveland.

Mr. Watson is a certified public accountant and serves as a principle in a Cleveland based CPA firm.

He has received numerous awards including the JC's "outstanding young citizen for 1973."

AUDIT AND MONITORING

The audit function in the Department of Labor (DOL) has long been one recognized as both necessary and helpful. DOL was employing auditors to perform program as well as fiscal audits long before the Government Accounting Office (GAO) Audit Standards of 1972 were published.

However there has been a recent shift in DOL. The move from the categorical grants under the Emergency Employment Acts and the Manpower Training Acts to the block grants of the Concentrated Employment and Training Act have provided the Department of Labor and Congress with new opportunity.

Categorical grants were audited at least once per year. The audit, performed on behalf of the Department of Labor, was structured to evaluate compliance with the categorical grant conditions and basic DOL and Equal Employment Opportunity guidelines. This audit was inevitable. As a result, compliance with the grant conditions, and so forth, was necessary. If the grantee was found in non-compliance by the auditor, his subsequent funding was in jeopardy.

The emphasis has now changed. The audit function cannot now be only a watchdog to discover and report noncompliance with the intent of the law. Auditors should now be employed by both DOL and the prime sponsors of DOL grants, to develop systems and methods of measuring service delivery costs and operational efficiency.

The block grant program has provided more flexibility for local government to respond to the needs of the people. It appears that not enough emphasis has been put on the audit and monitoring function. DOL should encourage the use of grant funds for these purposes.

If there has ever been a time for Congress to emphasize accountability and efficiency in Government, it is now. Government must develop the ability to deliver needed services to the people in an efficient, cost conscience and responsive manner. In this effort, administrative costs for increased accountability are a good investment.

Often in an effort to be responsive to the needs of the people, Government cuts administrative and audit budgets. These cuts cause more inefficiency and duplication of effort and result in losses in service delivery. For better service delivery and efficient operation, the reverse should happen.

Congress is accountable to the people for the dollars that are appropriated. How can you render an accounting if you have not developed sufficient auditing and monitoring support.

We feel the need for emphasis on using auditors to assist the DOL service delivery units (grantees) in developing systems for monitoring their performance.

As accountability in Government is demanded from more fronts, economy and efficiency begin to play key roles in the evaluation of service delivery. The auditor can assist in planning and evaluation of service delivery.

Audits have been performed by and on behalf of DOL. With the coming of CETA and the concept of block grants rather than catagorical grants, we have a new opportunity. Auditing and monitoring must be performed not only as before but also on the service delivery units, sub grantees. CETA programs should be encouraged to perform program and fiscal audits and use DOL grant funds for those purposes as well as direct service delivery.

People have raised a number of concerns—from racial discrimination in DOL programs hiring practices to using DOL funds for political patronage. These charges are often not answered because the information is not readily available. Performance of regularly scheduled program and fiscal audits will provide that data.

The consequences of misuse of scarce Government dollars are felt by the "haves" as well as the "have-nots." We cannot afford to move backward in the effort toward economic stability. DOL funds properly applied should be a part of the plan.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WITNESS

RICHARD VERVILLE, VOLUNTEER, NATIONAL EASTER SEAL SOCIETY

Mr. NATCHER. Our next witness is Mr. Richard Verville. I believe you represent the National Easter Seal Society, and we are glad to have you appear.

Mr. VERVILLE. Thank you, Mr. Chairman.

I would like to mention that the past president of the National Easter Seal Society was Mr. Clay Stewart of your great State of Kentucky, and it is just a coincidence that the annual convention of the National Easter Seal Society for Crippled Children and Adults is in Louisville this November 4 through 8.

The National Easter Seal Society is thought of by many people as just a fundraising organization, but I would like to make it clear that it operates programs and 70 percent of the money which is contributed into programs and services for disabled children and adults.

Most of those programs are medical rehabilitation programs. In some cases vocational training and educational services are provided. The essential thrust, though, I would say, is medical rehabilitation.

I would like to focus my comments in the brief time that I have, and I fully understand why you limit people to 10 minutes, on the program.

The rehabilitation services program which is a program of grants to the State from the Rehabilitation Services Administration in HEW is the first I would like to comment on.

While the Easter Seal Society local programs are operated in the majority from contributed funds, voluntary effort, a good portion of services are paid for by the State rehabilitation agencies in all 50 States, and we would like to urge you to support that program at the level of $720 million for the fiscal year 1976.

That is the authorization level in the 1974 amendments but that is a program under which appropriations are geared to authorization level, as long as the States can match, and it is my understanding the States can match as much as $900 million from talking to the State administrators of voc rehab who will appear before you.

Second, title V of the Social Security Act program, maternal and child health and crippled children's program, that program also purchases services for crippled children from the Easter Seal Society.

It also funds preventive care by the Easter Seal Society for child health. That program, as you know, has been in danger of being radically reduced. The administration has requested $212 million for a program whose fiscal year 1975 level under the appropriation law is $294 million.

We would urge you to maintain that program at the level of at least $294 million for fiscal 1976.

Finally, I would just like to touch on research. Congressman Roybal was not here when Dr. Finley spoke, but I would like to back up the statement he made.

Dr. Finley made a presentation supporting more money for rehabilitation research in the budget of the Rehabilitation Services Administration. He argued for a $32 million level, which is the level at which that program was funded in fiscal year 1972, and it has come down to $20 million now.

It has been $20 million for the last 3 years. The administration has requested only $20 million again. I think he didn't have time to explain well enough how some of those devices that were put on the table here work, but one of those devices is a device which is an electrical one that will enable a person who is paralyzed to use his legs, one or both, and to talk again. His function won't be totally restored but one of those electronic devices will enable that person to operate his muscles. It will be a substitute for the nerve system really and make the muscles and the joints function again.

Some extraordinary things have been done, for example, Congressman Roybal, at Rancho Los Amigos, and this is the kind of research we are talking about when we are talking about rehabilitation research in the Rehabilitation Services Administration budget.

It is medical research. It is not ivory tower medical research. It is research aimed directly at improving the functional capacity of patients, and the Easter Seal Society is a provider of care to those people, particularly to severely disabled people.

We just urge you to support the request of the Congress of rehabilitation medicine and the academy for that $32 million level to get the program back to its fiscal 1972 level.

I appreciate the opportunity to testify and I would like to leave with the committee a breakdown we did of the HEW budget as it affects the disabled which is a breakdown you may not normally see because it is not by agency category.

This looks at disabled people and takes the various parts of the HEW budget and shows where it has been in the last 2 years and what the request is for 1976.

[The statement follows:]

TESTIMONY OF THE NATIONAL EASTER SEAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

Mr. Chairman, I am Richard Verville, and I am testifying on behalf of the National Easter Seal Society for Crippled Children and Adults, Easter Seal Society. I am testifying in the capacity of a volunteer, one of the many volunteers who participate in Easter Seal Society programs throughout the country. We are committed to improved care and services to disabled children and adults and our testimony will focus on a number of HEW programs which relate to the needs of the disabled.

Our Easter Seal Society programs are multiservice programs which include medical treatment, preventive medical care, social services, vocational training for those of appropriate ages, and special summer camp programs for disabled children. We therefore have a somewhat unique perspective on care for the disabled, one which is comprehensive. Our own budget for all of our programs is

supported mostly from voluntary contributions. More than 70 percent of such contributions are returned in the form of services or programs for the disabled. We do receive reimbursement or payment from some Federally sponsored programs, however, and I am here today to urge a continuing Federal effort in these programs.

Our testimony today will touch on three of the most important programs for the disabled: rehabilitation, maternal and child health, and NINCDS.

In rehabilitation, we endorse fully the request of the Council of State Administrators of Vocational Rehabilitation for an appropriation of $720 million. The States, we understand, can easily match this required funding level. As a matter of policy, money could be spent no better way. A recent study published by the National Academy of Science has confirmed that rehabilitation dollars spent return almost 10 in benefits measured in terms of reduced maintenance payments, and increased tax revenues.

We also want to emphasize the need for expanded rehabilitation research efforts. One of the preceding witnesses, Dr. Finley of Temple, has clearly set forth the value of rehabilitation research and why it must be expanded. You will hear other witnesses emphasize this same need; those representing bioengineering, mental illness, and vocational research. From the perspective of the provider of care, research is clearly needed in order to really achieve the goals of the 1973 Rehabilitation Act: the rehabilitation of the severely disabled. The severely disabled need special care because their impairments are severe yet we are far from capable of dealing with their needs at this stage in our rehabilitation efforts. Just as we have sought to conquer cancer, we must be willing to conquer severe disabilities and permit the severely disabled—the quadriplegics, the double amputees, the blind, and others—to lead full and productive lives. We support the request of Dr. Finley and the American Congress of Rehabilitation Medicine and the Coalition for Health Funding for an appropriation of $32 million for rehabilitation research.

In other rehabilitation programs such as training and facility improvement, we endorse the position of the National Rehabilitation Association and the International Association of Rehabilitation Facilities.

With regard to children, our Easter Seal Society programs work closely with the State crippled children's program and the maternal and child health program. We have also been one of the major contractors regarding the early and periodic screening and detection program under medicaid and under the maternal and child health programs. We wish to acknowledge the efforts of this subcommittee to provide for the continuation of the crippled childrens and maternal and child health programs. The "Forward Plan for Health fiscal year 1976–80," published in June of 1974 by the Assistant Secretary for Health concerning this program indicated that "maternal and child health programs have had a significant and demonstrated influence in reducing national infant mortality rates," page 29. We would urge that the title V program therefore be funded at least at the fiscal year 1975 level of $295 million, if not more. The recommendation of the Coalition for Health Funding and the American Academy of Pediatrics is $339 million. We think this represents a reasoable level for it would provide some new money for a program whose effectiveness has been demonstrated.

We would also urge that you continue and not reduce the funding for the National Institute of Neurological Diseases, Communicative Disorders, and Stroke. We recommended a level of $156 million, which was also supported by the Coalition for Health Funding. The fiscal year 1975 level was $142 million, and $165 million will simply enable the Institute to begin research efforts into one of its new foci—communicative disorders.

I thank you for the opportunity to testify and will be happy to assist the subcommittee or staff regarding any of the items discussed in my testimony at any time.

HEW BUDGET FOR FISCAL YEAR 1976 AND SERVICES TO THE DISABLED EXCLUDING MEDICARE AND MEDICAID

	1974 level	1975 appropriation law	1975 rescission level	1976 request	Difference between 1975 law and 1976 request
A. SERVICES PROGRAM					
1. Rehabilitation Services (RSA)	$650	$680	$680	$680	0
2. Title XX Social Services (aged, disabled, and family and children's services)	1,300	1,400	1,892	1,500	−$342
3. Maternal and child health, crippled children's program—including services (90 percent, research and training (10 percent) (HSA)	268	291	[1] 265	212	−82
4. Mental Health Services including drug abuse and alcoholism (ADAMHA)	460	470	[2] 426	424	−46
5. SSI Rehabilitation Services (SSA)	[3] 25	49	46	55	+6
6. Development Disabilities—total of services and special projects	54	54	54	54	0
7. Education for Handicapped	147	[4] 299	[5] 196	[6] 175	−124
8. Headstart—10 percent earmarked for disabled children	392	414	414	434	+20
B. TRAINING					
1. Rehabilitation	17	22	15	22	0
2. Allied health	36	[7] 35	[8] 0	0	−35
3. Mental health training-psychiatry, psychology, social work, nursing	100	[9] 95	[10] 62	45	−50
4. Alcoholism and drug abuse training	22	[9] 22	[11] 12	10	−12
5. Maternal and child health research and training	22	[9] 26	.....	19	−7
6. Educational personnel for handicapped children (spec. ed.) (OE)	40	[7] 40	[12] 38	40	0
C. AID TO INSTITUTIONS OF HIGHER EDUCATION FOR RESEARCH					
Biomedical health (NIH):					
1. Neurological diseases and stroke	121	142	[13] 112	114	−28
2. Cancer Institute	527	692	[14] 569	605	−87
3. Child health and human development	125	141	[15] 118	106	[16] 19
4. Aging, Institute of	[17] 0	[17] 0	0	16	.....
Other research:					
1. Mental health	90	81	[18] 70	81	0
2. Drug abuse	37	32	[12] 30	32	0
3. Alcoholism	9	9	[12] 7	9	0
4. Rehabilitation research—Rehabilitation Services Administration (HEW)	20	20	20	20	0

[1] Rescission request of $29,000,000.
[2] Rescission request of $44,600,000 total.
[3] ½ year only.
[4] Includes advance funding item.
[5] Includes $50,000,000 advance funding for next year.
[6] Includes $50,000,000 advance funding.
[7] Continuing resolution.
[8] $35,000,000 rescission requested.
[9] Appropriation law for fiscal year 1975.
[10] $33,000,000 rescission requested.
[11] $10,000,000 rescission requested.
[12] $2,000,000 rescission requested.
[13] $30,000,000 rescission requested.
[14] $123,000,000 rescission requested.
[15] $23,000,000 rescission requested.
[16] Including aging below as a +$16,000,000.
[17] Part of human development above.
[18] $11,000,000 rescission requested.

Mr. NATCHER. Fine.

Thank you, Mr. Verville. We are glad to have you before the committee.

Mr. VERVILLE. Thank you.

WITNESS

PAUL HARING, NATIONAL ADVISER, U.S. COALITION FOR LIFE

Mr. NATCHER. Now, Mr. Haring, come around. Mr. Paul Haring, Legal Counsel for the U.S. Coalition for Life.

Mr. Haring, we will be glad to hear from you.

Mr. HARING. Thank you, Mr. Natcher.

In addition to my own statement I have a statement prepared by Randy Engel of the U.S. Coalition for Life.

Mr. NATCHER. It will be inserted in the record immediately following yours in its entirety.

Mr. HARING. Thank you very much, Mr. Natcher and Congressman Roybal.

I appreciate the opportunity to be here.

By way of background, I am a graduate of the University of Texas Law School, the University of St. Thomas, and formerly served in the Texas Legislature for three terms.

We are here primarily to focus on the expenditure of funds appropriated by this committee for abortion by HEW. These funds are principally being spent under two titles, Title XIX, the Medicaid section, and Title IV, Aid to Families with Dependent Children.

Mr. Chairman, I am sure that you are aware and all the members of the committee are very much aware of this issue. It is one issue which will not go away. As long as HEW continues to expend public tax funds for killing unborn children we will be here to urge you to take action to prohibit HEW from using the money for abortion, because it is wrong.

Abortion involves the destruction of an unborn human being. This is a medical fact. Prior to the abortion controversy no one ever stated to the contrary. I am sure HEW has numerous pamphlets that they have distributed stating that abortion kills a child.

Planned Parenthood distributed materials to the general public stating without any qualification that abortion kills a child. It is wrong because an unborn child is a human being just as much as you or I. He is made in the image and likeness of God. He has an eternal destiny and the Government has no right to destroy this life.

That is the issue before this committee, whether or not the funds you provide HEW will be used to destroy human lives.

Congress has only authorized the funds to be used for medical procedures to promote health. In no way could anyone possibly conceive that Congress ever intended for the funds to be used for abortion.

Last year we appeared before the Senate Appropriations Committee. We were greeted with skepticism as to whether HEW was actually using this money for abortion. After that appearance Senator Bartlett offered an amendment that passed the Senate last year prohibiting the HEW appropriations bill funds from being used for abor-

tion. At that point HEW came forward and admitted that they were using in the neighborhood of $50 million a year to perform or pay for close to 250,000 abortions a year under the medicaid program.

They did not give Congress the feticide figures under title IV of the Social Security Act, that is the aid to families with dependent children program. HEW has approved plans in at least 17 States to pay for abortions in those States with the funds that you appropriate to be used to benefit dependent children. HEW takes funds appropriated by Congress to benefit dependent children and allows the use of the funds to kill dependent unborn children. How long will this committee tolerate this intolerable misuse of funds?

Mr. FLOOD. You are talking about abortion now as distinguished from what they call family planning?

Mr. HARING. That is right; but we are very much concerned about the entire massive Federal antilife programs such as artificial birth limitation and sterilization programs. We ask this committee to put a restriction on the appropriation bill to prohibit HEW from continuing to use this money for feticide and that it not fund antilife programs that lower the general morality of the Nation. If you do act, it is clear that HEW will continue to spend upward of $100 million during the next fiscal year for over 300,000 abortions.

This country is made up basically of hard-working, religious, God-fearing people who go to work every day, earn a living by the sweat of the brow, try to teach their children respect for all the values that this country stands for, and these citizens are forced to kick into this giant killing fund for HEW.

You have no choice. If you work for a living you are forced to pay for this killing. Now, this is not Government neutrality. This is just the opposite. We hear the argument that it is discriminating against the poor not to provide abortions. Well, how is it discriminating against the poor if you do not provide funds for any person to obtain an abortion? If you take the position that for every constitutional right you have to provide Federal funds to fulfill that right, then what about the case of pornography?

The Supreme Court has held that a woman or a man has the constitutional right to possess pornography in their home. (Naturally we do not agree that the Constitution provides a right to possess pornography or a right to kill unborn children, but the Supreme Court has written opinions that such rights exist.) Now, no doubt the Federal Government expends money to purchase decent literature for libraries. There are some people who might be too poor to buy pornography or else have a very limited supply. Are you discriminating against the poor when you do not provide funds for pornography? Is it unconstitutional not to provide funds for pornography? Of course not.

If you take the viewpoint that you have to provide funds for every so-called constitutional right, then there would be no limit. Congress would have very limited authority in deciding which programs to support with public funds. You would have to let the Supreme Court decide what you will spend for and what you will not spend for.

The primary movers behind the abortion movement are a few wealthy families who have contributed directly or indirectly millions of dollars for feticide. Their theory of helping the poor is to eliminate

their children. That is not aiding the poor. I am sure that this Nation can do better than that.

Mr. Chairman, I would like to comment on the grossness of HEW in giving a cost analysis on raising a child versus the cost of killing an unborn child. They have given a large sum of money, I think $2,200 per child per year, that it will cost if you don't abort that child.

I hope that we haven't reached so low that we put a dollar sign on the life of an individual and say we have to kill because we can't provide $500 million or whatever is necessary to provide for human needs. That we have to kill individuals in order to provide for more "important" programs.

I hope that we haven't reached that point. But this is the argument that HEW is using. This is essentially a neo-Nazi argument, that you look at the cost of an individual. A human being has intrinsic worth. He is of value because he is made in the image and likeness of God, because he has an immortal destiny.

Regardless of what color or how little money he has, he is of infinite value, and that is the principle this country was based on and we have done very well respecting this principle. It would serve us extremely well if we would continue to abide by these principles.

So, Mr. Chairman, we ask that you put a restriction in the bill not to allow HEW to continue this killing. If you look at the Federal legal history of abortion you would see that as far back as 1876 Congress has passed statutes against abortion. As late as last year Congress had passed restrictions against abortions.

The Supreme Court has not held the Federal statutes to be unconstitutional. Despite this history HEW has gone ahead and used the money for abortion. It doesn't make sense. On the one hand, you say we are going to put you in prison if you promote abortion, and, on the other hand, you turn around and let a Government agency spend $100 million to promote abortion.

Thank you very much, Mr. Chairman.

[The statements follow:]

STATEMENT OF PAUL B. HARING, NATIONAL ADVISOR, U.S. COALITION FOR LIFE

Mr. Flood, I wish to thank you and the other members of the committee for the opportunity to appear here today. By way of introduction, I am a member of the Advisory Board of the U.S. Coalition for Life, have served as Executive Director of Americans United for Life, am a member of the legal advisory board of the National Right to Life and am speaking on behalf of the U.S. Coalition for Life and myself today. By way of background, I am a member of the Texas Bar, a graduate of the University of Texas School of Law and of the University of St. Thomas, Houston, and have served three terms as a member of the Texas House of Representatives.

The primary purpose of appearing here today is to protest Federal funding of abortion and, more specifically, H.E.W. subsidization and promotion of abortion and to urge respect for the dignity of both women and men.

First, I believe it would be well to consider that Congress, for over one hundred years, has demonstrated a respect for human life. This respect has been demonstrated in a series of acts passed by Congress to protect the lives of unborn children. In 1873, a mere five years after the ratification of the Fourteenth Amendment, which the Supreme Court has interpreted to prohibit States from protecting the lives of unborn children, Congress passed a statute to protect the unborn. 17 Stat. 598 (1973) prohibited the sale, lending or giving away of any drug, medicine, or any article whatsoever for causing unlawful abortion within the District of Columbia, any of the Territories of the United States, or any place within the exclusive jurisdiction of the United States. The statute passed in 1873 also prohibited the importation of any drug, medicine, or article for causing unlawful abortion. 17 Stat. 598–599 (1873)), Title 19, Section 1305. United States Code.

Three years later in 1876, Congress prohibited the use of the mails for the support of operations to effectuate an abortion through the mailing of information concerning these operations. 19 Stat. 90 (1876), Title 18, Sec. 1461 United States Code. In late 1970, Congress initiated a new form of anti-abortion legislation through its Family Planning Services and Population Research Act which prohibits the use of funds appropriated under the Act for family planning service "programs where abortion is a method of family planning." 84 Stat. 1504 (1971), Title 42, Section 300 a–6 United States Code. On June 18, 1973, Congress prohibited a court or public official from requiring an individual or organization, such as a hospital which received any grant, contract, loan, or loan guarantee under three major Federal statutes, to perform or provide facilities for the performance of any abortion if it is contrary to the religious belief or moral convictions of that person or organization. Pub. L. 93–45 (June 18, 1973). On December 18, 1973 Congress prohibited the use of foreign aid funds for the performance of abortions.

Professor Joseph Witherspoon of the University of Texas School of Law states, "The specific Federal legislation spanning a hundred years certainly manifests a clear-cut anti-abortion policy on the part of Congress extending not only to action in the private sector but also to action being taken on Federal government property or with the assistance of Federal government funds. While the above Federal policy may be affected by the decisions of the Supreme Court in the private sector, as a result of its recent decisions in the *Wade* and *Bolton* cases, supra, it is abundantly clear that specific anti-abortion policy is in no way adversely affected by these decisions in the Federal governmental sector with respect to the Congressional control of Federal public property and the use of Federal public funds."

One would think that with such a clear-cut pro-life, anti-abortion policy by the United States Congress, H.E.W. would administer its programs in accord with Congressional intent of over a hundred years duration to protect unborn human lives. Unfortunately, nothing could be further from the truth. Congressman Roncallo of New York states that from April 1971 to August 1972, the Department of Health, Education and Welfare paid 2.7 million Federal dollars for 27,000 abortions in New York State. Page H 5989 Congressional Record, June 28, 1974. Twenty-five thousand abortions were paid for in 1971 with Federal-State funds in the State of California. H.E.W. is not only routinely paying hundreds of millions of dollars for abortions under the Medicaid program but is actually issuing directives attempting to force all States to pay for abortion on demand. Because a specific anti-abortion amendment has not been placed on Title XIX (Medicaid) of the Social Security Act, H.E.W. has used this section of the law to promote elitist right to kill philosophy. With no authorization for abortion and a clear-cut Congressional policy against abortion, H.E.W. arrogantly proceeds to finance mass murder. Murder is a strong term, but I ask you to look at the actual pictures of abortion which are attached to these statements and ask how else it should be described. The victims are clearly identified as nothing more and nothing less than little human beings.

Why should not the intentional killing of another human being, since self-defense is not involved, be described as anything other than murder. How many citizens would voluntarily spend their dollars to pay for deliberate killing of their fellow human beings? When H.E.W. uses tax funds for such atrocities, it is forcing every taxpayer in this nation to participate in killing babies. H.E.W. is forcing pro-abortion morality on the American taxpayer. How much longer will this committee and Congress allow this bloodshed to continue? The good

policy enactments of Congress are not sufficient. We insist that this committee adopt a strong amendment to H.E.W.'s appropriation bill to bring this atrocity to an immediate halt. H.E.W. should not be allowed to perform, fund or encourage abortion. When fourteen Jewish children were murdered at Maliott, there was justified outrage in Congress, but there is no outrage when 1,400 American unborn children are killed each day in this country. This country is literally on a national suicide binge with the most radical, loose abortion policy of any country in the world. Our birth rate has plummeted below the rate needed to even replace the present population. Over 1.4 million human lives were destroyed last year by abortion. The number of unborn destroyed in this country by abortion will soon approach the number of Jews destroyed by Nazi Germany—6 million. The lesson of Nuremburg has taught us that citizens have a duty to speak up when atrocities occur, but how few members of Congress have spoken up and how few members of the Press have spoken up?

Fortunately, some members of the secular and religious Press have given the facts and will continue to do so until justice is done. I have attached a July 4, 1974 editorial of the Catholic Standard of Washington, D.C. which examines the Senate's recent vote to protect dogs from chemical experiments but overwhelmingly rejects protection for the unborn by the Senate vote against cutting off Federal funds for abortion. The editorial states that, "unborn children were rated somewhere below rats and rabbits and were not considered to be in the same league as Beagles. We are hard put to rationalize the deep concern for the Beagles and the complete lack of concern for unborn human beings . . . In fairness to some Senators, it can be said that did not feel either amendment should have been raised in connection with a military hardware appropriations bill. Nevertheless, both were voted on. The Beagles were voted up and the unborn children were voted down. What is left is a miserable record of priorities as given us by the United States Senate."

In addition to providing abortions in its health facilities, operating abortion referral services, and subsidizing abortions, if this were not enough, H.E.W. has now come up with a totalitarian plan to force every public school and many private schools from kindergarten to graduate school to purchase abortion medical insurance benefits. Every school throughout the breath and length of this land which receives even token Federal funds for education will, according to the plan, purchase abortion coverage in its health insurance plan for faculty, students or staff or it will have its Federal funds terminated. This proposal is part of H.E.W.'s so-called sex discrimination rule guidelines which were proposed last month. Religious schools would have to write and explain to H.E.W. their regilious opposition to abortion and request H.E.W. to rule them exempt from the abortion insurance requirement. This committee should use its authority to prohibit H.E.W. from using any of the funds in this Act to enforce such rules. All H.E.W. abortion activities should be halted, including abortifacient drugs and devices.

When Congress passed the Family Planning Act in 1970, it passed as previously mentioned Title X Section 1008 which provides, "'None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning." The amendment is very clear that funds appropriated for family planning may not be used where abortion is a method of family planning. The amendment is not limited to surgical abortion: it includes any type of abortion. Birth control pills as they existed in 1970 were allowed because they acted by preventing ovulation from occurring, thereby preventing a new life from being created. Such pills were not considered abortifacient. Recently, drugs have been designed with the action to abort the new life by preventing implantation of the fertilized ovum in the event the action to prevent ovulation and fertilization failed. In other words, what is being pushed off on the American woman as birth control pills are actually abortifacient drugs. This fact has not been made known to the American public. One reason why H.E.W. would not make the fact widely known is because it is prohibited from expending family planning funds for such abortifacients. A program providing drugs to cause abortions is prohibited by Sec. 1008. It is obviously to the drug manufacturers' interest to keep the facts from the general public, because millions of women would not take pills which cause abortion. There is no authority for H.E.W. to use family planning funds for abortion, and the illegal use of funds should be stopped by this committee.

There are other means of family planning that are used very successfully by many millions of women throughout the world, means which respect the dignity of the couple, enhance their mutual esteem, contain no threat to life or health of the woman or her potential offspring and are more effective in preventing pregnancy from occurring than drugs and, last but not least, "cost nothing." These means are natural family planning. I am not speaking about just the old rhythm method which does not work for women with irregular cycles but another method which has been tried and proven to be successful. I have attached to this paper copies of brochures describing two of the family planning methods, the Ovulation Method or Billings Method and the Sympto-Thermic Method. The United States is currently spending approximately 500 million dollars annually for domestic and foreign family planning. If Congress would stop all funds for abortifacient drugs and H.E.W. and A.I.D. would make these natural family planning methods available to women, billions of dollars of taxpayers money would be saved and most importantly the health and lives of women who are now being killed and seriously injured by drugs, I.U.D.s and surgical abortions would be saved. This information also helps the woman with infertility problems achieve pregnancy. Despite the obvious advantages of this type of family planning, this information is disributed in only a very small number of Federally supported family planning

clinics and the few which give out such information generally do not use up-to-date methods or give adequate information. Why is there this great prejudice against a more reliable, safe and free family planning service? One important reason is because the gross profits made by drug companies who are using women as human guinea pigs would be eliminated.

Secondly, population controllers cannot manipulate women by the natural family planning methods. Women are free to use or not use natural family planning according to the judgment of the couple's conscience and what is best for them. H.E.W. would rather continue sterilizing persons who do not meet their quality standards; they would rather keep experimenting on poor persons than leave the decision to conceive or not to conceive a child up to the parents. As long as Congress demands that the Welfare Department push birth control by drugs, there will never be respect for human rights. There is necessarily coercion involved when the grantor of benefits pry's into the personal lives of welfare recipients and suggests how the recipient should act.

Mr. Chairman, when Pope Paul VI issued his Encyclical Letter on the Regulation of Birth, Humanae Vitae, he was unjustly pillared and ridiculed by even some Catholic priests. Some who had openly rebelled initially are now the greatest exponents of the wisdom of this document.'

With your permission, I would like to quote two especially pertinent paragraphs, especially pertinent because this country is searching for answers to the deep troubles facing our nation.

17. Upright men can even better convince themselves of the solid grounds on which the teaching of the Church in this field is based, if they care to reflect upon the consequences of methods of artificial birth control. Let them consider, first of all, how wide and easy a road would thus be opened up towards conjugal infidelity and the general lowering of morality. Not much experience is needed in order to know human weakness, and to understand that men—especially the young, who are so vulnerable on this point—have need of encouragement to be faithful to the moral law, so that they must not be offered some easy means of eluding its observance. It is also to be feared that the man, growing used to the employment of anti-conceptive practices, may finally lose respect for the woman and, no longer caring for her physical and psychological equilibrium, may come to the point of considering her as a mere instrument of selfish enjoyment, and no longer as his respected and beloved companion.

Let it be considered also that a dangerous weapon would thus be placed in the hands of those public authorities who take no heed of moral exigencies. Who could blame a government for applying to the solution of the problems of the community those means acknowledged to be licit for married couples in the solution of a family problem? Who will stop rulers from favoring, from even imposing upon their peoples, if they were to consider it necessary, the method of contraception which they judge to be most efficacious? In such a way men, wishing to avoid individual, family, or social difficulties encountered in the observance of the divine law, would reach the point of placing at the mercy of the intervention of public authorities the most personal and most reserved sector of conjugal intimacy.

Mr. Chairman, I urge this committee to reflect on the seriousness of the issues involved and adopt the necessary amendments to protect and respect human life and the integrity of the human person.

STATEMENT OF THE UNITED STATES COALITION FOR LIFE

Mr. Chairman, the United States Coalition for Life is a national and international prolife research agency specializing in federally funded and promoted policies and programs related to family planning and population control, including but not limited to abortion, sterilization, and government anti-family legislation. Our main research office is located in Export, Pa., just outside of Pittsburgh.

We thank you and the members of this committee for this opportunity to testify on fiscal year 1976 appropriations for HEW programs related to family planning and population control. At this time we would request that our statement and all attachments be entered into the record in addition to the remarks of Mr. Paul Haring, national adviser to the United States Coalition for Life, who will present oral testimony before this committee today.

Taxation without representation

Mr. Chairman and members of this committee, as our Nation prepares to celebrate its 200th birthday, it is appropriate that we recall one of the war cries of the American Revolution: Taxation without representation is tyranny! For today, millions of tax dollars—not 1 cent of which has ever been duly authorized by this Congress—is being used to encourage, promote, and finance the widespread destruction of unborn children and policies and programs which are destructive of family life and personal freedoms under the guise of so-called family planning services and population research Federal programs.

The Constitution provides for the levying and collection of taxes for the payment of debts, for the common defense, and general welfare of the United States.

Last year, during the Senate debate on HEW abortion programs, the Department of Health, Education, and Welfare sent to the conference committee on the Labor-HEW Appropriations Act (H.R. 15580) a memorandum entitled "Effects of General Provision 413 of the Labor-HEW Appropriation Act" in which HEW implicitly argues for "low cost" abortions over the "high cost" of supporting the children of the poor under current Federal programs. We quote:

"The program that would be most affected would be the medicaid program, in 49 States and the District of Columbia. It is estimated that medicaid is currently financing between 222,000 abortions annually at a cost of $40 to $50 million. For each pregnancy among medicaid eligible women that is brought to term, it is estimated that the first year costs to Federal, State, and local governments for maternity and pediatric care and public assistance is approximately, $2,200 . . ."

Mr. Chairman, for the record will you kindly state any explicit Senate or House measure which authorizes or appropriates 1 cent of Federal tax dollars for elective abortion?

The fact of the matter is, there is no such measure in existence. Congress has never taken such action. Quite the contrary. The original Family Planning Services and Population Research Act of 1970 (Tydings bill) contained the Dingell amendment to prohibit the use of funds under title X for abortion as a method of family planning.

Therefore, we ask, if Congress did not authorize or appropriate tax funds for elective abortion, who did? The Department of Health, Education, and Welfare? But who elected the bureaucrats in HEW? No one. Hence,

Taxation without representation

In the spring of 1974, the coalition issued a special edition of its quarterly publication titled "A Profile Guide to Federal Antilife Abuses."

The specific purpose of this issue of "The Profile Reporter" was to detail the mechanism by which HEW circumvents congressional legislative abortion prohibition amendments under title X—PHSA and how HEW uses tax dollars to promote and finance abortion, and antifamily policies.

We request that this information be entered into the record as part of our testimony. Extra copies are available to you Mr. Chairman and the members of this committee and its staff. Additional information and/or research materials will be provided on request to any Member of Congress intereted in verifying these Federal antilife abuses, and coalition charges.

Among those abuses documented in the attached Reporter are:

(1) The use of tax funds for underwriting the research costs of the Upjohn Co. for the development of prostaglandins for second trimester abortions. (Contract Nos. NIH-HD-92208/HD-12224/HD 92208). Today, the Upjohn Co. and

its international affiliates are reaping huge financial profits from the sale of Prostin Alpha F_2 for second trimester abortions.

Mr. Chairman, again, for thet record when has Congress authorized or appropriated 1 cent of Federal funds for the clinical development and research and testing of abortion death technology under its NIH population or family planning research programs? The answer is never. Secondly, what is the American taxpayer doing subsidizing the pharmaceutical empire of the Upjohn Co. or any other drug company?

(2) The use of tax funds to underwrite the cost of population control; that is, regulation of family size and quality of offspring, by government.

Mr. Chairman, our charge is very specific. The grant in question is NIH–HD–04602, a 5-year contract for $337,652 to Dr. Kingsley Davis of the University of California at Berkeley title "Goals and Conditions of Population Control." Dr. Davis is expected to file his report with HEW by the end of 1976.

For members of this committee who are not acquainted with Dr. Davis' concepts of population control, we quote from an ad placed in the Wall Street Journal (Dec. 27, 1974) by the Environmental Fund directed by a corps of hard line population control advocates including Garrett Hardin and Adolph Schmidt.

The purpose of the ad was to sound the call for Federal legislation designed to regulate the size of families, that is, a call for programs and policies of population control. (See attached coalition policy statement on population policies.) The full page Journal ad ends with the following series of quotes from Dr. Davis (Daedalus: Journal of the American Academy of Arts and Sciences, fall, 1973).

"People Want a Miracle"

"If people want to control population, it can be done with knowledge already available. As with other social problems, the solution is easy as long as one pays no attention to what must be given up. For instance, a Nation seeking to stabilize its population could shut off immigration and permit each couple a maximum of two children, with possible license for a third. Accidental pregnancies beyond the limit would be interrupted by abortion. If a third child were born without a license, or a fourth, the mother would be sterilized * * *. Obviously, then, reproductive freedom still takes priority over population control. This makes a solution of the population problem impossible because, by definition, population control and reproductive freedom are incompatible * * *." (Emphasis added.) So sayeth Dr. Kingsley Davis.

Mr. Chairman, what is Dr. Davis doing with the more than a third million dollars he received under the NIH grant related to population control? Why should the American taxpayer subsidize totalitarian concepts such as those proposed by the various population control groups such as the Environmental Fund?

To the best of our knowledge, Congress has never authorized a single penny for anything else but family planning as opposed to population control a lá Kingsley Davis. How does HEW justify such a grant? And by whose authority if not by Congress?

Our special newsletter on Federal abuses related to Government family planning services and population research includes many more life-death questions and answers for this committee and we trust each of you on this committee will read and study the document before final decisions are made on HEW-Appropriations related to family planning and population control.

To return to the coalition's basic theme for this hearing—the use of tax funds for abortion and related antilife programs, we clearly state that the Federal Government is raping the conscience of millions of Americans who abhor the wanton destruction of innocent human life in the womb and the evergrowing bureaucratic power in HEW and other Federal agencies who seek solutions to human problems by eliminating humans. Who shall be safe any more? the old? the defective/retarded? the unwanted?

Mr. Chairman, these abuses have been going on for many years. Most Congressmen are well aware that the Federal Government, both directly and indirectly, is the biggest promoter of abortion in the United States and via the Agency for International Development—State Department—around the world.

Knowing this, what has been the attitude of Congress toward abortion and the Federal subsidy of abortion programs and antilife and antifamily policies?

Has the Congress insisted that HEW live up to the letter and the spirit of the Dingell abortion prohibition amendment? Has Congress acted to prohibit the use of tax funds for killing hundreds of thousands of unborn children? Has the Congress acted with any singular evidence of concern over a human life amendment to the Constitution to protect all innocent human life from the time of conception to natural death, that is, fertilization to natural death?

No! On the contrary. Congress, with rare exceptions, has failed to curb abuses under the Federal family planning services and population research programs.

In the Senate we have the Constitutional Rights Subcommittee dragging out hearing after hearing. When the Bartlett amendment to H.R. 15580 passed the Senate last fall, the Conference Committee on Appropriations killed the amendment in committee behind closed doors. When the Bartlett amendment was attached to a recent bill on family planning, the Senate voted to table—kill—the amendment thus assuring a continuous supply of blood money for elective abortions under various social security programs.

In the House, we have brought our complaints to the subcommittees which have jurisdiction in the family planning area but our complaints have fallen on deaf ears. Population control is big money. And groups such as the United States Coalition have a difficult time competing with powerful interest groups such as drug firms and antilife groups such as Planned Parenthood-World Population and its affiliates. These groups, many of which receive considerable tax funds, are not grassroots groups as is the Pro-Life Movement yet they hold greater sway in Congress than do the average American citizen who foots the bill, for the antilife programs of HEW and AID.

Various human life amendments have languished in the House Judiciary Subcommittee on Constitutional Amendments for more than 2 years and still no action.

Mr. Chairman, this committee has the power to set Congress on the right road again in defense of human life by prohibiting the appropriation of funds for elective abortions and related programs of population control. Since Congress has never, in any bill, authorized such expenditures, such a prohibition is in keeping with the mandates of this committee.

In addition to this antiabortion measure, we also recommend:

1. A prohibition of funds under any HEW program for research for the purpose of developing or modifying new means of performing abortions. (That is, grants and contracts such as those awarded to Upjohn mentioned earlier in this testimony.)

2. A prohibition of funds to federally funded family planning programs which provide services, including abortion, sterlization and contraception, to minors without the specific written consent of a parent or legal guardian of said person.

3. A prohibition of funds to any private entity—directly or indirectly—which includes as a substantial part of their activity, abortion and abortion related services—referrals et cetera.

4. A prohibition of funds to any agency or entity which receives, directly or indirectly, any part of the fees paid by any patient for the performance of any abortions (that is, financial kickbacks).

5. A prohibition of funds to any agency or entity which does not obtain the express permission of a patient or client for the use of personal data related to family planning and sexual habits prior to the submission of such data by said agency or entity to any Federal Data Bank in HEW or in any other Federal department or agency. Such a prohibition should forbid the use of social security identification numbers on family planning record charts used to monitor clients and patients attending family planning centers receiving Federal funds.

6. A prohibition of funds for grants and projects related to fostering population control-involuntary Federal programs and policies.

Mr. Chairman, we want an end to the Federal subsidy of antilife programs and we ask this committee to act on these recommendations quickly. Let us end taxation without representation and return government to its role of protecting and nurturing all innocent human life, before the people rebel against these grave injustices as did our forefathers almost 200 years ago. Thank you.

Mr. FLOOD. Thank you.

WITNESSES

JAMES D. KNEBEL, EXECUTIVE VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

LEROY MANN, SENIOR EXECUTIVE VICE PRESIDENT, PENNSYLVANIA BLUE SHIELD

Mr. FLOOD. Mr. Knebel, executive vice president, and Leroy Mann, senior executive vice president, Pennsylvania Blue Shield, National Association of Blue Shield Plans.

Mr. KNEBEL. Mr. Chairman.

I am James D. Knebel, executive vice president of the National Association of Blue Shield Plans. With me is Leroy Mann, senior executive vice president of Pennsylvania Blue Shield. The national association consists of 71 locally based, not-for-profit medical care prepayment plans. Thirty-two of our plans act as carriers for medicare part B, and in that capacity collectively serve some 13 million medicare beneficiaries. (A listing of these 32 carriers is attached and submitted for the record.)

Mr. Mann and I are here today to discuss the issue of medicare part B cost limitations, specifically with respect to a carrier's data processing function. I will present a brief summary statement concerning Blue Shield's position, while submitting for the record a more detailed analysis. Mr. Mann will then provide you with the more operational perspective of a carrier which is directly concerned with this particular issue.

Almost since the beginning of the medicare program, the costs and effectiveness of part B data processing—EDP—have been of special concern to the private carriers and the Government alike.

Our plans were selected and undertook the partnership arrangement to administer medicare because they were the most experienced. The unforeseen demands of the part B program quickly created situations that forced individual plan management to focus on alternative methods of claims processing. Many made decisions to gear up their in-house capabilities while others elected to subcontract for services as the best interim solution to their immediate problem. All were decisions of prudent management made in concert with the Medicare Act and administrative guidelines.

Mr. Chairman, the basic question again is the extent to which prudent management can be reflected when a private medicare carrier moves—or is trying to move—such a previously subcontracted operation back in-house.

In this respect, last year's Stevens amendment, which was set aside in conference, said—in effect—that any carrier which resumes its own medicare EDP function can't be reimbursed for any costs—including first-year start-up costs—beyond the fixed price which the existing contractor—or any other "competitor"—would have charged to continue the work. The stated intent of this amendment was to control costs and promote competition in the administration of medicare part B.

As much as we share and support those goals, we are convinced that the proposed amendment actually would have produced the opposite.

Instead of containing costs it would have boosted them, mainly because the carrier's longer range savings to the Government simply are not recognized in the amendment. Instead of promoting competition, the effect would have dampened medicare subcontracting competition—by discouraging carriers from subcontracting in the future.

We are in a highly technological world. Right now the 71 Blue Shield plans, in cooperation with 74 Blue Cross plans, are investing millions of dollars on long range systems and EDP planning—all at no cost to the Government. We are developing change. A Blue Shield plan must be able to deploy a new data processing system when it becomes operational. To do otherwise would deny Government the efficiencies of that system. No one desires this.

Mr. Chairman, EDP is little more than the automated extension of some of a carrier's many services and responsibilities mandated by the original Medicare Act. That function is an integral part of the carrier role, as outlined under section 1842, and in the criteria for selection of carriers by the Secretary of HEW.

From the very first, we have espoused the view that the carrier selection process inherently includes the carrier's decisionmaking as a means to be used in performing the undertaking.

In fact, the Perkins Committee—whose recommendations were commended to SSA by last year's conferees—urged that Government should reduce its role in the carrier decisionmaking process. Instead, the committee recommended that Government should reply on its capacity to test carrier performance by results, and on its authority to terminate a carrier contract for poor performance.

At this time, Mr. Chairman, I'd like Mr. Mann to give you the timely benefit of an individual carrier's perspective on this issue. I am sure that you are aware that Pennsylvania Blue Shield constituted the "instant case" during much of last year's debate on section 210, and I can assure you that Mr. Mann and his staff have given plenty of expert thought to the subject. Thank you.

[The attachments follow:]

BLUE SHIELD PLANS WHICH ARE MEDICARE PART B CARRIERS

Alabama; Blue Cross-Blue Shield of Alabama, 930 South 20th Street, Birmingham, Ala. 35298, (205) 328–8111.

Arkansas; Arkansas Blue Cross-Blue Shield, Inc., 601 Gaines Street, Little Rock, Ark. 72203, (501) 378–2200.

California; Blue Shield of California, Two North Point, San Francisco, Calif. 94133, (415) 445–5000.

Colorado; Colorado Medical Service, Inc., 700 Broadway, Denver, Colo. 80203, (303) 831–2131.

Delaware; Blue Cross-Blue Shield of Delaware, Inc., 201 West 14th Street, Wilmington, Del. 19899, (302) 658–6940.

District of Columbia; Medical Service of D.C., 550 12th Street SW., Washington, D.C. 20024 (202) 484–4500.

Florida; Blue Shield of Florida, Inc., 532 Riverside Avenue, P.O. Box 1798, Jacksonville, Fla. 32201, (904) 791–6111.

Illinois; Illinois Medical Service, 233 North Michigan Avenue, Chicago, Ill. 60601, (312) 661–4846.

Indiana; Blue Cross-Blue Shield of Indiana, 120 West Market Street, Indianapolis, Ind. 46204, (317) 263–4625.

Iowa; Blue Shield of Iowa, Liberty Building, Des Moines, Iowa 50307, (515) 283–8121.

Kansas; Kansas Blue Shield, 1133 Topeka Boulevard, Box 239, Topeka, Kan. 66601, (913) 234–9592.

Maryland; Blue Shield of Maryland, Inc., 700 East Joppa Road, Baltimore, Md. 21204, (301) 494–5040.

Massachusetts; Blue Shield of Massachusetts, Inc., 133 Federal Street, Boston, Mass. 02106, (617) 357–8000.

Michigan; Blue Shield of Michigan, 600 East Lafayette, Detroit, Mich. 48226, (313) 225–8521.

Minnesota; Blue Cross-Blue Shield of Minnesota, 3535 Blue Cross Road, St. Paul, Minn. 55165, (612) 456–3595.

Missouri; Blue Shield of Kansas City, 3637 Broadway, P.O. Box 169, Kansas City, Mo. 64141, (816) 756–2400.

Montana; Montana Physicians' Service, 404 Fuller Avenue, P.O. Box 1677, Helena, Mont. 59601, (406) 442–5450.

New Hampshire; New Hampshire-Vermont Physician Service, Two Pillsbury Street, Concord, N.H., (603) 244–9511.

New York; Blue Shield of Western New York, Inc., 298 Main Street, Buffalo, N.Y. 14202, (716) 849–8984.

New York; Blue Cross-Blue Shield of Greater New York, 622 Third Avenue, New York, N.Y. 10017, (212) 490–4567.

New York; Genessee Valley Medical Care, Inc., 41 Chestnut Street, Rochester, N.Y. 14647, (716) 454–1700.

North Dakota; Blue Shield of North Dakota, 301 Eighth Street South, Fargo, N. Dak. 58102, (701) 235–1191.

Pennsylvania; Pennsylvania Blue Shield, Camp Hill, Pa. 17011, (717) 236–9011.

Rhode Island; Blue Shield of Rhode Island, 444 Westminster Mall, Providence, R.I. 02901, (401) 831–7300.

South Carolina; Blue Cross-Blue Shield of South Carolina, I–20 At Alpine Road, Columbia, S.C. 29219, (803) 788–3860.

South Dakota; South Dakota Medical Service, Inc., 711 North Lake Avenue, Sioux Falls, S. Dak. 57104, (605) 336–1976.

Texas; Group Life and Health Insurance Co., Main at North Central Expressway, Dallas, Tex. 75201, (214) 741–8946.

Utah; Blue Shield of Utah, 2455 Parley's Way, P.O. Box 270, Salt Lake City, Utah 84110, (801) 487–6441.

Washington; Washington Physicians Service, 220 W. Harrison, Seattle, Wash. 98119, (206) 281–3414.

Wisconsin; Wisconsin Physician Service, The Blue Shield Plans of the State Medical Society of Wisconsin, 330 East Lakeside Street, P.O. Box 1109, Madison, Wisc. 53701, (608) 257–6781.

Wisconsin; Surgical Care, The Blue Shield Plan of the Medical Society of Milwaukee County, 756 North Milwaukee Street, Milwaukee, Misc. 53202, (414) 224–6099.

Puerto Rico; Seguros De Servicio DeSalud De Puerto Rico, Inc., GPO Box 3628, San Juan, Puerto Rico 00936, (809) 765–3232.

STATEMENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Mr. Chairman, I am James D. Knebel, executive vice president of the National Association of Blue Shield Plans. With me is Leroy K. Mann, senior executive vice president of Pennsylvania Blue Shield.

The National Association consists of 71 locally based, not-for-profit medical care prepayment plans. Thirty-two of our plans act as carriers for medicare part B, and in that capacity they collectively serve some 13 million medicare beneficiaries.

Mr. Mann and I are here today to elaborate on the issue of medicare part B cost limitations, specifically with respect to a carrier's data processing function. With the chairman's permission, I will review the background of the problem and give you a general analysis and statement concerning Blue Shield's position. Mr. Mann will then provide you with the more operational perspective of a carrier which is directly involved in this particular issue.

Almost since the inception of the Medicare program, the costs and effectiveness of the part B EDP function have been of special concern to the carriers and to government alike. This is so chiefly because EDP has been the subject of carrier subcontracts, on the one hand, and direct government involvement and development on the other.

Mr. Chairman, as much as we appreciate the essential intent of the last year's Stevens Amendment, we think the proposal would tend to have an opposite effect.

The alleged "anomalies" in the existing law which troubled the conferees, would, we fear, be replaced by some rather severe inequities. For example:

1. The requirement that all one-time startup and conversion costs be recovered in 1 year, rather than amortized over a reasonable period of time, is not consistent with the generally accepted practice that an ordinary prudent man would use in determining the cost versus benefits of a proposed course of action. No such requirement was levied on the present EDP subcontractors; they were allowed to allot their startup costs over a projected period of time (6 or 7 years). In addition, to be worthwhile, the projected conversion must be cost-effective over a period of years—a period when the government may rightfully expect to share in the savings.

2. Based on the actual facts of the history of Medicare subcontracting, only one organization would benefit in any way—if at all—from so restrictive a provision. If conversion, installation, and startup costs are to be included in the cost comparisons, it would be virtually impossible for even another potential subcontractor to be successful.

3. It would be impossible to determine with any precision what the total administrative expenses would have been if EDP services had been provided or continued under a subcontract instead of an in-house operation, particularly if the subcontractor used or proposed a different type of system.

4. It is unreasonable to expect that valid bids could be obtained in a situation where the carrier prefers to bring its EDP operations inhouse.

5. It is incongruous to impose a potential liability on one carrier which, perhaps for very good reason, decided for a specific period of time to subcontract its data processing.

6. The requirement as proposed in Section 210 contained no provision whatsoever for any analysis of the overall quality, performance, or results of the opposing operations.

But beyond these alministrative and technical difficulties, Mr. Chairman, the basis for our position lies in the original medicare law itself.

Section 1842 of title XVII of the Social Security Act firmly established the use of private carriers, in order to provide for the administration of medicare benefits with maximum efficiency and conveniences for individuals entitled to benefits.

Because EDP technology is so widely utilized by the larger medicare carriers, it is important to note the exact carrier functions contemplated under the original act and how those functions correlate with the carrier's historical service capabilities.

Section 1842(a) of the Social Security Act provides that "the Secretary is authorized to enter into contracts with carriers * * * and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(a) Make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable); (b) receive, disburse, and account for funds in making such payments; and (c) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2)(a) Determine compliance with the requirements of section 1861(k) as to utilization review; and (b) Assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2) to make reviews of utilization;

(3) Serve as a channel of communication of information relating to the administration of this part; and

(4) Otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part."

These functions spelled out by Congress are the general elements contained in the carrier's role. The wording of these functions is noteworthy. For purposes of emphasis, key wording in the above has been underlined to identify the general nature of carrier's performance responsibility and authority in these functions.

Congress has provided that the Secretary of Health, Education, and Welfare should utilize to the extent possible the private and prepayment health insurance industry as carriers to perform these functions.

The key element in the carrier's role is the determination and execution of payment for services provided under the medicare program. Section 1842(b)(3)(A) and (B) establish the role of the carrier as a general contractor with respect to payment for services by providing "that the carrier—

(A) Will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v)):

(B) Will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier * * *"

The experience of the carrier, and the carrier's experience in a given locality, in rendering the various services required by the functions is a key characteristic of the carrier. Medicare pays for the personal health care services of this Nation's senior citizens. The law anticipated that carriers experienced in local areas would utilize their existing administrative services, already familiar to many of medicare's beneficiaries, in making payments under the medicare program.

The carrier employs many services that it has developed through years of private business experience in carrying out the required medicare functions. Among these are claims examination; public, professionals and provider relations; claims reviews and appeals; reasonable charge determination; utilization review; and contract, financial, and medical policy management. In performing these services, the carrier employs a number of tools and resources available from his private business. These resources include professional advisors, business managers, technical and research personnel, and skilled clerical staff, as well as data processing. The carrier determines, consistent with budgetary limitations, the extent and nature of the resources to be utilized in the performance of carrier functions.

The carrier's role established in the law (that is, "takes such action as may be necessary") carries with it an exclusive reliance on the carrier for a determination of how the required services are to be discharged from the resources available to the carrier. Generally, the carrier relies exclusively upon its own resources and experience in the required services. On occasion and as required by circumstances for specific periods of time, the carrier elects to augment its own resources through subcontracts for such services as management consultation, facilities planning, legal advice, systems software development and data processing.

In this respect, Mr. Chairman, and in the interest of time, I have appended as Exhibit 1 a more complete description of the matrix of these essential carrier services. However, that exhibit should be referred to in any deliberation concerning the carrier's decisionmaking process.

The situation in which many carriers found themselves in the early stages of medicare, will be well illustrated by Mr. Mann's outline of his plan's situation and decisions. The magnitude of the EDP task, the pressing and immediate priorities of money and resources (including availability of people, recruitment and training costs, lack of adequate recruitment time, space allocations, et cetera) led some carriers to the decision that the EDP function could best be handled at that point in time under a subcontracting arrangement, therefore leaving the carrier's own resources available to be directed to other functions and general administration.

Thus, the decision to subcontract involves augmenting the carrier's own services and contributing skills, resources, and priorities not then available to the carrier from those utilized in his private business. Where a subcontract is employed, the carrier does not relinquish its accountability under the law of management of the assigned functions and direct administration of the required services. The Secretary holds the carrier responsible for determination of the resources required and the cost/benefit ratios.

The carrier is accountable for cost effective administration of its contract, and the Secretary is responsible for assuring Congress of the carrier's cost effectiveness in the administration of the medicare program. Thus, the carrier bears the responsibility to continue to seek new ways to improve the cost effectiveness of its administration within the services it performs. Substantial cost benefits to government are available through the carrier's ability to carry out medicare

program administration in concert with its private business. Carriers may elect, where improvements in cost effectiveness can be obtained, to share cooperatively in selected services required for the medicare program. This cooperative sharing of services should not be subject to competitive bidding since such services are jointly developed as a mutual part of the carriers' own resources. This is consistent with the provision of law exempting the carrier contracts from competitive bidding. However, instances occur because of the magnitude of the EDP process, that dedicated systems for the program are more feasible and cost effective. Carriers follow an agreed upon procedure in developing bid requests and evaluations through open competition bidding.

Mr. Chairman, since EDP is little more than the automated extension of manual processes and services, it certainly seems to us that a meaningful carrier role precludes competitive bidding when a carrier, which has subcontracted its EDP operation, wishes to reconstitute that function in-house on a cost-effectiveness basis. We believe the intent of the proposal is best accomplished by assuring flexibility in the program administration to select the most cost effective method. For that reason, we submit the following principle for your consideration:

"In situations of change to a new subcontractor or of a return to carrier 'in-house' capacity, the cost of such change is allowable to the extent that the administration and the carrier agree that the new arrangement provides long-range cost efficiency for the program."

We offer this principle as a more constructive and equitable interpretation of the basic medicare law which provides that intermediaries and carriers will be fully reimbursed the actual cost of their operations so long as those costs are reasonable. To the extent that such costs may be unreasonable, the program can deny reimbursement and the matter is then subject to review and decision by the Armed Services Contract Appeal Board. This is quite foreign to either a legislative provision or an administrative directive that could ultimately require every carrier to provide data processing services on a subcontracting basis. If the carrier fails to perform its contractual responsibilities, the ultimate protection to the government lies in nonrenewal.

Mr. Chairman, thank you for the opportunity to present this formal statement to the committee, for the record, as a back up to our general statement.

EXHIBIT NO. 1.—THE CARRIER'S ROLE

The complexity of the essential services performed by the carrier in carrying out its medicare functions is frequently overlooked. Accurate claims examination is required in order to discharge the function of receiving, disbursing and accounting for funds and to make determinations of the rates and amounts of payment.

Accurate claims examination requires the carrier to draw on its experience in the development and application of comprehensive and detailed conventions for the coding of medical and health related services. Extensive interrelationships between the health care services and the coding conventions must be described, maintained and updated. Extensive knowledge of community resources for delivery of health care services is essential. Experience in applying a given set of benefits to the conditions and environment of local medical practice is required. Extensive knowledge of the problems and concerns of beneficiaries under health insurance and prepayment programs also is a necessary resource in carrying out the responsibility of claims examination.

Medicare program carriers utilize their extensive experience in public, professional and provider relations when they serve as a channel of communication of information relating to the administration of the medicare program. Skilled personnel are required to deal with the providers of service and physicians if determinations of rates and amounts of payment are to be effective. Government must be assured that it receives accurate and effective information concerning professional and provider satisfaction with medicare program reimbursement. The complexities of medicare program administration must be dealt with by the carrier through communication in a manner which minimizes their impact upon the providers and the medical profession. The use of experienced carriers provides substantial assurance to providers and the profession that medicare claims and payments will be handled in an established and accustomed manner. Carriers experienced in communicating effectively with providers and physicians concerning aspects of their private business constitute the most effective means available to government for communicating informa tion regarding the administration of the Medicare program.

Claims reviews and appeals under the medicare program are necessarily more complex than those experienced by the carriers in their private business. However, the experience of the carrier's personnel in claims examination and legal and financial relationships between patients, providers of service and third parties is essential to effectively carrying out the provisions of the Medicare program for hearings and appeals. The carrier's responsibilities in this regard are essentially no different from responsibilities of other Government contractors where such hearing and appeal procedures apply. As a general contractor, the carrier's responsibility to conduct such hearings and appeals is an exclusive one and subject only to guidance by the secretary.

Reasonable charge determination is the key service performed by the carrier in carrying out its functions for making determination of rates and amounts of payment. While the medicare law provides the carrier with the general conditions he must take into account in determining reasonable charge reimbursement, the carrier's own experience and resources are essential to implementing the provisions of the law. Medicare carriers are experienced in dealing with the complex decisions required in the development, maintenance and updating of physician charge profiles. Professional and provider relations are particularly important in assuring that communications regarding the maintenance and updating of reasonable charge profiles is effective. Extensive knowledge of physician charge patterns, trends in medical economics, and the relationships of health care resources to health care financing is required. Applying this knowledge to the actual charges claimed by physicians requires the carrier to compare the charge with the physician's usual charge for the service provided and to the charge usually made by physicians within his area and specialty of medical practice for the same service. If satisfactory charge information is not available to permit these comparisons on a direct basis, the carrier then employs a series of complex decisions which permits him to relate the service to other kinds of medical services performed for which charge information is available. In addition, the carrier frequently employs its experience and the experience of professional advisors to assure that the charge for an unusual service is established on a reasonable basis.

Determining compliance with the requirements of utilization review is a major function of the carrier. Utilization review services rely heavily upon the experience of the carrier in its private business and with other government programs. Utilization review requires much more than manipulation of health care data. The presentation of utilization review data is only the first link in a sequence of complex events and decisions which lead ultimately to the peer review of selected cases by peer review committees and by the developing professional standard review organizations. The carrier combines its experience with the professional guidelines available to establish detection screens for both prepayment and postpayment review. Claims data is passed against those screens. Claims selected by the screens are then subject to skilled clerical review by personnel with medical training. These personnel have the capability to approve payment but deny payment only where established guidelines specifically limit program benefits to less than the services claimed. These personnel also research additional claims, develop added documentation and prepare written summaries of each case for review by professional advisors. Professional advisors of the carrier recommend cases for payment or for denial in instances where guidelines established by peer review do not require the case to be subjected to further peer review; and they recommend other cases for peer review by the Peer Review Committee or PSRO. The information requirements and decision process followed by the plan's skilled personnel and professional advisors in carrying out the requirements of utilization review involve hundreds of steps and knowledge of widely, varying conditions and circumstances in medical practice. Their activities are distinguished from those of the peer review process in that they operate within the framework of guidelines laid down by the peer review committee or PSRO's. Peer review is conducted by the PSRO or the committee on cases and special studies prepared by the carrier in order to enforce utilization safeguard provisions in the law, and to establish utilization guidelines to assist the physicians and providers of service in complying with the utilization safeguards.

The development and management of medical policy related to the interpretation and management of medicare program benefits is a service performed by the carrier. In performing this service, the carrier draws heavily from its private business experience with the medical community. Extensive use is made of established relations with the specialty practices of medicine and ancillary health care professionals to develop and implement policies used in claims payment and

utilization review. While the formulation of medical policy is based upon professional medical decisions and consultation, implementation of the policy and communication to the providers and beneficiaries requires the experienced skills of the carrier in the administration of health care benefit programs. Government benefits from the carrier's utilization of professional resources and communications media established in its private business assure that medical policy is made available to the medical profession and providers of service and to the carrier's own personnel. The carrier's private business experience with management tools and resources also is employed in carrying out related medicare program contract and financial management services.

The law does not charge the carrier with the responsibility for development of medicare program policy. This is clearly a responsibility of the Secretary of HEW. The Secretary, in turn, charges the Social Security Administration with implementing medicare program policy. The Secretary also bears the responsibility of issuing general instructions to the carriers to assist them in carrying out their functions in keeping with program policy. These general instructions are sufficiently broad to assure that the carrier is able to apply them to his accountabilities within the specific context of his jurisdiction and experience. The emphasis of these general instructions is connected largely with specifying the results to be expected from the carrier's administration rather than to specifying the means to be employed by the carrier in carrying out its administrative responsibilities. General instructions provided to the carrier also establish the criteria, objectives, and measures of performance on which success in the administration of the contract is judged. The carrier is held accountable by the Secretary for development by the carrier of detailed administrative instructions and other documentation required to assure that administration of the general instructions is carried out in a cost effective manner. Performance evaluation by the Secretary takes into consideration the management competence demonstrated by the carrier through its documentation and control procedures in implementing the general instructions and in achieving the desired results. The carrier is held responsible by the Secretary within the framework of the general instructions to assure that its administration is in full compliance with the intent of Congress and the Secretary for assuring full, public accountability in administration of the program and in the receipt and disbursement of public funds. The carrier functions in this regard as an agent for the Government, in the public trust, to the medicare program. In this relationship, the carrier's administration differs markedly from the objectives of its private business which is administered in keeping with its private business objectives. While the objectives in both private and government business may have the end result of competent, fiduciary service to the beneficiary or subscriber, the extent of the carrier's public accountability is far greater in the medicare program.

Thus, the role of the medicare carrier is seen as that of a general contractor managing a set of experience-based services in the performance of functions established by law in a noncompetitive environment. Performance of these functions and services entails the management of many and varied complex relationships within the framework of general instructions issued by the Secretary of Health, Education, and Welfare. The carrier's performance of these functions requires detailed administrative attention that is fully documented and responsible to the Government's provisions for public accountability, and this performance is evaluated and directed by the Secretary on a results basis in accordance with the carrier's position as an agent of Government for the administration of the medicare program.

Statement of Leroy Mann

Mr. Mann. Mr. Chairman, I am Leroy Mann, senior executive vice president of Pennsylvania Blue Shield.

As Mr. Knebel indicated, I will describe the operational aspects of the situation in which Pennsylvania Blue Shield—PBS—was involved during the time the issue of medicare part B cost limitations was the subject of various committee investigations and reports. But first let me go back a few years to put this presentation in proper perspective.

The advent of medicare had a major and, by and large, disruptive affect upon the health care environment in this country. It was late in 1968, during the third year of operation as a medicare part B

carrier, that PBS found a pressing need to develop, or otherwise obtain, improved highly automated cost effective systems for processing claims for both medicare part B and its private business.

Development of such systems in-house was judged impractical from the standpoint of time and available expertise. The only viable alternative at that time to meeting PBS requirements for medicare part B was the claims processing system developed by Electronic Data Systems Federal—EDSF. No other vendor could provide such a system at that time. However, the EDSF system, which had already proven to be cost effective, was available only through a facilities management contractual arrangement.

After an extensive evaluation, PBS took the only realistic approach existing at the time and entered into a 6-year facilities management contract with EDSP on February 1, 1969. The contract was reviewed and approved by BHI. EDSF assumed responsibility for all electronic data processing services at Pennsylvania Blue Shield (excluding data entry, however) and began working with PBS personnel to install the EDSF medicare claims processing system.

Needless to say, the installation was successful. The resultant utilization of the EDSF system and associated data processing services has assisted PBS in maintaining a high level of performance among the medicare part B carriers across the Nation.

Late in 1973, PBS began planning for the termination on January 31, 1975, of its original with EDSF for medicare part B. In December, PBS placed a tentative order for a hardware configuration that was in the same family of computers used by EDSF which would be compatible in the event that we later elected to bring the operation into our own facility. The tentative order was placed that far in advance because of the unusual long leadtime associated with acquiring equipment of this type.

During the next 4 months, PBS conducted an intensive study to determine whether subcontracting or an inhouse operation would be the more cost effective approach to meeting its medicare EDP requirements for the future.

The feasibility study clearly demonstrated that an in-house operation would be more cost effective than subcontracting and, as a result, the following actions took place:

1. May 15, 1974—Confirmed, under a 1960 lease agreement between PBS and IBM, an order for equipment compatible with the EDSF system.

2. May 23, 1974—Notified SSA of management's decision to establish in-house capability to maintain and operate the present EDSF medicare system. We also requested approval of a 6-month extension, to July 31, 1975, of the current contract with EDSF in order to effect implementation in July rather than during the peak workload period in January.

3. August 9, 1974—Submitted to SSA a detailed proposal for an in-house EDP medicare claims processing system, including adequate cost justification and a concurring report by an outside consulting firm. This proposal called for startup expenditures of $900,000 during fiscal 1975, which would be fully recovered in fiscal 1976 through cost reductions over the current arrangement.

4. November 14, 1974—Executed a standard lease agreement for an IBM 370/145.

All these events were in conformance with provisions of the agreement between PBS and the Secretary of the Department of Health, Education, and Welfare, dated July 1, 1973, which read as follows:

ARTICLE XVIII

DATA PROCESSING

The carrier shall provide the Secretary with written notice to include design specifications and cost analysis at least 120 days in advance of any planned major changes relating to data processing system(s), arrangements for data processing, methods, configurations, or facilities or sites utilized for Medicare claims processing and shall not implement any such change without prior written approval of the Secretary. Such approval shall be deemed to be granted unless the Secretary notifies the carrier of disapproval within 60 days of receipt of notice of the proposed change.

During this time when PBS was proceeding in a planned orderly fashion with in the terms of its agreement, the issues surrounding the Steven's amendment surfaced. Although the intent of this amendment was laudable, PBS was opposed to its passage because it would have created very serious legal and administrative problems for PBS, two of which are:

1. It would be impossible to determine with any precision what total administrative expenses would have been if EDP services were provided under a subcontract instead of through an in-house operation, particularly if the subcontractor proposed a different type of system.

2. The only way PBS could have changed from subcontracting to in-house operation for EDP would have been to risk exposing its own private funds to potential nonreimbursement of costs incurred in administering the medicare program. Such a risk on the part of PBS is unwarranted since the Government will receive all the benefit of substantial savings occurring after the first year.

PBS does agree with the concerns about cost effectiveness expressed in Conference Report No. 93–1489 of the House of Representatives, 93d Congress, issued November 21, 1974. In fact, the four specific criteria contained in the report, which the Secretary is to evaluate in determining if a change will be cost effective and in the best interests of the Government, parallel precisely the criteria used by PBS in making its decision to go in-house. We believe PBS met these criteria as follows:

Cost projections of the carrier

Claim volumes used by PBS in developing its cost projections were agreed to in advance by SSA. Cost projections in the proposal submitted by PBS on August 9, 1974, were thoroughly reviewed and subsequently accepted by SSA.

2. The amount previously incurred as costs under the subcontract adjusted to the future contract period

This amount for fiscal year 1975–76 as showin in the proposal is $1.2 million more than projected in-house costs. It should be noted that projected in-house costs reflect only those EDP activities affected by the change from subcontracting to in-house operation. The cost of all other carrier activities will be the same under either a subcontracting or in-house operation because the same EDP system will be utilized.

3. The costs incurred by comparable carriers (i.e., those carriers with a comparable workload size and composition which, through direct or subcontracted performance of their medicare responsibilities, have met and are meeting the perfomance standards applied to all carriers)

The high level of performance achieved by PBS is a matter of record, as well as the fact that its costs, from the beginning of the medicare program to date, have been well below the costs of its peer group. For example, the BHI report "Analysis of Intermediaries' and Carriers' Administrative Costs for the Fiscal Year Ending June 30, 1974," shows the following unit cost per claim processed:

Pennsylvania Blue Shield	$3.01
13 other largest carriers	3.26

Cost projections in the proposal show an anticipated reduction of 31 cents per claim for fiscal year 1976 as a result of the change to an in-house operation. The startup cost incurred in fiscal year 1975 is not expected to cause PBS's total unit cost for this year to raise above that of its peer group and, in addition, the total amount of startup costs will be recovered fully during the first 6 months of in-house operation.

4. Probability of achieving the projected costs

PBS believes its projected costs are sound and submitted in April 1975, its fiscal year 1976 budget showing a savings of 34 cents per claim in data processing costs, or 3 cents more than projected in its proposal. In addition, PBS submitted on March 11, 1975, a supplemental budget for fiscal year 1975 which included start-up costs of $641,000, an amount considerably lower than that projected in its proposal of August 9, 1974, due to a revised implementation schedule.

The foregoing facts, the track record in budget performance of PBS during the last 7 years, and the bugetary limitations imposed by article 16 of its agreement with the Secretary should be ample evidence of a high probability of achieving its projected costs.

As you may know, SSA concurred in our findings. In a letter to James R. Calloway, chief counsel and staff director, Committee of Appropriations, U.S. Senate, dated November 21, 1974, Mr. Cardwell stated, and I quote, "We have examined the Pennsylvania proposal, as you know, and found it cost effective."

In conclusion, Mr. Chairman, I can report to you today that we have successfully completed parallel operations and next Monday will move the medicare EDP operation in-house. We have accomplished this 6 weeks ahead of schedule and at a cost less than the projected budget.

Mr. ROYBAL. Thank you very much.

We will recess and come back.

Thank you.

[Brief recess.]

VENEREAL DISEASES

WITNESS

DONALD P. CLOUGH, EXECUTIVE DIRECTOR, AMERICAN SOCIAL HEALTH ASSOCIATION

Mr. NATCHER. Dr. Heimoff, come around.

Doctor, we are glad to have you before the committee.

Mr. CLOUGH. Thank you, Mr. Chairman.

I am a substitute for Dr. Heimoff.

I am Mr. Donald Clough, executive director of the American Social Health Association.

Mr. NATCHER. We are glad to have you appear. We will be pleased to hear from you. Go right ahead.

Mr. CLOUGH. Thank you very much.

Mr. Chairman, at the invitation of the subcommittee, I am addressing you on behalf of the association. The American Social Health Association, founded in 1912, is a voluntary, nonprofit agency dedicated to the elimination of venereal disease as a major social health problem through a comprehensive program of research, information and education, and citizen action.

Mr. Chairman, my statement is extremely brief and if it would please the committee, I would welcome the opportunity to read it into the record.

The problem of epidemic VD continues to require the support of the Federal establishment. In our opinion, within the context of present authorizations, this support must take a somewhat different form if significant incidence reduction and ultimate elimination of these diseases are ever to occur. Specifically, we must simultaneously fund those activities that best serve the short-term goal of incidence reduction and those research functions that hold the promise of eventual resolution of the VD problem. Aside from tragic human consequences, epidemic VD poses a serious economic problem to this Nation that is often not fully appreciated. We estimate that the costs associated with the care and treatment of persons suffering from venereal disease exceed $360 million annually.[1] These costs are directly proportionate to incidence. We therefore suggest that additional investments in incidence reduction activities and research will be more than offset by decreases in patient-care costs. To achieve this balanced two-tiered approach, the American Social Health Association submits the following appropriations recommendations for your consideration:

1. The establishment and maintenance of quality public health programs for the diagnosis and treatment of VD is a vital necessity. The effectiveness of existing programs and clinical settings is being threatened by the erosion of inflation. In addition, increased public awareness and education have created increased demand for VD diagnostic and treatment services. This increase is straining existing clinics and has created a demand in locales where no such clinical settings exist. The States must be both encouraged and supported to improve existing settings and institute them where demand warrants their availability. We therefore recommend a minimal appropriation of $10 million under section 318(c) of the Public Health Service Act so that formula grants to State could be made proportionate to needs and opportunities.[2]

2. We strongly urge the continued application of VD prevention and control methodologies such as screening, education, and epidemiology. At this critical juncture, with past support for these activities beginning to have an incidence-reducing effect, we urge that fiscal year 1975 levels of activity be maintained. We therefore recommend an appropriation of $30 million under section 318(d) of the Public Health Service Act to continue these project grants.[3]

Footnotes at end of article.

3. Within the context of research and the promise of ultimate solutions, we see the need for increased operational and methodological investigation. Only by pilot study can we hope to develop and test the efficacy of new techniques and approaches. Gonorrhea particularly clearly requires further exploration. We therefore very strongly urge that an appropriation of $5 million be made under section 318(b) of the Public Health Service Act to support such a vital research and pilot study to be administered by the Center from Disease Control's Venereal Disease Branch.[4] This additional $5 million should be appended to the administration's request for $43.429 million for CDC's disease investigation, surveillance, and control activities.

4. Finally, we are much encouraged by the increase in basic biomedical research under the auspices of the National Institute of Allergy and Infectious Disease. While much has been learned, many incredibly complex questions have yet to be answered. Ultimately, it is our hope that such research will lead to the development of effective vaccines that will check venereal disease for once and for all. In support of such research we recommend that you appropriate to NIAID $4 million for biomedical VD investigation. We further wish to express major concern about the current attempt to eliminate NIAD-supported institutional awards. There is a pressing need for more well-skilled and well-trained investigation in the field of VD. Without an influx of new professionals, VD research will come to a halt regardless of how much money is available for it. The NIAID institutional award program is a prime vehicle for cultivating a cadre of highly competent VD scientists. It is our hope that you share our concern and act on it by urging the continuation of the institutional grant system. Failure to do so will most assuredly permit its demise.

I thank you for the opportunity to present the recommendations of the American Social Health Association and hope that you find them useful. I would like to make one last point prior to answering any questions you may have. The recommendations just presented relate to fiscal year 1976 ending June 30, 1976. With fiscal year 1977 beginning on October 1, 1976, I would suggest that the 3-month gap, July–September 1976, be funded at 27 percent of the fiscal year 1976 levels in all of the above-stated VD related areas.[4]

[The attachments follow:]

APPENDIX 1.—ANALYSIS OF VD PATIENT CARE COSTS

	Units	Unit cost	Total cost
1. Serologic testing (syphilis)	38,000,000	$0.50	$19,000,000
2. Culture testing (gonorrhea)	8,000,000	1.00	8,000,000
3. Private sector—Gonorrhea	1,625,000	25.00	40,645,000
4. Private sector—Syphilis	25,000	35.00	875,000
5. Public VD clinics			30,000,000
6. Maintenance of syphilitic insane, blind, crippled			50,000,000
7. Costs—Persons suffering complications of gonorrhea			211,893,189
Total, VD patient care costs			360,413,189

SOURCES OF DATA

1. DHEW, U.S. Public Health Service, Center for Disease Control.
2. DHEW, U.S. Public Health Service, Center for Disease Control.
3. DHEW, U.S. Public Health Service, Center for Disease Control.
4. American Social Health Association.

Footnotes at end of article.

5. DHEW, U.S. Public Health Service, Center for Disease Control and American Social Health Association.
6. DHEW, U.S. Public Health Service, Center for Disease Control.
7. JAVDA, volume 1, No. 1, September 1974, "Economic Consequences of Gonorrhea in Women."

APPENDIX 2

Section 318 (c).—Recommended funding $10 million.

Minimal funding of $75,000 for each of the 50 States and the 6 other territorial units mentioned would amount to $4,200,000.

Considering the disproportionate needs of such States as New York, California, Illinois, Ohio, Pennsylvania, New Jersey, Michigan, et cetera—With their population centers such as New York City, Los Angeles, San Francisco, Chicago, et cetera—we suggest that the additional $5,800,000 be used to satisfy these disproportionate needs on the basis of the formula delineated in the law.

APPENDIX 3

SEC. 318—RECOMMENDED FUNDING $30,000,000

Fiscal year	Number of cases—Reported gonorrhea	Rate of increase (percent)
1972	718,401	15.0
1973	809,681	12.7
1974	874,161	7.9

Note the declining rate of increase of gonorrheal infections. The fiscal year 1974 rate of increase was about one-third less than it was in fiscal year 1973 and about one-half of what it was during 1972. These changes reflect the impact of sustained GC control activities.

Fiscal year	Number of cases—Infectious syphilis	Rate of increase (percent)
1969	18,679	----------
1970	20,186	8.0
1971	23,336	15.6
1972	24,000	2.8
1973	25,080	4.5
1974	24,728	−1.4

Note that infectious syphilis registered a decrease in fiscal year 1974. This is attributable to the sustained levels of control activities over the past several years.

Computation of recommended funding:

Fiscal year 1975 funding		$28,000,000
Inflation factor	percent	8
Ideal fiscal year 1976 funding		$30,240,000
Authorization ceiling 318(d)		$30,000,000
Recommended fiscal year 1976 funding		$30,000,000

APPENDIX 4

Recommended funding—July–September, 1976:

318(b)	$1,350,000
318(c)	2,700,000
318(d)	8,100,000
NIAID	1,080,000

NOTE: Computation based on 27 percent of fiscal year 1976 funding levels.

Mr. NATCHER. Thank you very much, Mr. Clough. We appreciate your appearing at this time.

Mr. CLOUGH. Thank you.

WITNESS

DR. BRENDAN A. MAHER, PROFESSOR AND CHAIRMAN OF THE DEPARTMENT OF PSYCHOLOGY AND SOCIAL RELATIONS, HARVARD UNIVERSITY

Mr. NATCHER. We take up next the Association for the Advancement of Psychology and we have before the committee Dr. Maher.

Doctor, we will be pleased to hear from you.

Dr. MAHER. Mr. Chairman, I have already sent ahead several copies of the extended testimony and with your permission I would like to present directly here just a part of it and then to summarize the main points of the remainder in the hope that that will be in the interest of brevity.

Mr. NATCHER. You may proceed and the entire statement will be inserted in the record.

Mr. Chairman, member of the committee, I am Dr. Brendan A. Maher, currently professor and chairman of the department of psychology and social relations at Harvard University. I am here today representing the American Psychological Association, whose nearly 40,000-member psychologists are working, for the most part, in the health area; either in direct service delivery, in research, in administration in health delivery systems, or in teaching in health manpower training institutions. I speak also for the Association for the Advancement of Psychology, a nonprofit group representing the interest of psychology and psychologists, professional, social, and scientific, in the national public policy arena.

Although American psychologists have a broad ranging interest in the appropriations this committee is considering, as well as agreement with much of the testimony presented here, I wish to address today a very specific concern—the issue of the research budget request of the National Institute of Mental Health. I speak as a psychologist who has been engaged for many years in research and treatment in all aspects of mental health. As a professional, I have been concerned primarily with research on psychopathology, particularly language and thought disorders in schizophrenia. My publications include research papers in schizophrenia and a standard textbook in abnormal psychology. I am editor of the "Journal of Consulting and Clinical Psychology."

The NIMH budget request for research focuses upon three problems; schizophrenia, depressive disorders, and childhood mental illness. These areas are the primary targets of NIMH. Let me comment briefly on each of these problems.

Schizophrenia, which commonly develops in late childhood or early adulthood, strikes 1 to 3 percent of our citizens at some point in their lifetime; it accounts for 20 percent of the admissions to psychiatric hospitals and up to 50 percent of the resident population of these hospitals and nursing homes for the chronic patient.

Schizophrenia is a particularly pervasive and disabling disorder. Not only does it cause serious personal disruption in the life of the patient, it has serious impact on the life and welfare of family members of those affected, both adults and children. The schizophrenic contributes to society far below potential personal capacity. More-

over, the prolonged treatment required by schizophrenia produces a great drain on our Nation's hospitals and community resources. Socially and economically, society suffers.

The extramural research grants programs of NIMH over the past 25 years, supplemented by high quality intramural programs, have made possible the initiation of a major research attack on understanding the basic cause of schizophrenia and on mitigating its crippling effects through innovative treatment. This research has been carried out in a number of universities, clinics, and hospitals throughout the country.

Let me leave the prepared aspect of this, Mr. Chairman, if I may at this point and add in what I feel are perhaps the high points of this particular issue.

I think it is fair to say that in the past 15 years we have come within an arm's reach of what might amount to a breakthrough in the understanding of the causes of schizophrenia. I think this has arisen entirely because of the systematic and long-term nature of NIMH research.

Up until then what we had were expenditures of short-term, one-shot, single issue research investigations and until NIH started into a far-sighted and continuous research program almost all of the central issues in schizophrenia were never looked at directly.

I would like to emphasize that the reason for this is that the evidence suggests to us very clearly that schizophrenia is a developmental disorder, that the early signs, very minor signs, are there in early childhood, that in order to watch the development of the disorder to adulthood one must be prepared to do research the last half of lifetime almost.

We have been able to do this or at least been able to start on this entirely due to the initiative of NIH and as a result we have already made discoveries which have begun to indicate what the early signs in the young are.

The obvious importance of this, of the identifying of vulnerability, is that in that we think lies a key to ultimate prevention. In the long run I think our interests will be served by trying to identify the potential schizophrenic, to identify the early signs long before the disease has become full blown, and to deal accordingly.

NIH has in the past and in recent years funded a number of long term research operations and although it is in this one sense invidious to try and select any one of them let me mention in particular because they have had a profound international impact the work of such individuals of Rosenthal at NIMH itself, Holtzman at the University of Chicago, Garmezy in Minnesota, Kety at Harvard Medical School, Zubin at the New York State Psychiatric Institute. All of this work I think is a direct tribute to the wisdom of the long term planning which NIMH has been able to provide in the long term funding of that kind.

The other major item I would like to emphasize in this is that as we discover what the early signs of schizophrenia are, we often find that we need additional fundamental information about normal behavior.

Let me give you an instance. It looks as if disorders of attention and perception are a fundamental element in the schizophrenic syndrome. In order to understand that and quite how it goes wrong, we

need to know a good deal more about the operation or perception in the normal individual. Hence we need as a integral aspect of this support for the basic research, which helps us make use of the clinical findings. We particularly need it in the areas of child development perception and attention, neuropsychological processes, genetics, and all kinds of treatment.

I want on behalf of the association to express our strong support for the kind of program NIMH has so far been able to fund and to launch, our real concern that were it to be reduced significantly at this point, we not only would not get the fruit of the early work, but in fact we would have thrown away I think a lot of highly critical information and highly critical investment of effort.

The administration support for NIMH research in fiscal year 1976 is in fact rather meager, $81.4 million, which is a reduction of $11.7 million from fiscal 1975. If the administration recommendation is accepted, NIMH will be able to fund only 639 projects in fiscal 1976 as compared to 862 projects in 1975, that is, we will lose the support of over 200 existing forms of research.

In addition, with the cut, and here we are making no observations about the effects of inflation even upon the kind of research that can be done, the effect will be to render NIMH unable to fund $20 million worth of approved 1975 research investigations.

In short, Mr. Chairman, I would like to say that we as psychologists and research scientists are very much aware of the fact that it is the slow long term accumulation of knowledge that both the applied and the basic research which has brought us to the point that we are at right now.

It is wished to urge very carefully that the funding of research now being done, and the future of these research programs, not be abandoned but be at least maintained hopefully improved beyond the levels that they now have.

Thank you, sir.

[The balance of the statement follows:]

The NIMH has made possible a coordinated research effort, involving psychological, biological, medical and social scientists and clinicians.

Before this coordinated national effort was initiated by NIMH the scientific resources which could be brought to bear on schizophrenia were extremely limited. Firm knowledge, crucially needed to build an effective treatment and preventive program with some hope of reducing the personal and social costs of the disorder, was lacking. There were too few investigators, too few clinical treatment and research settings, and far too few research-trained clinicians from the concerned disciplines to implement even very modest programs. The NIMH grant programs in research provide the research and service manpower and resources with which to mount a concerted effort on this disorder.

By the 1970's, research advances had widened our biological, psychological, and social understanding of this disorder. Treatment of schizophrenia through phenothiazines, combined with major modifications in psychological and social treatment approaches, has begun to make possible an initial shift away from the warehousing in state hospitals of chronic unrecovered patients. More and more these heretofore unrecoverable human beings are being returned to the community as contributing members of society.

Psychologists, sometimes in concert with investigators in other disciplines, sometimes independently, have played a central and particularly important role in this research effort.

Psychological scientists and clinicians have participated in much of the research on the new therapeutic approaches and have conducted many of the critical studies which have made it possible to eliminate those approaches to therapy which were ineffective.

Research by psychologists has helped in the development of new standards of care.

Applications drawn from both basic and applied research in such areas of psychological inquiry as child and personality development, learning, perception, and behavior modification have suggested new treatment modalities currently being implemented in various settings.

Psychological research on animals has contributed to the development of more powerful behavioral methods of testing the effectiveness of pharmacological agents which have proven very useful in alleviating some of the more crippling effects of schizophrenia.

Research by neuropsychologists and psychological geneticists has begun to provide a critical understanding of the ways in which biological mechanisms can influence the rate of incidence of the disorder, as well as some aspects of its course.

Investigations have led to more effective diagnostic tools through use of psychological assessment instruments and tests in identifying and measuring those attributes of schizophrenia which differentiate it from other conditions of psychopathology.

One can continue with many such illustrations, for the list is long. These advances have made possible systematic research studies of schizophrenia that need to be completed in order to assess the effectiveness of specific drugs, or innovative modifications in treatment procedures. It would be particularly unfortunate if the momentum we have gained were to be lost now by a shift of priorities.

It is critical, therefore, that there continue to be a systematic and adequately financed long-range coordinated research support policy. At the same time, we need to supply sufficient resources to evaluate and continue to apply new knowledge as it becomes available, with a minimum loss of time and with maximum effectiveness and regard for the safety and welfare of the patient.

Our current knowledge points to several areas in which research support is especially timely. It is possible now, for example, to make headway on the identification of children and adolescents and their families "at risk" for schizophrenia, before the disorder develops. Progress in such research would make possible early treatment, while prognosis is most favorable. Only now can we dare to look ahead to the possibility of familial counseling and intervention before psychosis develops. Such progress could sharply reduce the incidence as well as the severity of the disorder. We are beginning to develop more effective psychological intervention methods for treating the disorder which, with further research, hold promise for reducing its incidence. There is current evidence that with further research such psychological methods, in close concert with effective drug therapy, may be able not only to reduce the hospitalization of schizophrenics, but return them sooner to productive life in the community.

Considerable progress has been made in recent years in the training of psychological manpower and development of clinical resources for mounting a successful effort. It is wasteful, if not a serious error in national policy to allow these trained psychological manpower and research resources to go unused at a time when continuing efforts show promise of significant payoff.

A continuing and long-range research support policy will make it possible for research investigators to commit themselves to intensive investigations, particularly those which require a following of schizophrenia-prone individuals through extended periods of their lives. Such research is impossible in a context of underfinanced short-term research in which the emphasis is largely limited to goals of immediate application. Certainly, much accumulated psychological knowledge can currently be applied with continued research, but it is also of critical importance to mtaintain very high on the list of priorities adequate financing of long-range systematic psychological research, which could lead to far more effective and efficient treatment, and possibly the elimination of schizophrenia as a threat altogether, enabling us to turn to other areas.

Depression rivals schizophrenia as the Nation's No. 1 mental health problem. Previous estimates fixed a prevalence rate of 2 to 4 percent of the population, but a recent survey indicates that during any given year, 15 percent of all adults between 18 and 74 may suffer significant depressive symptoms. Whatever the accurate count, it is clear that depression accounts for a very large share of human suffering and continues to be underestimated, both by mental health professionals and by the general public. In general, the significance of these studies is the high incidence, from 15 to 56 percent, of depressive symptomatology which turns up in randomly sampled normal populations.

Depressive illness and suicidal behavior have an intimate association. It has been reported that suicide was the evenutal cause of death in 14 percent of a cohert sample of manic-depressive patients. Depressive illness has been diagnosed retrospectively in as much as 80 percent of reported samples of suicidal patients. Suicide numbers are increasing, and it now ranks above homicide as the leading cause of teenage death. Clearly, identification of a person as depressive indicates a person "at risk" for suicidal behavior.

Depression is a pervasive phenomenon with many and diverse roots. It should be understood, therefore, that when one attempts to talk about the cause of depressive disorders one is, in fact, describing the outcome of many forces; genetic, biological, psychological, and sociocultural. Psychologists have been primarily involved in efforts to identify psychological and sociocultural factors, but they have also played a role in genetic and biological studies of depressive illness. In these latter studies they have assumed major responsibility for the development of measures designed to assess psychopathology and for research design and statistical analyses of the study data.

For purpose of classification, treatments for the depressive illnesses can be divided into two broad categories: somatic and psychological. The significant increase over the past decade in biological and psychopharmacological research has partially eclipsed the study of psychotherapy of the depressive illnesses. Despite this trend, we must remember that the burden of therapy for the greater proportion of the depressive illnesses still falls squarely upon the psychosocial therapeutic modalities.

Psychologists have been engaged in a variety of roles in evaluating the efficacy of treatments in both animal and clinical drug trials, since the introduction of the psychoactive drugs in the early 1950's. The animal studies have had two major foci. One is a study of the toxicity of the drug in question, both for short-term and long-term use. This may involve studies of the possible mutagenicity and teratogenicity of a compound which could lead to birth defects. The second is the early screening of psychoactive agents in animals to chart the behavioral profile of a drug (that is, does it have any marked sedative-hypnotic effects?). Clinical drug trials with both normal and inpatient populations have also been undertaken with psychologists playing key roles.

Despite some recent dramatic advances in our understanding of the biological antecedents and concomitants of various forms of depressive illness, depression is a very serious public health threat, with increasing prevalence in this country, especially among the young and members of the working class. Basic research is essential in this field, especially as regards the psychogenic origins of many forms of depression. An understanding of the antecedents of this illness in early childhood and adolescent experiences cculd lead to improved techniques for identifying youngsters and/or parents in need of psychotherapy or counseling to forestall later attacks of severe depression.

Additional basic research is needed to evaluate the respective roles that psychotherapy and drug treatment play in the treatment of depressed patients. Evidence to date suggests that drug treatment of depression is most useful during the acute phase of the illness, for reducing the major symptoms of depression; whereas, the benefits of psychotherapy occur later in treatment and seem to affect the individual's personality and ability to deal with life-stress events. Consequently, one would predict that a successful course of psychotherapy should augment a successful course of drug treatment, but research must be continued.

Explicit in much of the foregoing material has been a logic which places the vicissitudes of childhood in a significant role as precursors to the adult problems of schizophrenia and depression. Not every child with a disadvantage of any kind is, of course, a problem to self or others. Many use their relative disadvantage as a motivating force toward successful performance in adult roles. We have, however, in recent years become able to diagnose more effectively those aspects of a child's background that make him more or less vulnerable to the challenges of particular situations in which life places him. It is the importance of this knowledge, and the potential benefits results from the wise and informed use of it, that makes the science of child development and childhood mental illness important concomitants to the proposed NIMH research program.

In an era of growing scarcities, children remain our most important national resource. In 1970, the national census revealed our population to be 203.2 million persons. Of that number, 50 million plus—approximately 26 percent—were under the age of 18, and of this group, 25 million were below the age of 10.

Fortunately, most of these children are growing straight and strong. But against this large number, we are still confronted with a rather frightening set

of statistics. According to the National Health Education Committee: (1) 10 percent of all school-age children (an astronomical count that indicates a problem involving millions) have emotional problems sufficiently severe to require psychological help; (2) children comprise 34 percent of the total caseload of the Nation's outpatient psychiatric clinics; (3) in 1966, almost one-half million children under 18 years of age received some service in a psychiatric facility in the United States; and (4) the number of young boys between ahe ages of 10 and 14 in mental hospitals increased sixfold between 1950 and 1970—a period that saw, by contrast, a doubling of our total population.

Add to these human statistics, the dollar costs to a nation beset by vandalism (the recent Senate report on school vandalism projects the tip of an iceberg), destructiveness, and the growing potential for youth-initiated violence. Add to this, the lost dollars resulting from years of low productivity by individuals encumbered by mental and emotional disturbance. Add further, the dollar costs in terms of hospitals, clinics, welfare programs, and the myriad of support services needed by those who will only know a lifetime of dependence and dread. When one attempts to total these figures, the significance of Federal support for research into the causes and correlates of child mental disorders, and child mental health, becomes self-evident.

Children are our great national resource and the threats to that resource are considerable. Poverty, disorganization in families and communitiees, victimization by prejudice, lack of schooling, the absence of work skills—all these erode the happier images of childhood. The issue is not treatment alone. We not only lack the resources for treating millions of needy children, we also lack the know-how to treat certain types of problem children. Solutions to the severe problems of childhood psychoses escape us. Success in treating children seemingly committed to violent and antisocial behavior is limited. We need support for exploring new avenues of treatment for many types of deviant children. Funds solely for the expansion of treatment resources for meeting the problem of mental disorders of childhood, would be ineffectual if funds for basic research into the origins of children's mental disorders are not forthcoming.

We sometimes forget that this Nation has been built by adults who, as children, personally experienced the stress of economic, as well as other forms of environmental disadvantages. What makes for the stress-resistant child and the stress-resistant adults as well?

If research on the mental health of children has a broad purpose, it is not simply to learn about the origins and the correlates of deviant behavior. The future strength and well-being of our Nation requires us to understand how children develop work competence, acquire skills, and engage in reasonably harmonious relationships with their families and their peers. We need to know how individuals become capable of forming meaningful relationships with others to the betterment of family and neighborhood; how they develop self-esteem and potential for meeting new challenges that will generate not only pride in self but pride in citizenry as well.

This is what child mental health is all about—to preserve a great national resource, and to cultivate and foster a product which more than any other guarantees the future of our Nation—our children.

In enlarging on these three areas of mental health research, I have tried to illustrate for the committee just what the NIMH budget request for research can do. Psychologists believe the programmatic targeted effort suggested by NIMH is a strategically fruitful approach to the funding of mental health research. Many years of slow but steady interdisciplinary progress on these intractable problems have put solutions in range of our methodological weapons. Probably no other areas are as close to the "breakthrough" stage or as ripe for major gains in our understanding of procedures for prevention, diagnosis, and treatment as are these three problem areas. We know that it is important to demonstrate payoff, and in testifying today, we laud the proposed NIMH strategy.

In closing, we would like to add that, as psychologists, we are also aware that it was the piece-by-piece accretion of knowledge, through processes of basic research, that has gotton us where we are. Thus, we are careful to urge that present and future funding of basic research not be abandoned. There are indeed a number of unsolved problems worthy of our attention.

Mr. NATCHER. Doctor, we want to thank you for appearing before our committee at this time.

Dr. MAHER. Thank you very much, Mr. Chairman.

American Dental Association

WITNESS

DR. EDWARD J. FORREST, DEAN, UNIVERSITY OF PITTSBURGH SCHOOL OF DENTAL MEDICINE

Mr. Natcher. We take up next Dr. Edward J. Forrest. You represent the American Dental Association. We will be glad to hear from you.

Dr. Forrest. Thank you, Mr. Chairman. My name is Dr. Edward Forrest. I am Dean of the University of Pittsburgh School of Dental Medicine and a member of the American Dental Association's Council on Research. I am appearing today on behalf of both the American Dental Association and the American Association of Dental Schools.

I would like to begin by presenting some of our association's views regarding appropriations for the support of health manpower education. My remarks will be brief since there are as yet no authorizations to continue the health manpower programs beyond fiscal year 1975. The brevity of these comments, however, should not be taken as a measure of our concern over the appropriation levels requested in the Administration's fiscal 1976 budget. The fact is that, were these levels to stand, the proposed reductions for institutional support alone would have a crippling effect on our educational institutions. The President's budget calls for a cut of $50 million in basic institutional assistance to the health professions schools. This proposed decrease for fiscal 1976 would be the first of three annual reductions leading to the complete elimination of institutional support. In 1974, our dental schools received over $40 million under this program. Alternative sources of support simply do not exist. If this assistance is withdrawn, many of the institutions would find it difficult if not impossible to continue operation. For this reason, we recommend that the Subcommittee, in its consideration of health manpower funding, appropriate sums that are equal to the levels authorized for institutional grants.

NATIONAL INSTITUTE OF DENTAL RESEARCH

At this point, I would like to turn to the National Institute of Dental Research. Before commenting on the proposed fiscal year 1976 budget for the Institute, it is important to recognize two basic factors that have influenced the growth of dental research in this country. First, the entry of dentistry into biomedical research occurred at a considerably later date than that of its sister profession of medicine. It is fair to say, I believe, that a concerted and coordinated dental research effort did not begin until after World War II. Because of a shortage of trained investigators it was necessary to, in fact, develop a dental research community from the ground up. Second, the progress of dental research—particularly over the past 25 years—is a direct product of the assistance and encouragement that Congress has given to the NIDR. Alternative sources of support were not, and to a large degree are not, available for dental research. Even today, the total of public and private funds available for dental research represents only a fraction of the sums expended for research by otther disciplines.

I mention this as background in order that the subcommittee may understand and appreciate a fundamental concern of our associations: adequate Federal funding of the NIDR is not simply desirable—it is

absolutely necessary to sustain a productive and creative research environment for dentistry.

The Department has requested $43.5 million for the NIDR in fiscal year 1976. This represents a decrease of $6.3 million from the current operating level. Because of the fragile financial base upon which dental research already functions, a reduction of this dimension will have a profound impact on basic investigations into the causes of dental diseases. Potential research breakthroughs will be delayed. Promising avenues of research may have to be abandoned. The bulk of these proposed reductions will fall most heavily on the extramural programs of the Institute. In fiscal year 1975, a total of $17.9 million was awarded for 316 research grants. The Department's fiscal year 1976 budget, if approved, would permit the funding of only 219 research grants at a reduced level of $12.6 million. A similar fate is proposed for the important program of research training grants. Grants awarded under this authority would, as a result of the administration's budget, be reduced from 48 to 34 with an accompanying loss of approximately $600,000 in Federal assistance. These decreases would occur at the very time that our dental schools are struggling to develop a permanent research base with less than 4 percent of the total NIH research budget.

In 1975, Congress appropriated $49.8 million for the NIDR. An increase over this level for fiscal year 1976 can, in our opinion, be well justified. Last year our associations recommended an appropriation of $51 million for the Institute. We believe that this amount for 1976 will allow the Institute to continue and expand its research efforts into the causes, prevention and treatment of: dental caries, periodontal diseases, oral cancer, cleft lip and palate, and other oral birth defects; malocclusion and facial growth deformities; the control of oral facial pain; the funding of five ongoing dental research centers—one of which is in Pennsylvania; and the support of the very important research activities of the National Bureau of Standards in the area of new dental restorative materials.

GENERAL RESEARCH SUPPORT

Since 1962, dental and other health professions schools have participated in the general research support program NIH. This program provides a vital supplement to the limited resources available from NIDR. In 1975, 34 dental schools are expected to receive $1.9 million in GRS grants. The administration proposes to eliminate this program in fiscal 1976. Because of the modest sums otherwise available for dental research, the termination of this assistance would seriously retard the developing research programs in many of our dental schools and research institutes. It is important to note that, in contrast to targeted research, the purpose of GRS support is to improve the overall quality of research. This is an essential factor in dentistry's efforts to become an integral part of the total research community. We respectively recommend, therefore, that $55 million be appropriated for GRS in 1976.

A second issue that must be addressed is the proposed changes in the eligibility criteria for GRS grants. It is our understanding that if support for GRS is continued, HEW intends to raise the minimum base of sponsored research necessary to qualify for GRS support from the current level of $100,000 to $200,000 per year. If this should occur,

we estimate that at least one-third of our dental research programs would be denied participation in the program. For those institutions, a higher eligibility base would have the same effect as the elimination of GRS altogether.

We strongly oppose the proposed changes and urge this subcommittee to instruct the Department to maintain the current GRS award standards.

DIVISION OF DENTISTRY

The final area which our associations would like to address is the Division of Dentistry. As this subcommittee is aware, the Division and its forebearers were regarded for many years as the organizational focus for dental public health within the Federal Government. Recently, however, we have witnessed a distinct change in the emphasis and orientation of the Division's activities.

The financial and personnel resources of the Division that were previously directed toward prevention, epidemiology, dental care and disease control have either been withdrawn or transferred to other agencies within HEW. To a large extent, this change in emphasis coincided with the Department's decision in 1973 to eliminate the line item budget status of the Division. This action has not only made it difficult for Congress to directly review many dental activities but it has also enabled the Department to submerge many traditional dental public health programs within medically oriented agencies.

We are particularly concerned that this reordering of the Division's priorities is having the greatest impact upon the highly successful preventive dentistry programs. A loss of focus for these activities would occur at a time when the practice of preventive dentistry is of upmost importance in reducing dental disease and containing dental costs to the public. Historically, the Division has been the core Federal agency for a nationwide fluoridation effort. It is our understanding that responsibility for this activity is to be placed in another unit of the Department. A transfer of the fluoridation program to a nondental agency would, in our opinion, significantly reduce the emphasis that has been given to this important function by the Division of Dentistry.

The Department has attempted to obscure these unilateral actions through a series of reorganizations within the Public Health Service that are apparently to be patterned along functional rather than categorical groupings. However meritorious this may appear as a concept, the result has been a gradual dismantling of the dental public health programs with which this subcommittee is familiar.

The loss of budget visibility for the Division has, we respectively submit, diminished the traditional accountability that HEW was required to make for its dental responsibilities. Our associations have examined the proposed fiscal year 1976 budget for the Department and are unable to identify sources of support for any significant efforts in the area of preventive dentistry. We urge, therefore, that the subcommittee restore the line item budget of the Division of Dentistry and instruct HEW to provide an annual justification for and a description of the dental programs of the Department. It is specifically recommended that the Department include within such a justification a statement detailing the dimensions of the Division's program on Training in Expanded Auxiliary Management (TEAM) and its conformity with acceptable educational and professional

standards in States where Federal funds are being utilized for this purpose. Thank you, Mr. Chairman.

Mr. NATCHER. Dr. Forrest, we want to thank you for your appearance before our committee at this time.

Dr. FORREST. Thank you, sir.

GORGAS MEMORIAL INSTITUTE

WITNESS

DR. JACK MILLAR, PRESIDENT AND CHAIRMAN OF THE BOARD

Mr. NATCHER. Our next witness is Dr. Jack W. Millar.

Come around, Dr. Millar. Doctor, we will be glad to hear from you at this time.

Dr. MILLAR. Thank you, Mr. Chairman. I have prepared a statement for the record.

Mr. NATCHER. The entire statement will be inserted in the record and you may proceed, Doctor.

Dr. MILLAR. Mr. Chairman and members of the committee: I appreciate the opportunity to come before the subcommittee and to testify in support of increased fiscal year 1976 appropriated funds for our organization.

I am Jack W. Millar, M.D., and in the capacity of president and chairman of the board of directors, I represent the Gorgas Memorial Institute of Tropical and Preventive Medicine, Inc. (GMI). The institute is a private, nonprofit organization which was incorporated under the laws of the State of Delaware and registered in the Republic of Panama in 1921 as a living memorial to the distinguished U.S. sanitarian and medical scientist, William Crawford Gorgas. It was the president of Panama who originated the idea of a research center in his country, where the American nations would cooperate in trying to solve their common disease problems.

The memorial efforts of the two countries came to fruition in 1929 when the United States and the Republic of Panama collaborated in the creation and support of the Gorgas Memorial Laboratory (GML) in Panama. By direct negotiation of the Gorgas Memorial Institute with the two governments, this cooperation has continued to date, to the satisfaction of all parties, setting an almost unique example of international collaboration.

The institute, with headquarters in Washington, D.C., is governed by a 47-member board of directors, which includes government officials of the United States and Panama, representatives of national and international agencies active in areas of common interest, and leading U.S. and Latin American scientists and professionals. The board meets annually to determine the policies of the institute, review the managerial and fiscal operation, approve budgets, and elect the officers, executive committee, and advisory scientific board, all of whom serve without compensation. Between meetings, the board's functions are delegated to the nine-member executive committee, which meets monthly under the chairmanship of the president. The 24-member advisory scientific board consists of scientists in various disciplines and advises in the development and review of the scientific programs.

In compliance with the original act of May 7, 1928, as amended (45 Stat. 491; 22 U.S.C. 278a), the institute submits to the Congress annual reports, including financial statements, of the work and operations

of the Gorgas Memorial Laboratory. Likewise, by arrangement with the Comptroller General of the United States, biannual audits are conducted by the General Accounting Office; in alternate years a private firm selected by the executive committee carries out the audits.

The numerous achievements of the laboratory have been recognized by the United States and Panama who continue to lend direct and effective support to its operation. The U.S. Congress has reaffirmed this support throughout the years by steadily increasing the U.S. permanent annual contribution to the institute, through amendments to the original act of 1928. The budgetary responsibility for these annual contributions was initially the responsibility of the Department of State. In 1955, it was transferred to the Department of Health, Education, and Welfare (DHEW), which assigned it to the National Institute of Allergy and Infectious Diseases (NIAID); and in 1971 the Fogarty International Center (FIC), National Institutes of Health, became the Federal agency charged with this task. FIC is represented by an official at all meetings of Gorgas' executive committee and boards.

In fiscal year 1966 the authorization ceiling was set at the amount of not to exceed $500,000 and remained at that level until the enactment of the Foreign Assistance Act of 1974 (Pub. L. 93–559 of December 30, 1974) which increased the ceiling to not to exceed $2 million.

At the time the Fogarty Center was asked to develop and process its fiscal year 1976 budgetary request, the new increased legislative authority for Gorgas had not been enacted; accordingly, the amount requested by FIC for the Gorgas operation in fiscal year 1976 is limited to the previously authorized ceiling of only $500,000.

The urgency for an increase in this basic contribution is clear from the financial statement provided herewith (table B). The reduction of contract and grant support (table C)—including termination of the contractual arrangement with NIAID for the operation of the Middle America Research Unit (MARU)—and the fixed authorization ceiling of the last 9 years were recognized during the hearings of March 13, 1974; these were held by the House Subcommittee on Inter-American Affairs of the Committee on Foreign Affairs and paved the way for the subsequent increase in the legislative authority mentioned previously.

A look at the financial statement in table B reveals that our operational costs in fiscal year 1975 are anticipated at $1.9, with NIAID providing additional interim funding—as authorized in the HEW fiscal year 1975 appropriation—during the second half of the fiscal year. Projected income for fiscal year 1976 is $760,000, reflecting a $500,000 U.S. congressional contribution. I respectfully request, Mr. Chairman, that this amount be increased—in line with Gorgas' new legislative authority—by $1 million, for a total of $1,500,000. Such action would bring our level of funding in fiscal year 1976 to $1.7, or approximately $200,000 less than the previous year. Therefore, this request for additional funds represents, in effect, some savings in the Federal budget. Nevertheless, at this operational level, the new funds would permit Gorgas to consolidate in the Gorgas Memorial Laboratory, research work previously conducted by the laboratory facility known as MARU, and to reorganize and reprogram GML research activities, the better to perform its mission in the Americas.

Worth mentioning is the continued support lent by the Government of Panama, aware as they are of Gorgas' present fiscal constraints. During the past month, Panamanian officials have expressed willingness to fund virological work in the Bayano, and have also expressed interest in negotiating, through the ministry of health, medico-ecological studies to be conducted by GML along the route of the Pan American highway.

Using our revised organizational chart (table A), we propose to utilize these funds as follows:

1. Biomedical educational resources center	$105,000
Regional Medical Library	
Computer Center	
Educational Center	
2. Primate center	75,000
Reproductive studies	
[1] Simian diseases	
Experimental models	
3. Division of infectious diseases	645,000
Bacterial diseases	
Parasitic diseases	
[1] Experimental biology	
Virus diseases	
[1] Animal diseases	
4. Division of ecology and epidemiology	340,000
Epidemiology and human ecology	
Plant and animal ecology	
Environmental biology	
[1] Health services research	
[1] Chronic diseases	
5. Division of clinical investigations	100,000
Immunopathology	
[1] Prevention and control	
6. Administration	245,000
7. Maintenance of plant and equipment	250,000
Total	$1,760,000

[1] To be developed in future.

Emphasis will continue on long-range programs to discover factors in tropical disease ecology which may be used in prevention and control of diseases of the tropics. We have developed approaches to in-depth ecological studies which result from socioeconomic projects in the Western Hemisphere tropical countries. One of the most important of these projects is the Bayano, which studies the effects of drastic environmental changes on the transmission cycles of tropical diseases; the changes result from the construction of a hydroelectric dam in a tropical forest and the Pan American Highway. Such studies may develop models for similar projects in tropical America, thus assisting in the prevention of serious ecological derangements.

The program on parasitic diseases will be reoriented to include malarial studies where the disease exists in the field; to monitor insecticide resistance in malarial vectors; to study and monitor the occurrence of synthetic antimalarial drug resistance; to look for new malarial vectors that may be in the Darien jungles as a result of the environmental disturbances noted above; to study the natural history of malaria in Kuna Indians who will remain along the Bayano reservoir shore; and to carry out constant surveillance along the Colombian border both before and after completion of the Pan American Highway, in order to note the possible introduction into Panama of such

dangerous South American vectors as *Anopheles darlingi* and *A. nuñez-tovari*. Chagas and leishmaniasis will also be studied to determine epidemiology and treatment requirements.

Current bioenvironmental studies on the blackfly inhabiting certain areas of the Darien Province will be continued in an attempt to find economically and biologically feasible methods of control. The solution of this problem is essential if fertile areas are to be made habitable for populations being relocated because of the hydroelectric project.

Essential arbovirus work conducted under the already mentioned NIAID contract at MARU, which terminates on 30 June, will continue; this includes isolation and identification of yellow fever virus and studies to measure specific yellow fever antibodies in materials from mosquitoes, wild animals and humans, in support of the studies on the epidemiology of jungle yellow fever.

It has been said that William Crawford Gorgas is best known for his accomplishment in eradicating urban yellow fever from the Republic of Panama during the early construction of the Panama Canal (1904–06). GML has long been interested and involved in the continuing study of yellow fever. In 1948, jungle yellow fever was found near the Canal Zone, invading that area the following year and moving westward through the Central American Isthmus to Mexico during the next decade. These countries were able to keep yellow fever from entering their urban areas, thanks to the advance warning from Panama.

In the midfifties, GML observed and confirmed a second invasion of jungle yellow fever in the Canal Zone and subsequently, the laboratory established long-term observation points in eastern Panama for the early recognition of new threats to the region. This sentinel duty is of utmost importance not only to Panama but also to Central America, Mexico and Southern United States.

In February 1974, GML again confirmed another reinvasion of the virus some 70 miles east of the canal. Some research results to date have made available, for the first time, well documented data on the feasibility of eradicating the vectors of jungle—sylvan—yellow fever and the real possibility of interdicting the westward march of the virus toward the canal. The two most probable sites of the advancing wave have been identified east of the canal, where ultralow volume spraying of malathion should clear the area of the transmitting vectors and prevent the disease from gaining a foothold on the west side and subsequently moving north.

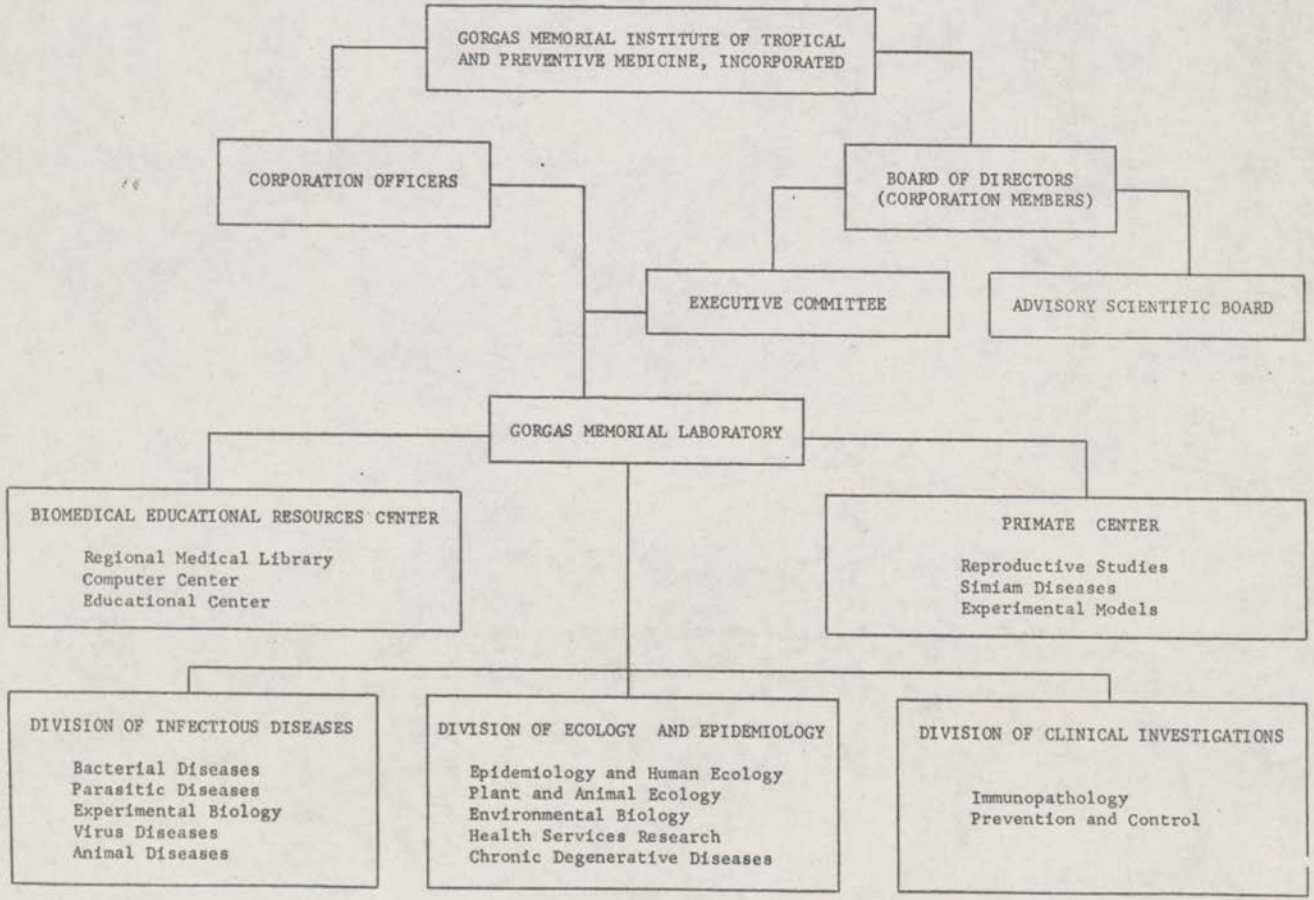
GML will continue its expertise in providing research support and epidemiological consultation for countries other than Panama, as well as provide its all-important service of southern disease-early-warning for the United States.

The use of Gorgas' research programs in training U.S. biomedical scientists, which has been filling an important need, will be continued and expanded as our resources permit.

Again, thank you, Mr. Chairman and members of the committee, for the opportunity to bring before you our vital need for the $1 million increase here requested to support our fiscal year 1976 operation.

[The attachments follow:]

15 May 1975
TABLE A



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GORGAS MEMORIAL INSTITUTE OF TROPICAL
AND PREVENTIVE MEDICINE, INCORPORATED

STATEMENT OF REVENUE AND EXPENDITURES
FOR THE FISCAL YEARS ENDED JUNE 30, 1975 AND 1976

	ANTICIPATED JUNE 30 1975	PROJECTED JUNE 30 1976
FUNDS AVAILABLE:		
Contribution by the United States	$ 707,500	$500,000
Interest and Miscellaneous Income	3,000	2,000
Total Funds from Regular Sources	$ 710,500	$502,000
Research Grants and Contracts:		
Department of Health, Education, and Welfare		
AI02984 Ecology of Vector Borne Viruses	$ 111,893	$115,000
AI01251 Leishmaniasis in Panama	50,101	-
AI11889 Microclimate of Arthropod-Borne Diseases	24,726	20,000
RR05769 General Research Support	12,525	25,000
AI22514 Middle America Research Unit	696,967	-
Total DHEW	$ 896,212	$160,000
Department of Defense		
Army C-2031 Monkey Hosts of Human Malaria	$ 70,235	$ 30,000
G-9406 Biohazards of Blackfly in Panama	54,333	39,000
C-4053 Army Unit at MARU	99,500	-
Total Army	$ 224,068	$ 69,000
Navy C-0019 Medical Postgraduate Courses	$ 25,000	$ 25,000
C-0108 Chagas Immunity	15,000	3,750
Total Navy	$ 40,000	$ 28,750
Agency for International Development		
C-1134 Malathion Spraying against Yellow Fever	$ 107,344	$ -
Panamerican Health Organization	$ 12,000	$ -
Smith, Kline & French Laboratories	$ 2,000	$ -
Harvard: New England Regional Primate Center	$ 5,000	$ -
Total Research Grants and Contracts	$1,286,624	$257,750
TOTAL FUNDS AVAILABLE	$1,997,124	$759,750

GORGAS MEMORIAL INSTITUTE OF TROPICAL
AND PREVENTIVE MEDICINE, INCORPORATED

STATEMENT OF REVENUE AND EXPENDITURES
FOR THE FISCAL YEARS ENDED JUNE 30, 1975 AND 1976

CONTINUED

	ANTICIPATED JUNE 30 1975	PROJECTED JUNE 30 1976
EXPENDITURES:		
Direct Research		
1. Biomedical Educational Resources Center		
Regional Medical Library	$ 33,698	$ 60,000
Computer Center	-	20,000
Educational Center	11,128	25,000
	$ 44,826	$ 105,000
2. Primate Center		
Reproductive Studies	$ 14,260	$ -
Experimental Models	-	75,000
	$ 14,260	$ 75,000
3. Division of Infectious Diseases		
Bacterial Diseases	$ 63,768	$ 75,000
Parasitic Diseases	371,714	200,000
Virus Diseases	182,474	370,000
	$ 617,956	$ 645,000
4. Division of Ecology and Epidemiology		
Epidemiology and Human Ecology	$ -	$ 100,000
Plant and Animal Ecology	157,988	190,000
Environmental Biology	-	50,000
	$ 157,988	$ 340,000
5. Division of Clinical Investigations		
Immunopathology	$ 94,275	$ 100,000
6. GMI-MARU	$ 625,619	$ -
TOTAL DIRECT RESEARCH	$1,554,924	$1,265,000
7. Administration	$ 257,818	$ 245,000
8. Maintenance of Plant and Equipment	$ 148,526	$ 250,000
TOTAL EXPENDITURES	$1,961,268	$1,760,000
Excess (Deficiency) of Income over Operating Expenditures	$ 35,856	($1,000,250)

TABLE C

GORGAS MEMORIAL INSTITUTE OF TROPICAL
AND PREVENTIVE MEDICINE, INCORPORATED

RELATIONSHIP OF APPROPRIATED TO GRANT/CONTRACT FUNDS

FOR THE PERIOD 1965 - 1976

	U.S. GOVERNMENT		GRANTS		
FY	$ AMOUNTS	% OF TOTAL	$ AMOUNTS	% OF TOTAL	TOTAL
65	350,000	73	128,000	27	478,000
66	350,000	60	235,745	40	585,745
67	500,000	63	294,180	37	794,180
68	500,000	50	499,349	50	999,349
69	500,000	45	612,211	55	1,112,211
70	500,000	49	522,985	51	1,022,985
71	500,000	47	561,000	53	1,061,000
72	500,000	41	709,397	59	1,209,397
73	500,000	26	1,418,714	74	1,918,714
74	500,000	29	1,198,470	71	1,698,470
75	707,500	35	1,286,624	65	1,994,124
76	500,000	66	257,750*	34	757,750

*estimates

Mr. NATCHER. Dr. Millar, thank you very much for appearing at this time.

Dr. MILLAR. Thank you.

ALCOHOLISM

WITNESS

DR. NATHAN S. KLINE, DIRECTOR, ROCKLAND PSYCHIATRIC CENTER

Mr. NATCHER. Dr. Nathan S. Kline, director of the Research Center, Rockland Psychiatric Center.

Dr. Kline, it is a pleasure to have you appear before our committee and we will be glad to hear from you.

Dr. KLINE. Thank you, sir.

Might I request that the statement and also the qualifications, curriculum vitae of Mr. Cooper, my colleague and myself be included?

Mr. NATCHER. Both will be inserted in the record in their entirety.

[The statement and curriculum vitae follow:]

LITHIUM IN THE MANAGEMENT OF ALCOHOLISM

(By Nathan S. Kline, M.D. and Thomas B. Cooper, Rockland Research Institute, Orangeburg, N.Y.)

Lithium, a common element like sodium, may be of great importance in the management of alcoholism. An exciting feature of this new approach is that the user is able to drink but, when the results are satisfactory, can do so in a normal instead of a compulsive manner.

Lithium has been used in medicine for more than a century but it wasn't until 25 years ago that Cade in Australia described its use in the treatment of a hyperexcitable patient [1]. The particular efficacy of this medication against manic phases of the manic depressive illness was clarified in subsequent clinical trials and has been confirmed in well controlled double blind trials, that is, neither the observer nor the patient knew whether the patient was ingesting active medication or an identical capsule containing an inert filler (placebo).

In recent years lithium has entered a new phase through the demonstration that it has prophylactic action against endogenous affective disorders including manic depressive disorder and recurrent (cyclical) endogenous depressions. Clinical experience has shown that lithium is not immediately effective in these situations but that after time (weeks to months) a gradual lessening of the mood swings (both frequency and amplitude) can be observed [2].

Our recent observation has been that lithium apparently has some efficacy in the treatment of chronic alcoholic patients [3]. The importance of this finding (if confirmed) cannot be overestimated since there are more than 9 million Americans who are problem drinkers today. The fact that the Government formed a new institute, The National Institute of Alcoholism and Alcohol Abuse, is a measure of the concern felt at all levels of society.

At Rockland Research Institute we have been investigating the biology, pharmacology and clinical efficicacy of lithium for many years. In 1969 Dr. James C. Wren (a colleague of Dr. Nathan S. Kline) had accepted a post with the Veterans Administration in Maine and was interested in becoming more actively involved in research. However he found that an overwhelming number of patients in his charge were chronic alcoholics and therefore knowing the difficulties such a population presented for a research study consulted with our group.

During this meeting several observations were made: (a) with the exception of passing reference to a small group of alcoholics who were given lithium, but in whom the results were not systematically followed, lithium had not been investigated as a possible therapeutic tool in the treatment of chronic alcoholism. (b) Many investigators have observed that a large percentage of alcoholics are

also suffering from depression which raises the question whether or not control of the depression would influence the addiction. (c) The very nature of the time course of the illness suggested that a form of continuous long term therapy would be mandatory. (d) Other antidepressant medications have been used with varied therapeutic response but some investigators question whether these medications can be given for protracted periods of time. Lithium, however, has been given continuously to patients for more than 15 years [2]. (e) The vast number of proposed treatments (from psychoanalysis to LSD) indicate the extreme difficulty in finding an effective treatment. (f) Lithium has the decided advantage that the blood level can be monitored easily to determine whether the patient is taking the medication as prescribed (an important factor when treating a group not noted for their reliability.). (g) The group of patients in Maine seemed an ideal population in that the Veterans Administration Center was the only hospital at which they could receive treatment and therefore good contact could be maintained.

A collaborative study involving the Veterans Administration Center, Togus, Maine and the Rockland Research Institute, Orangeburg, N.Y., was proposed by us and funded by the NIAAA. Volunteer patients were screened and if found physically healthy, alcoholic and suffering from a depression of exogenous origin were given either lithium or an identical placebo for a period of 1 year. At the end of that year the placebo group was changed to active medication.

The patients were seen and interviewed at monthly intervals throughout the study period (2 years). The degree of depression was quantified throughout each 2 month period of the study. The patients were asked to describe their drinking habits at each interview but the criterion selected as a quantitative measure of improvement or lack of improvement was the number of disabling drinking episodes experienced during the study. Disabling drinking was defined as "drinking to the point of interference with normal daily life whether as an in-patient or an out-patient necessitating admission to, or transfer to, a special unit for detoxification".

Seventy-three patients were treated and as expected the drop-out rate was high. Thirty patients completed 1 full year of the study and 21 completed 2 full years. Table 1 shows the data obtained for these patients and table II shows the patients who have completed 2 full years of active medication and their previous history of drinking episodes. A surprising finding was that while the depression ratings of these patients improved, i.e. they were less depressed at the end of the study, this was true whether the patients received active medication or placebo.

Lithium therefore appears to have had a marked and statistically significant beneficial effect on this group of 30 patients. We frankly did not expect to find such a dramatic improvement following the lithium treatment. The original hypothesis that it was because of the alleviation of their depression that chronic alcoholics might be helped was neither confirmed nor disconfirmed by this study.

It is exciting that lithium seems to have some effect upon the manifestations of chronic alcoholism. Whether the improved behavior was or was not related to depression is secondary; primary is the fact that lithium may be a powerful ally in the prevention of periodic or chronic drinking problems. Additional controlled studies are presently underway to further resolve these findings.

Since this finding was published, several other investigators have confirmed in open trials that lithium is effective in the management of chronic alcoholism. The largest study, which involved more than 100 patients, was reported by Dr. Marshall of Buffalo, N.Y. [4].

There are animals who have been systematically bred to prefer to drink an alcohol solution when given the choice between alcohol and a sucrose solution. Drs. Ho and Sinclair [5, 6] have reported that if these animals are given lithium then they change their behavior and avoid the alcohol solution and drink the sucrose solution.

In alcoholism we are dealing with a true "addictive state". Dr. Flemenbaum [7] published a theoretical paper after our own work was published in which he hypothesized that lithium would be of therapeutic benefit in many such states.

Recently case notes on three chronic amphetamine abusers [8] indicated that when given lithium these patients did not experience the high they normally achieved and they found that they did not use amphetamine whilst on lithium therapy. Professor Arnold Mandell at a recent conference [9] has postulated

with experimental data a brain biochemical pathway that may be specifically affected by lithium and amphetamine.

Collaborative work with Dr. Wagner of Columbia University utilizing the scanning electron microscope has demonstrated that lithium has a specific effect on an area of the brain known as the choroid plexus [10]. This area is sometimes known as the kidney of the brain, in that it controls the brain level of a variety of chemicals by selective excretion or retention.

The exciting finding in this area is that lithium increases the water content of these cells and that conversely alcohol decreases the water content of the same cells. Thus a possible mode of action for lithium is the prevention or reversal of the depletion of water content caused by alcohol. Further it is possible that the reversal of this specific physiological event triggers or inhibits, by a mechanism not yet defined, other biochemical pathways so that the compulsive need to drink to extinction is diminished or reversed completely.

Additional evidence that this finding is of considerable importance is that there is a section of the Sixth International Conference on Pharmacology at Helsinki, Finland (June 1975), devoted to the subject of lithium and alcoholism.

COMPARISON OF 1ST YR LITHIUM AND PLACEBO VERSUS PREVIOUS YEAR HISTORY OF DRINKING EPISODES

Placebo group (n=14)			Lithium group (n=16)		
Patent No.	Previous year	Placebo year	Patent No.	Previous year	Lithium year
2	6	6	3	0	0
4	3	1	9	2	0
5	4	5	14	5	2
7	4	0	15	4	0
10	3	5	20	2	0
13	0	0	21	3	5
28	1	0	22	3	0
36	2	2	24	2	0
48	3	10	25	1	0
58	5	4	40	2	0
65	2	1	41	2	1
66	1	0	43	1	0
72	1	1	55	1	0
73	1	0	57	1	0
			59	5	1
Total [1]	36	35	68	2	0
			Total [2]	36	9

[1] Chi square difference not significant.

[2] Chi square difference significant at $P<0.01$.

TOTAL NUMBER DISABLING DRINKING EPISODES IN PATIENTS COMPLETING 2 YR TREATMENT COMPARED TO PREVIOUS 2 YR PERIOD (N=18)

Patent No.	Previous 2 yr	Lithium 1 yr	Lithium 2 yr
2	12	0	1
3	2	0	0
9	2	0	0
13	0	0	0
15	6	0	2
20	3	0	2
22	3	0	0
24	2	0	0
25	1	0	0
28	1	0	0
36	4	1	2
40	2	0	0
43	1	0	0
48	13	4	0
55	1	0	0
57	3	0	0
66	1	1	1
68	2	0	0
Total	59	6	8

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SUMMARY

1. In a controlled study, that is, one half of the patients were given active medication, the other half a blank identical capsule (placebo) and the investigators did not know which patients were receiving the active medication during the study; lithium profoundly decreased the number of hospitalizations for detoxification required by the patients.

Number of hospitalizations during 2 years prior to study—59.

Number of hospitalizations during first 2 years of study—14.

2. This work has been confirmed in open studies by several workers, the largest study involving more than 100 patients has been reported by Dr. Marshall of Buffalo, N.Y.

3. Dr. Sellers of Toronto University has reported that patients given lithium during alcohol withdrawal experienced less withdrawal symptoms than control subjects not treated with lithium.

4. Patients inform us that they do not enjoy drinking as they used to, and do not feel the compulsion to drink to extinction.

5. It has been reported that chronic amphetamine (speed) abusers did not experience the expected high when on lithium and were able to cease using amphetamines no longer feeling the need.

Professor Arnold Mandell, chairman of the department of psychiatry, University of California, San Diego, has demonstrated a possible explanation of the above findings, postulating an effect of lithium on a specific biochemical pathway in the brain.

6. A special strain of animals who, given a free choice between an alcohol solution and a sucrose solution always chose the alcohol. When tested with lithium they changed this preference, that is, those animals given lithium changed their preference from alcohol to sucrose.

7. Recent work at the Rockland Research Institute, in collaboration with Professor Bernard Wagner of Columbia University, has shown lithium to have a direct effect on a specific area of the brain (choroid plexus). This area controls (by retention or excretion) the levels of various compounds in the brain. It is important to note that lithium increases the water content of this area whereas alcohol depletes the water content. Thus we have a preliminary finding that may explain the action of lithium in the chronic alcoholic, that is, lithium prevents or reverses the depletion of water caused by alcohol and in this way through a mechanism not yet determined, decreases the need (compulsion) for excessing alcohol intake.

8. The data accumulated during the past 4 years has reached a level of acceptance by the scientific community such that a special conference is to be held in Helsinki, Finland, at the same time as the Sixth International Congress on Pharmacology.

THOMAS B. COOPER, CURRICULUM VITAE

PERSONAL HISTORY

Born March 22, 1935, South Shields, England. Married.

SCHOLASTIC TRAINING

1955—Intermediate examination of the Institute of Medical Laboratory and Technology covering the fields of biochemistry, hematology, bacteriology and histology.

1957—Associateship examination of the above Institute specializing in biochemistry.
1959—Fellowship examination of the above Institute, specializing in hematology and blood transfusion.
1970—M.A. Science. Chemistry major. Summa cum laude. Fairleigh Dickinson University, New Jersey.

POSITIONS

1958–1960—Senior Technician in charge of Biochemistry Department, General Hospital, South Shields, England.
1960–1961—Assistant Research Scientist, Rockland State Hospital, Orangeburg, New York, in charge of Clinical Chemistry Laboratory.
1961–1964—Research Scientist, Rockland State Hospital, Orangeburg, New York, in charge of Thyroid Department chemical analysis and Clinical Chemistry Laboratory.
1964–1965—Acting Chief Investigator, Senior Research Biochemist, Thyroid Department, Rockland State Hospital, Orangeburg, New York.
1966– to date—Chief Investigator, Associate Research Biochemist, in charge of Thyroid Department, Rockland State Hospital. Orangeburg, New York.

SOCIETIES

International Society of Psychoneuroendocrinology, New York Academy of of Sciences.

PUBLICATIONS

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Dr. KLINE. At the Lasker Luncheon Award last year Mr. Flood was the main speaker, and he invited favorable comment on supportive research, and I felt that it was only fair to return and come down to his committee.

Modestly, I have been the only person who has twice received the Lasker Award for medical research, and as I have sat here this afternoon and listened to the problems detailed from an overall point of view, I thought it might be interesting for you to listen to the story from someone who is out on the firing line and is doing the actual research.

The two previous contributions in this area which I have been able to make which have culminated in the Lasker Awards were one pioneering in the use of drugs for treatments of patients in mental hospitals. Those drugs were introduced in 1954 and 1955.

Since that time the mental hospital population of the United States has been more than cut in half, and the drugs that were introduced at that time played a very vital role in this tremendous reduction of hospital population.

The second contribution was in the form of drugs for the treatment of depression, which is among the most prevalent of all medical disorders, and certainly psychological disorders. These drugs, and in the citation for the Lasker Award it pointed out that there are literally hundreds of thousands of people who are functioning today who would not be, were it not for the introduction of these drugs, and this was something that we very clearly pioneered before anyone else.

At the present time we believe we have a third contribution to the field, and I bring this up and come down with a sense of urgency, because the research was funded by a grant of $25,000 from the NIAAA. It was this that enabled us to get started in the work.

It appears that we may have very fortunately, as most researchers are, found something that is of extreme importance in the management of alcoholism. The great advantage of this particular medication is that it has interestingly been around for a long time, and we know it to be quite safe if properly given.

A second advantage is that it appears from the research which has been carried out that it is possible for the individuals to continue drinking, but instead of drinking compulsively, which is the big trouble with alcoholism, these individuals are then able, in a very substantial number of cases, to drink as the ordinary person would, that is enough to enjoy themselves but not such that they would end up having to be detoxified.

The problem that we will face is the same, at our local level, that the grant support will shortly run out. The National Institute of Alcoholism and Alcohol Abuse, the grants this year run around $11 million. In the President's budget they are down to $9 million, which would mean that when we go in, as we hope to, to expand the work, that there is not going to be any money for us to continue what we consider to be very crucial and very important work.

Dr. Mandell who had hoped to be here, from Mr. Roybal's State of California, was one of those who applied last year for a grant to confirm our original findings. His was one of the 55 projects which was approved but unfunded because of lack of support.

In view of the tremendous importance, both economically as well as in terms of human welfare, a contribution that would enable people to drink without the problems that 9 million of our fellow citizens have, I would very warmly urge that all possible support be given to not only the NIAAA, but to the Adama of NIMH budgets for medical research. In the end it is this sort of thing that more than pays for itself.

I thought it would be important for you to know that when figures are quoted, I am sure you are aware of it in the abstract, but we have what we consider a first-rate project going. We are in the process of attempting to expand it to determine whether it is really true that, based on the first two papers that we published, that people would be able to use alcohol, even those who at the present time cannot safely use it, and here is a specific example of an important piece of work which will be cutoff, unless the budgets are increased to allow not only the continuance of what has already been committed, but moving into an area in which more important work can be done.

Thank you.

Mr. NATCHER. Doctor, we want to thank you for your appearance before our committee at this time.

The committee will adjourn until 10 o'clock in the morning.

FRIDAY, MAY 16, 1975.

NATIONAL INSTITUTE ON AGING

WITNESS

DR. DENHAM HARMON, EXECUTIVE DIRECTOR, AMERICAN AGING ASSOCIATION

Mr. NATCHER. The committee will come to order.

Our first witness this morning is Dr. Denham Harmon, executive director of the American Aging Association.

You may proceed.

Dr. HARMON. Mr. Chairman and Gentlemen: My name is Denham Harmon. I am executive director of the American Aging Association (AGE), Millard professor of medicine and professor of biochemistry at the University of Nebraska College of Medicine and chief of the Nebraska geriatric service at the Douglas County Hospital in Omaha, Nebr.

I appreciate having the opportunity to speak in support of the newly formed National Institute on Aging.

The new Institute has a broad mandate, for the conduct and support of biomedical, social, and behavioral research and training related to the aging process and the diseases and other special problems and needs of the aged." In essence, the Institute has been mandated to find practical means of coping with the aging process and to improve the quality of life for older members of our society. These problems are not of equal weight.

Everyone should be concerned with the troubles of older people for most will join their ranks in due time. Fortunately relatively few will experience to a significant degree the problems associated with age. The concerns of older persons are largely rooted in the interrelated problems of the maintenance of self-esteem, health, and income. A great deal is known about these problems but there is little doubt that we can still increase our knowledge of how best to cope with them.

Life expectancy at birth is a rough measure of the average span of vigorous life. Life expectancy, 45 years in the United States in 1900, gradually rose to a value of 70 years in 1954–55, but has not increased since. Thus, in 1954–55, aging emerged as a major health problem. Aging is still not recognized for what it is, the major determinate today, and in the future, of our healthy life span.

We continue to be concerned mainly with the elimination of the obvious causes of death paying little attention to the consequences. About 70 percent of deaths are now due to cancer (17 percent) and

cardiovascular disease (52 percent)—most deaths from these two disorders occur in the older age groups, while the remaining 31 percent are the result of a wide variety of causes. Mortality rates for the various causes of death in the elderly increase rapidly with advancing age. Thus, decreasing deaths from cancer and cardiovascular disease in the older members of society will simply permit the average person to live slightly longer to die of some new "leading cause of death"; most likely a disorder of the central nervous system, with a marked increase in the incidence of chronic brain syndrome, a disorder that is even now a major health problem.

It is very apparent that future significant increases in the average healthy life span will be achieved only by modifying the aging process. Prospects for doing this are excellent. However, the time when practical means of enhancing the years of vigorous human life will become available depends largely on research support. The Administration's 1976 budget request for the National Institute on Aging is small, $16,190,000, categorized below along with the fiscal 1975 budget for comparison purposes:

BUDGET FOR AGING RESEARCH

	Fiscal year 1975	Fiscal year 1976 [1]
Research grants	$6,386,000	$8,035,000
Training	1,892,000	1,762,000
Intramural research	3,784,000	4,741,000
Contracts	800,000	702,000
Research, management and program services	1,560,000	950,000
	14,422,000	16,190,000

[1] President's budget.

Judging from the proposed budget and that for fiscal 1975 it is apparently the intent of the administration that next year's program be very similar to that of the past. With the formation of the National Institute on Aging it was hoped that the administration would take a more aggressive approach to the aging problem, particularly to the very important area of biomedical aging research. As a first step toward a more realistic aging program for the National Institute on Aging it is suggested that $70.26 million be added to the President's budget and apportioned as follows:

	Million
1. Creation of a new department in each medical school (114) to be devoted to teaching, training, and research in geriatrics and related areas	$13.80
2. Biomedical gerontology research centers (10)	31.46
3. Increase funding for the research grant category	25.00
Total	70.26

$25 million of the total of $70.26 million suggested addition to the President's budget is a onetime expense for the construction and equipment of the 10 research centers.

With the foregoing additions, the suggested budget for the National Institute on Aging for fiscal year 1976 is $86.45 million.

In summary, the newly formed National Institute on Aging has been mandated to study the aging process, now a major health problem, and to improve the quality of life of older persons. The proposed

budget for 1976 is woefully small, particularly in view of the potential contribution of biomedical aging research to our health and well-being. As a step toward a realistic aging program for the new institute we urge that the proposed budget for fiscal year 1976 be increased by $70.26 million so that the total budget of the National Institute on Aging would be $86.45 million, apportioned as follows:

Suggested budget for the National Institute on Aging for fiscal year 1976

Research grants	$33,035,000
Training	1,762,000
Intramural research	4,741,000
Contracts	702,000
Departments of geriatrics (114)	13,800,000
Biomedical gerontology research centers (10)	31,460,000
Research, management, and program services	950,000
Total	86,459,000

Thank you very much.

I will be glad to answer questions on the testimony.

Mr. NATCHER. Dr. Harmon, we want to thank you for appearing before our committee at this time. A great many of you people travel long distances to come here and we appreciate your testimony. Thank you very much, Doctor.

VOCATIONAL REHABILITATION ACT

WITNESSES

MRS. EVELYNE VILLINES, EXECUTIVE SECRETARY, IOWA GOVERNOR'S COMMITTEE ON EMPLOYMENT OF HANDICAPPED
FRED R. TAMMEN, LEGISLATIVE ANALYST, NATIONAL REHABILITATION ASSOCIATION

Mr. NATCHER. Next is Mrs. Villines. We are glad to have you appear before the committee at this time. You are the executive secretary of the Iowa Governor's Committee on Employment of Handicapped. We will be pleased to hear from you.

Mrs. VILLINES. Thank you.

I have a written statement I would like to give.

I would like to introduce Mr. Fred Tammen, legislative analyst for the National Rehabilitation Association.

Mr. NATCHER. We are glad to have you with us.

Mrs. VILLINES. Mr. Chairman, I am Evelyne Villines representing the National Rehabilitation Association in appearing before this subcommittee in support of appropriations under the Vocational Rehabilitation Act. The National Rehabilitation Association has appeared before this subcommittee many times and very much appreciates the opportunity to appear again today.

The National Rehabilitation Association is an organization of over 35,000 members representing both handicapped people and the programs that serve them. The association has had 50 years of experience in working with rehabilitation programs and handicapped people and considers itself to be in a prime position to speak with much authority.

Before discussing appropriations for various items under the Rehabilitation Act we would like to take this opportunity to commend

the subcommittee on their previous action in not supporting the President's proposed rescissions of $29.8 million for various programs under the Rehabilitation Act [R75–78] which means that at a minimum 20,000 handicapped individuals will receive the rehabilitation services that could not have otherwise been provided. We are deeply concerned about the administration's continued lack of interest in funding the innovation and expansion grant program. I will further discuss this issue later in my presentation.

Basic formula grants to the States

	Millions
Appropriation authority	$720
Administration recommendations	680
NRA recommendation	720

This is the direct service program provided to handicapped youth and adults through the State-Federal vocational rehabilitation program. As noted above, appropriation authority is $720 million. The administration has requested a funding level of $680 million which is the amount that was appropriated in fiscal year 1975. The administration has indicated that this is a hold-the-line budget request however, obviously it does not even consider the basic increases in the cost of providing services.

The 1973 legislation emphasizes the rehabilitation of severely disabled individuals. The current estimates prepared by the Rehabilitation Services Administration indicates that just over 30 percent of all individuals rehabilitated are categorized as having severe disabilities. Target estimates indicate that within 5 years 50 percent of the handicapped individuals rehabilitated will be considered to have had severe disabilities. The National Rehabilitation Association wholeheartedly supports this emphasis on the rehabilitation of severely disabled individuals, however, at the same time it must be realized that the mere definition of a severely handicapped individual, being one that requires multiple services over an extended period of time, would in itself imply expanded services and increased costs. These additional costs must be supported through increased appropriations if the program is to carry out its mission. Therefore, the National Rehabilitation Association recommends appropriation of the full legislative authority of $720 million for fiscal year 1976.

Innovation and expansion grants

	Millions
Appropriation authority	$42
Administration recommendation	0
NRA recommendation	30

The administration obviously indicates that it would like to phase out the innovation and expansion grant program. These grants carry 90 percent Federal share and have been most useful in the past to stimulate expansion of programs to groups of handicapped individuals not adequately served in the basic program. Funds are allocated to States on a population basis. Projects developed under this program may be administered by either State agencies or voluntary agencies with State approval. A large part of expansion grant programs have been carried out throughout the voluntary agencies.

During the last 2 or 3 years, practically all appropriations under this section have been used to support projects designed to increase

the numbers of public assistance recipients being rehabilitated and for projects to serve the severely handicapped population. There is an attempt on the part of the administration to make one think that both of these target groups can now be rehabilitated under the basic State grant formula program. However, the purpose and intent of the expansion grant program remains more valid then ever and its need even more necessary.

The intent of these projects is to pay a portion of the cost of planning, preparing for, and initiating special programs. This includes programs to initiate or expand services to individuals with servere disabilities, or special programs, or services to classes of handicapped individuals who have unusual and difficult problems in connection with their rehabilitation and may not normally be accepted under the title I program. The innovation and expansion grant program is designed to be the leading edge in giving direction to future services and programs to handicapped individuals.

The continuation of the innovation and expansion grant program is vital if we are to have a means by which we may test varying methods and services to an expanding population of severely handicapped people. The NRA strongly supports funding of the innovation and expansion grant program to a level of at least $30 million. This represents an increase of $7 million over last year's appropriation and $12 million less than the appropriating authority.

Training

Appropriation authority	$32,000,000
Administration request	22,200,000
NRA recommendaiton	25,372,000

The administration seemed determined to phase out entirely Federal support of training rehabilitation workers 2 years ago. There seems to be a reversal from this firm position; however, the Rehabilitation Services Administration admits that this year $6,682,000 appropriated will be available to be carried over into fiscal year 1976. Again, the congressional intent of appropriating money for training purposes seems to elude the administration. A recent survey conducted by rehabilitation counselor educators indicates that for the 1974–75 academic year the programs surveyed had received 6,063 applications, of which only 2,810 were accepted for training programs. The major reason for such a small percentage being accepted into the training programs was lack of financial support. The survey further indicated that both faculty and clerical staff was needed just to meet current needs of the program.

As previously indicated, the primary purpose for the training funds appropriated under this section is to provide Federal support of training of professional personnel to work with handicapped individuals. Trained, qualified personnel is crucial to the rehabilitation movement as it is to any other program. The NRA urges this subcommittee to appropriate $25,372,000 for training for fiscal year 1976. This amount along with the $6,628,000 that RSA has indicated is available to carry over into fiscal year 1976 would provide an amount equal to that which is authorized in law. We further ask that this committee restate its position of last year; that funds appropriated for this program be obligated and spent during the fiscal year for which they were appropriated.

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The rehabilitation training program presents a unique problem for the 3-month interim period that provides for a new fiscal year. This 3-month period falls at a time when schools are opening and a majority of the total funds for rehabilitation training are obligated. Therefore, in view of this fact, we urge Congress to appropriate the full amount authorized by law, for training funds during this 3-month interim period. This, in turn, will provide Congress an excellent opportunity to move toward advance funding of the training program as provided for by law.

Rehabilitation facilities and projects

	NRA requests (millions)
Facility construction (sec. 301(b))	$40
Training services (sec. 302(b))	8
Facility improvement grants (sec. 302(c))	10
Technical assistance (sec. 304(e))	1
Initial staffing (sec. 301(c))	10
Projects with industry (sec. 304(a))	2
Mortgage insurance (sec. 303)	1

The administration seems determined to phase out rehabilitation facility construction, staffing and various projects. This is being done regardless of the fact that recently passed legislation continues to contain authority for these programs. The need for expanded and improved rehabilitation facilities is recognized as being greater than ever. If State rehabilitation agencies are to respond to the mandate of Congress that more and more severely handicapped individuals are to be served, then the need for expanded, well staffed, equipped, and adequately funded facilities are a must. I am submitting for the record a copy of a survey conducted by the International Association of Rehabilitation Facilities revealing a dire need for Congress to fully fund these programs.

I would also like to call to your attention a provision of the 1973 legislation establishing a program of mortgage insurance. It is of concern to the NRA that no appropriations have been recommended for this program. It is our understanding that HEW plans to delegate responsibility for this program to HUD, however, we have seen no document to this effect. In any event, we assume that any appropriations for this program would have to be made under the Vocational Rehabilitation Act. We have previously suggested, and are again suggesting, that $2 million would be sufficient to get this program started.

RESEARCH

Nearly 5 years ago appropriations for research were approximately $30 million. This amount has been steadily reduced to the point where the administration is again asking for an appropriation of only $20 million, an amount equal to that which was appropriated for the last 3 years.

This low amount is being requested despite the fact that the legislation calls for special research in the area of spinal cord injury, international research and bioengineering. Approximately one-half of the amount appropriated for this program will be used to support 19 research and training centers. This leaves little for any additional new research projects if the appropriation level remains at

the $20 million level. The NRA requests that $30 million be appropriated for research. This amount is less than authorized in law but will provide for minimal program growth.

ARCHITECTURAL AND TRANSPORTATION BARRIERS COMPLIANCE BOARD

It is the recommendation of the National Rehabilitation Association that the Architectural and Transportation Barriers Compliance Board be funded to the full extent authorized by law [$1.5 million]. The Board was established through Public Law 93-112, was given additional responsibility with the passage of the 1974 amendments to the Rehabilitation Act and has begun to function.

The Board has the tremendous responsibility of achieving elimination of environmental barriers to handicapped individuals. The dignity and independence of severely handicapped people will become a reality when they can function in a barrier-free environment. The Board can be a positive force in achieving this goal. The authorizing committee felt that: "to aid the Board in becoming a force for change considerably larger appropriations will be required than the $300,000 appropriated. * * * Furthermore, the committee felt that an appropriation of $1.5 million for fiscal year 1976 for the operation of the Board was more realistic. The NRA concurs with this statement and feels that the Board should be given every encouragement so that it may function to the maximum degree possible.

SUMMARY

We believe the requests as indicated in this statement to be realistic and in line with programmatic needs and desirable growth. We are appreciattive of this committee's efforts in the past, however, as we have indicated elsewhere in this statement, we believe that Congress must take the initiative, if the supporting programs to vocational rehabilitation direct services are not to be phased out or reduced to an ineffective level.

We thank the subcommittee for the opportunity to appear and testify. I would welcome any questions.

Mr. NATCHER. Mrs. Villines, we want to thank you for your appearance and also Mr. Tammen, we appreciate your appearing at this time.

Thank you very much.

NATIONAL CANCER INSTITUTE

WITNESS

DR. GEORGE ROSEMOND, AMERICAN CANCER SOCIETY

Mr. NATCHER. Our next witness is Dr. George Rosemond. You represent the American Cancer Society and we are glad to have you appear at this time.

Dr. ROSEMOND. Thank you, sir. I am pleased to be here.

Mr. Chairman, I am Dr. George P. Rosemond, president of the American Cancer Society. I am a clinician—I am professor of surgery at Temple University Health Sciences Center, in Philadelphia, and

have devoted my professional career to the treatment of cancer patients.

It is a pleasure and an honor for me to present the position of the American Cancer Society regarding the fiscal 1976 budget of the National Cancer Institute. I have submitted a detailed statement of the American Cancer Society for the record.

Mr. Chairman, I would like to read a resolution, approved by the Society's board of directors at its January 1975 meeting:

Resolved, That the American Cancer Society recommend the appropriation of $898.5 million on a 12-month basis for the National Cancer Institute for fiscal year 1976. This includes $830 million for general programs, and $88.5 million for cancer control programs.

The resolution further recognized that fiscal year 1976 would have 15 months and recommended an additional 25 percent, or $1,123, million.

Mr. Chairman, we firmly believe this amount is justified and necessary, and represents a minimum requirement to keep this unique program moving forward with the momentum it has achieved in the past 2 years.

Also, I want to express the confidence and support of the American Cancer Society in the leadership of the National Cancer program. We have the fullest confidence in Dr. Rauscher, the director, and support him completely. He has managed to make the most exciting governmental experiment ever attempted in medical research and disease control into a dynamic and productive venture for the American people.

Mr. Chairman, when the Congress approved the National Cancer Act, and this subcommittee initiated the funding of this great program, we pledged to you the full support and involvement of all resources of America's private sector of the fight against cancer, represented by the American Cancer Society. We have met our commitment during the past 4 years, and I am happy to renew that pledge to you, today.

Commitment of all of our resources represents the active, involved support of nearly 2½ million ACS volunteers, including some 50,000 doctors, in 58 divisions, and more than 2,700 county units throughout the country.

Last year this group raised nearly $100 million from private sources for ACS programs locally, and nationally. These programs complement—and in many cases, blend in with—the National Cancer program. If a dollar figure were placed on the value of time, effort, staff manpower, equipment, and facilities, of the ACS, we believe that the total would surpass the amount we are asking of you today.

In any event, through the unique, productive partnership of the public sector, represented by the National Cancer Institute, and the private sector, represented by the American Cancer Society, the American people are receiving far more than dollar-for-dollar from your investment in this fight against cancer. This is surely one of the best "matching" programs the country has.

This subcommittee has been a bulwark of support for the National Cancer program, and we are grateful to you. We believe more could, and can be done, but we recognize your many responsibilities. Our

job is to convince you to appropriate $898.5 million for the NCI for fiscal year 1976, and we will work very hard to do this.

This subcommittee has provided vital leadership in the cancer fight. Already the forward-looking actions you have taken have had great impact on the health and lives of your fellow countrymen. The support you have given to the cancer plan has already begun to save lives from some of our deadliest cancers: breast, bladder—and soon—lung cancer. It has resulted in the discovery of what is probably the first human cancer virus with enormous implications for diagnosis and treatment of leukemias, lymphomas and sarcomas. It has established 14 new comprehensive cancer centers—the very core of cancer progress—there are now 17 where there there were only 3 before the plan was implemented by the support of this subcommittee.

It has established a computerized data base to help all doctors everywhere treat cancers and do research in both laboratory and clinic.

You have set in motion a vast national program, yet one that is personal for every cancer patient, and every potential cancer patient in the country.

We sincerely and honestly believe that a 12-month, 1976 fiscal year budget of $898.5 million is necessary to maintain the dynamic, productive momentum that the cancer program has achieved.

NCI research grants will total $276 million in fiscal 1975. The citizens' budget for fiscal 1976 calls for $363 million for research grants. The manpower is there; the programs are there; the work can be done.

At the citizens' budget level 70 percent of the approved research grants would be funded and nearly a third unfunded. But at the President's budget level only 9 percent of the approved research grants could be funded. Actually, the OMB stated it differently: they stated the approval of funded would be 32 percent. But they achieved that higher percentage by proposing termination of $24 million in noncompeting grants. That termination would be legal, but would violate all historical NIH policy. It would be a terrible waste of $24 million in half-completed projects.

If the fiscal 1976 budget were implemented OMB's way, there would be 10 new research grants awarded in fiscal 1976 as compared to 542 in fiscal 1975. The rest of the 9 percent specified above would be 114 competing renewals.

If all noncompeting research grants and contracts were continued, as the historical policy dictates in fiscal 1976 and, in addition, if the level of new research grants were held at the 1975 level, then the budget needs of NCI for fiscal 1976 would be $785 million instead of what the President asked, $605 million. This $785 million is a no-growth budget. The new grants this year would match last year. Inflation, of course, would really make it a fall-behind budget.

Therefore, the citizens' budget is a modest growth proposal. It is less than the panel of consultants or National Cancer Plan advisers suggested. It is far below the level of other national priority programs this country has mounted in recent years.

Thank you very much.

Will you please give my personal regards—I am from Pennsylvania—to the chairman who is away on business today, Mr. Flood.

[The statement follows:]

STATEMENT OF GEORGE P. ROSEMOND, M.D., PRESIDENT, AMERICAN CANCER SOCIETY

Mr. Chairman, I am Dr. George P. Rosemond, president of the American Cancer Society. I live in Malvern, Pa., just outside of Philadelphia, and am professor of surgery at the Temple University Health Sciences Center in Philadelphia.

I am a past president of the Philadelphia County Medical Society and the Pennsylvania Medical Society, and the Philadelphia Academy of Surgery. I also serve as a member of the National Cancer Institute's Cancer Control Advisory Committee, and for 14 years served as a member of the cancer commission of the American College of Surgeons. I have served as a volunteer of the American Cancer Society for more than 25 years, and feel that I am qualified both professionally, and organizationally to represent the position of this society on the fiscal 1976 budget of the National Cancer Institute.

The American Cancer Society works closely and cooperatively with the National Cancer Institute. I believe that our two organizations share a unique partnership in our American system in a synergistic expression of cooperative endeavor, a coalescing of private and public sector resources in the common interest of the cancer patient and the potential cancer patient.

We are now in year 4 of the national cancer effort—year 3 of actual functioning. Already the initial investment in this program is realizing solid, productive returns. I expect to cite some examples of these programs further in this statement.

I am here to represent the position of the board of directors of the American Cancer Society on the NCI budget for fiscal year 1976. Here is the text of a resolution approved by the board at its annual meeting in New York City, January 31, 1975:

"*Resolved*, That the American Cancer Society recommend the appropriation of $898.5 million on a 12-month basis for the National Cancer Institute for fiscal year 1976. This includes $830 million for general programs, and $68.5 million for cancer control programs. In 1976 the Federal fiscal year is scheduled to change from a July-1-to-June-30 year, to an October-1-to-September-30 year. If this change takes place, making 1976 a 15-month fiscal year, the society recommends the addition of 25 percent to the recommended 12-month budget, for a total of $1,123,125,000 for the National Cancer Institute."

Mr. Chairman, we firmly believe this amount is justified and necessary, and represents a minimum requirement to keep this unique program moving forward with the momentum it has achieved in the past 2 years.

Also, I want to express the support of the American Cancer Society in the leadership of the national cancer program. We have the fullest confidence in Dr. Rauscher, the director, and support him completely. He has managed to make the most exciting governmental experiment ever attempted in medical research and disease control into a dynamic and productive venture for the American people.

The resources of the American Cancer Society are fully committed to the success of the national cancer program. This represents the enthusiastic efforts of more than 2 million active volunteers. If a dollar figure were placed on the value of the time and effort of these volunteers, together with the society's professional staff efforts and other resources, we believe the total would surpass the amount we are asking of you today. In any event, the American people are receiving far more than dollar for dollar from your investment in the fight against cancer.

This subcommitte has been a bulwark of support for the national cancer program, and we are grateful to you. We believe more could, and can be done, but we recognize your many responsibilities. Our job is to convince you to appropriate $898.5 million for the NCI for fiscal year 1976, and we will work very hard to do this.

This subcommittee has provided vital leadership in the cancer fight. Already the forward-looking actions taken have had great impact on the health and lives of your fellow countrymen. The support given to the cancer plan has already begun to save lives from some of our deadliest cancers—breast, bladder, and soon, lung cancer. It has resulted in the discovery of what is probably the first human cancer virus—with enormous implications for diagnosis and treatment of leukemias, lymphomas, and sarcomas. It has established 14 new comprehensive cancer centers—the very core of cancer progress—there are now 17 where there were only 3 before the plan was implemented with the support of this subcommittee. It has established a computerized data base to help all doctors everywhere treat cancers and do research in both laboratory and clinic.

You have set in motion a program so vast, and yet so intensely personal for every cancer patient in this country, I can only begin to summarize some of the achievements:

THE CONQUEST OF CANCER PROGRAM HAS SAVED THOUSANDS OF LIVES ALREADY

If it weren't for this subcommittee there would be women with breast cancer today, or women dead, who are in fact living and free of cancer. You have spared these women.

Through a series of jointly sponsored conferences the American Cancer Society and National Cancer Institute have instructed thousands of doctors on the new results and, of course, articles carrying the news have been put into magazines that practically all doctors get.

Breast cancer is the outstanding example, but there are others; and they are important.

For the record it should be stated that the many informal reports on these advances given to Members of Congress in their offices and in our formal testimony are even more positive now than when we first delivered them a year ago. The statistical significance ratios on disease-free patients under study have improved beyond the early results. This was true as recently as last Saturday when we checked with the lead scientist on the breast cancer treatment study, Dr. Bernard Fisher.

Let me repeat to you the exact figures on the recently demonstrated superiority of treatment with the chemical, L-Pam, of women with breast cancer. In 1 out of 30 patients so treated in the first group studied there was a recurrence of cancer within 2½ years after surgery. By comparison, in 11 out of 37 patients there was a recurrence of cancer after treatment by surgery only, and we have some reason to believe combination therapy-using several drugs will prove to be superior to L-Pam used alone.

The standard practice before this study was limited to surgery. Drugs were not involved. Chemotherapists were called in only if there were a return of the disease.

Scientists refuse at this early date—the National Cancer program is only 3 years old—to predict long-term survival rates on the basis of these studies. But there are 89,000 new cases of breast cancer per year. At the old rate, after surgery (11 out of 37 is 29.7 percent) some 26,400 of those women would suffer return of the cancer after 2½ years. At the new rate achieved in this study it appears as though only 2,960 women will suffer a recurrence after 2½ years (1 out of 30). That means over 23,400 women per year can be saved from this rapid return of the disease.

Dr. Fisher's study is approximately 3 years old. It certainly seems highly likely—and we want this record to show—that the Congress appropriations actions are at least extending and possibly saving thousands of lives.

Before money was supplied for Dr. Fisher's 1,680-person study headquartered at the University of Pittsburgh, but involving a cooperative group of investigators from many institutions, a National Institutes of Health clinical research project of this proportion was very rare. In three 1972 and 1973 issues of the National Cancer Institute's Chemotherapy Reports chosen at random the average number of patients in a clinical study was 57. The largest number was 443.

We have all heard comments that you cannot cure mysterious diseases by throwing dollars at the problem. The taxpayers' dollars have been well-spent in this breast cancer work. The drug in this study was not new. Only the way it was used, and the concentrated cooperative evaluation of it was new.

This successful study was based on many years of basic and applied research. Decades ago effective action against cancer in laboratory animals was demonstrated with several drugs. As more was learned of their pharmacology, how they act in the blood stream, in normal and abnormal tissue, it became safe to try the drugs in humans for whom no other therapy had been satisfactory.

Some drugs proved effective and years were occupied with many small trials and small, yet important, advances.

Patterns began to emerge. The search for "the" drug continued while clinicians found they could protect the patient longer if several drugs, each with a different chemical mode of action, were used in combination. Many early studies of single drugs had to be followed with combinations and the percentages recalculated, the survival rates redetermined.

Another large advance came when a new theory of drug administration was conceived. Basic research indicated that the intervals at which drugs were administered should be timed to hit cancer cells when they were most vulnerable. The man who discovered this is now on the National Cancer Advisory Board.

Practically all the old, familiar drugs again required re-study. For earlier results could have been negative because the drugs reached cancer cells during moments of dormancy. The cells needed to be reached while they were in the process of reproduction for the chemicals to be most effective.

The new theory of cell kinetics proved highly beneficial and, again, patient surival and tumor reduction statistics improved.

Medical practitioners were faced with hundreds of small, frequently successful studies. But there was no one course of therapy shown to be so superior as to demand widespread use.

A study large enough to produce very strong, convincing, statistical proof was needed. Money for the very big cooperative program headed by Dr. Fisher was provided by the conquest of cancer program.

Different branches of the study focused on various therapeutic approaches: Radical surgery, limited surgery, several drugs singly and in combination, surgery combined with drugs, radiotherapy in combination with other modes, etc.

It was finally realized through the statistical results that low doses of drugs given as preventive medicine soon after surgery could produce outstanding advances in months of disease-free life.

Scientists now believe that if a bulky tumor can be removed, taking with it most of the cancer cells in the body, then chemicals will demonstrate very high efficacy in attacking those cells which almost always remain behind.

Assuming that efficacy would be high, the Fisher team tried such small doses of drugs that they eliminated the bad side effects patients had suffered under standard treatment. In standard treatment the aim of clinicians was to give the patient the largest doses he could stand in order to maximize the damage to cancer cells.

This maximal treatment usually caused loss of hair, swelling of limbs and joints, extreme nausea and pain.

The new, low-dose preventive medicine regimen produces little side effect and, in some cases, none at all. Patient do not go bald. They are ambulatory. The drugs are taken by mouth, eliminating the hypodermic needle.

As for survival, all of the women in the study will be followed the rest of their lives. By 1977 we shall have 5-year survival rates.

As you have read in the newspapers, other arms of this study present statistical proof that in many cases limited surgery is as effective, with the use of drugs, as deeper, more extensive surgery. This means less disfigurement for women in the future, certainly a much-wanted result from science.

When the cancer institute found such favorable results with new ways of using one of the earliest chemotherapy agents and put under close scrutiny in breast cancer, the question naturally turned to old drugs in other forms of cancer.

In the delivery of a scientific paper scheduled for this week in Miami, a splendid advance in results in treatment of bladder cancer will be announced by Caude Merrin, M.D., and four other doctors including Gerald P. Murphy, M.D., the director of Roswell Park Memorial Institute where the bladder work was performed. This institute gets a fraction of its support from congressional appropriations.

Traditionally bladder cancer has been treated with surgery and/or radiotherapy, successful when the disease is localized in the bladder or pelvic area, but a failure when the disease has spread further. The patients in Dr. Merrin's care averaged about 70 years old and, of the 49 studied, 21 had cancer which had spread beyond the bladder.

Roswell Park scientists found that only three drugs for bladder cancer had been studied earlier to a significant degree despite the fact that there are at least a dozen possible drugs known to be effective against similar cancers. Here, again, the taxpayer's money is being put to work to add that last scientific effort which is needed to pull out of the academic journals the aid that patients really need.

Dr. Merrin is telling his colleagues that, since the drugs Cytoxan and Adriamycin were able to achieve complete clinical remission of the disease in 27.8 percent of the patients, including some with cancer metasticized beyond the bladder, that drug use in the future along with very limited surgery, might enable doctors

to avoid full removal of the bladder and all the trouble that operation causes the patient the rest of his life.

In this research over a 14-month period, with patients averaging 10 months on chemotherapy at the time data were recorded, only 11 percent of them showed any decline in health at all. Generally, upwards of 20 percent, or almost twice as many, would have died under ordinary treatment. The 20 percent is the national average for first-year deaths from bladder cancer. Several patients entered the study with disease advanced beyond the bladder. Yet none has died.

Some 9,400 persons per year die of this disease. It is too early to tell from this study whether the 1-year death rate will be cut in half. But, obviously, the research already points to a saving of at least 940 lives if only a 10 percent improvement is sustained.

Dr. Merrin, in reporting to the American Urological Association this week is saying, "Our series is indeed, by some standards, small and our followup, at present, limited in time. However, we feel these findings justify further studies with a large number of patients by other investigators or cooperative groups."

This is where the money goes in cancer research, among other places. It identifies patients statistically suited for studies that compare one treatment with another, establishes close collaboration between doctors so that variations in procedures don't upset the validity of the data, makes sure that data are complete when reports are drawn up and, of course, supports the expensive process of staying in touch with patients who return to normal life with the usual amount of moving to new residences, women changing names upon marriage, and all the other factors that make followup difficult.

Statistical chapter and verse could be cited to prove parallel advances in cancer of the prostate, which were reported at an American Cancer Society meeting for doctors in New York in November.

And for the first time, large studies in cancer of the bowel are zeroing in on which of the 50 drugs effective against cancer are particularly useful in colon and bowel malignancies.

One of the most exciting developments of this year's research came in the attack on bone cancer, osteogenic sarcoma.

Here again the widespread idea that cancer cannot be cured until we fully understand each facet of the disease has been proven to be a myth.

No one knows why bone cancer occurs. But the survival rate, even when cases are caught in time and the cancer lies where treatment is highly effective, has been only about 20 percent.

Dr. Normal Jaffe at the Sidney Farber Cancer Center in Boston has just finished data collection on 3 years of studying patients with this disease. The statistics indicate that the survival rate for patients given combination drug treatment will run approximately 70 percent, a truly remarkable gain.

One patient has remained free of tumor for 4 years. This was not just an accident occurring in one clinic. The promising results come from five different centers cooperating in the research.

The results have been so good that experiments are being shaped so that the arm and leg amputations which so often have been necessary with this kind of cancer might be totally avoided in the future.

People with osteogenic sarcoma, very often die from the secondary effect of cancer spreading to the lungs rather than from the original bone cancer, itself.

The big problem with lung cancer is that, by the time it shows up on an X-ray it is far too late to treat it effectively, with the result that only about 8 percent survive 5 years. And that is a very bad percentage when there are an estimated 91,000 new cases per year.

But now two new approaches to diagnosis are bringing lung cancer closer and closer to the point where a chemical attack on it can commence. The prospect is for advances being made like those against breast, testicular, bladder and colon cancer.

Improvement is underway in cancer detection tests of sputum, or fluid from the lungs. When this test is fully prepared for field use the possibility arises for quick, inexpensive, and close monitoring to find lung disease in patients with osteogenic sarcoma.

At the same time, the sputum test could be used the way Pap tests are now used. That is, screening can pay off when directed to high-risk populations even though it might be far too expensive to screen the entire population.

The sputum test, for instance, might be applied to heavy smokers with the probability that each case found would, on the average, cost relatively little

screening money. Once the sputum shows cancer, new fiber optic instruments can be used to find the exact location of the lesion in the lung. In Baltimore teams of doctors are being trained to use new fiber optic instruments to locate the lesions. They are able to find them, take a biopsy, and begin treatment 2 years in advance of when an X-ray would even show the disease's presence.

With this combination of targeted screening and positive identification of small, operable lesions, lives could be saved and the cost of treating early disease would be far lower than the cost of treating advanced disease.

The feasibility of targeting the screening is demonstrated by data from a long-term study of middle-aged men who smoke heavily—1 in 100 of them has cellular evidence of cancer in these relatively inexpensive sputum tests.

The surgery to remove a small lung lesion is a far better therapy than the traditional removal of the entire lobe of a lung that is necessary at the point when cancer of the lung is usually discovered today.

There cannot be any question that the tragically numerous deaths from lung cancer, 81,000 a year, are susceptible of reduction by this approach—and within the lifetime of people in this room.

This progress against lung cancer will be tragically limited, of course, so long as cigarette smoking is a widespread habit. The American Cancer Society is supporting a number of smokers' withdrawal clinics which use the most effective psychological methods we have to convince smokers to drop the habit. The results are not as good as we would like them to be. But some do stop and research shows that nonsmokers live longer (approximately 8 years longer) on the average.

The National Cancer Institute is devoting some of its money to a less hazardous cigarette. Manufacturers have been able to make small reductions in tar and nicotine in cigarettes marketed in recent years. Unfortunately people seem to smoke more of this "less hazardous cigarette."

A more fundamental approach would be the use of our agricultural resources for more food and less tobacco. After all, this is a world plagued in so many places with malnutrition. This concept is one which will be explored in June in New York City at the American Cancer Society's World Conference on Smoking and Health. Maybe we should subsidize farmers to switch crops and manufacturers to diversify more.

Along with medical science advances I have described at the clinical level, a truly outstanding advance has been made in the fundamental research on the origin of cancer. National Cancer Institute scientists, led by Dr. Robert C. Gallo, have isolated a virus from leukemic cells of an acute myelogenous leukemia patient.

In the early part of this century Dr. Peyton Rous proved that a virus causes cancer in chickens. It was years before proof followed that a virus caused cancer in mice. It is known to produce malignancies in apes and monkeys. There has long been the anticipation that a virus could be discovered as a cause of cancer in man.

The chain of scientific discoveries leading to the apparent success of Dr. Gallo is long enough to cover three continents. It began when a disease outbreak among soldiers in Thailand required the production of a vaccine. Jungle monkeys were captured and used the way horses and other animals are often used to produce vaccines. An unusual number of cancer deaths occurred among the soldiers. When a Japanese scientist was called in to investigate he found several reasons to believe that the vaccine had carried from the monkeys a virus producing cancer in the soldiers. But the prior release of the monkeys into the jungle prevented him from proving this.

Later a person in Cincinnati and one in Rio de Janeiro were afflicted with cancer after injury by jungle pets. Fragments of scientific data from the three incidents strengthened the belief in a viral cause of cancer.

The virus the NCI scientists have isolated from a human patient is immunologically and biochemically similar to the two viruses that cause cancer in the gibbon ape and the woolly monkey.

Studies in laboratories have associated viruses or viral particles with breast cancer and other malignancies for many years. The recent NCI work may be the first successful isolation of a human virus. And even if it is the same as the viruses responsible for cancer in nonhuman primates it may also be responsible for the human version of the disease.

The National Cancer Institute has warned that the popular view of all virus diseases as being contagious through sneezing, coughing, or other contact with

infected patients cannot be transferred automatically to the cancer patient. The cancer process, from all evidence, particularly the lack of any history of cancer "epidemics," would indicate that the viral involvement in cancer is not transferred by contact, though it might be transferred by inheritance, or by inheritance of some factor that favors accommodation of the virus.

Congressional appropriations prepared the way for early exploitation of this advance, quite possibly the major basic science breakthrough of the decade. For quantities of this viral material isolated by Dr. Gallo are being produced at the Frederick Cancer Center in facilities converted from biological warfare use.

Money appropriated in recent years for laboratories where virus research can proceed without danger to people nearby has made Dr. Gallo's work possible.

NCI research grants will total $276 million in fiscal 1975. The citizens' budget for fiscal 1976 calls for $363 million. The manpower is there. The programs are there. The work can be done. At the citizens' budget level 70 percent of the approved research grants would be funded and nearly a third unfunded. But at the President's budget level only 9 percent of the approved research grants could be funded. Actually, the OMB stated it differently. They stated the approval of funded would be 32 percent. But they achieved that higher percentage by proposing termination of $24 million in noncompeting grants that would be legal, but would violate all historical NIH policy. It would be a terrible waste of $24 million in half-completed projects.

If the fiscal 1976 budget were implemented OMB's way, there would be 10 new research grants awarded in fiscal 1976 as compared to 542 in fiscal 1975. The rest of the 9 percent specified above would be 114 competing renewals.

If all noncompeting research grants and contracts were continued, as the historical policy dictates in fiscal 1976 and, in addition, if the level of new research grants were held at the 1975 level, then the budget needs of NCI for fiscal 1976 would be $785 million instead of what the President asked, $605 million. This $785 million is a no-growth budget. The new grants this year would match last year. Inflation, of course, would really make it a fall-behind budget.

Therefore, the citizens' budget is a modest growth proposal. It is less than the panel of consultants or National Cancer plan advisors suggested. It is far below the level of other national priority programs this country has mounted in recent years.

COMPREHENSIVE CANCER CENTERS ARE PUTTING RESEARCH PROGRESS TO WORK FAST—IN HOSPITALS AND IN DOCTORS' OFFICES

Mr. Chairman, most of this research comes to final fruition in a comprehensive cancer center where scientists work close to stocks of laboratory animals, often baboons or other primates similar to humans, where surgery and other therapies can be applied in conditions verging on the clinical. Likewise, the final proof of the value of a mode of therapy often takes place where there is a heavy patient traffic. For instance, M. D. Anderson Hospital of the University of Texas system accepts 7,000 new cancer patients per year. In fiscal 1974, New York State's Roswell Park admitted 6,700 patients and accommodated over 55,000 outpatient visits. The biggest equipment can be economically operated only in such units. The combination of large numbers of patients and sophisticated facilities makes possible research big enough so that statistically significant results can be tallied.

These locations, too, are large enough to warrant in-depth supervisory and administrative staffs, computers and the experts to attend to those aspects of science which require a deep, intense focus.

That is why comprehensive cancer centers are so important. And that is why they are the spawning ground of new scientists, new careers, and for ideas which must reach the general practice physician if cancer is ever to be conquered.

These comprehensive centers often receive and evaluate many more tissue samples than just those taken from their own patients. With these tissue samples they get case histories from doctors and make important contributions to a patient's health even if he never sees the center, working with the family doctor, evaluating, providing the latest data on drugs and procedures which would be very time consuming for the busy practitioner to acquire otherwise.

The United States now has 17 of these centers, another two or three ready for designation, but we need at least 30 to 35 before all persons in the country are within a reasonable travel distance—100 to 150 miles—of a center.

The twofold research-and-service aspect of these centers comes into full bloom with the operation of some of the National Cancer plan's organ site efforts. For in comprehensive centers away from the Bethesda campus of the National Cancer Institute the administrative work of encouraging, receiving, reviewing and awarding of grants takes place. All of this is under the control of the National Cancer Advisory Board. But the administration is, by contract, performed by non-Government staffs. The task forces engage in basic research. applied research, treatment, and training.

The bladder task force is headquartered at St. Vincent Hospital, Worcester, Mass. The breast and pancreas cancer task forces operate directly from NCI but the breast force's largest single study, utilizing 37 hospitals, is headquartered at the University of Pittsburgh. The large bowel cancer task force is centered at M. D. Anderson in Houston, and prostatic cancer work is led from Roswell Park in Buffalo.

Frequently in the Congress one hears debates over whether health laws should be designed along categorical disease lines or along comprehensive program lines. The question is asked: "Why screen for one disease at a time when the patients can be tested several different ways simultaneously?"

The American Cancer Society contends that there is no conflict between categorical and comprehensive programing. The question really is where the two types of programs interface. We are firmly convinced that the best therapy, the best research, and the best advanced education of medical specialists can only take place in categorically focused programs and institutions.

However, the National Cancer Institute's funding of some activities at comprehensive cancer centers provides assistance and gives direct aid to medical units which are organized for the gamut of diseases.

Nine projects will soon be funded by NCI to plan and develop cancer control efforts which will ultimately be performed by community hospitals, practicing physicians, and the general public. Every comprehensive cancer center has such projects underway. New York has traveling oncology teams to give the latest data and methods to practicing physicians and, while on the road, they review cases which physicians are treating at the time.

Miami has organized a 60-lecture package from which groups of doctors can choose, or from which hospital educators can select.

Comprehensive cancer centers are embarked on building a communications network so that each center can better perform its community duties. This involves a communications office including a telephone response system, a director of regionally available services, interlock with divisions of the American Cancer Society, health departments of local government, and other units in cancer work. WATTS lines supplied to centers by NCI allow laymen and practitioners to call toll free for help in any clinical situation.

The comprehensive centers are taking part in drives to identify individuals at high risk to cancer. Where rehabilitation and psychosocial factors must be considered, the comprehensive center is moving more and more into community work, through, and with cooperation with the American Cancer Society.

Thus the categorical disease expertise is nourished in the cancer center which, in turn, provides comprehensive programs to save lives in community health facilities. The administrators and practitioners on the community scene are aware of the opportunities, costs, and benefits of combining categorical programs. They are better fitted to do so than a cancer center.

The community hospital, however, cannot develop the categorical disease quality, keep up with research results and educate specialists the way a cancer center can. The cancer center, of course, could not attempt to accomplish its mission if it had the entire range of diseases to care for.

Despite all of the activities that comprehensive centers perform, they are not, as centers, heavily funded by the Federal Government. Most of the NCI money they get comes from peer-reviewed, competitive projects of the type that are open to all applicants from the scientific and practitioner communities. About $150 million goes to centers per year. But only some $14 million of that is for core support. About $10 million more supports planning to complete the center system to make it beneficial to all citizens. The rest is work that centers win by reason of competition in research and program grant reviews.

With the citizens' budget of $898.5 million the core support and planning for centers would utilize some $45 million. Actually, the American Cancer Society's estimate of what the centers could economically spend if full resources were available for ready programs and ready personnel is another $150 million on top of what the centers now get from the Federal Government. Most of the

centers, of course, get far more money from non-Federal sources than from Federal.

THE CANCER COMMUNITY IS FINDING NEW WAYS TO COMBINE RESOURCES, COOPERATE, IDENTIFY AND SERVE NEGLECTED AREAS

The exact nature of successful leadership is as hard to define in medicine as it is on the battlefield. But there is no doubt that the Congress' designation of the war against cancer as a national priority program has greatly enhanced the cohesiveness, effectiveness, and the drive toward success of the various forces within the cancer community.

When the American Cancer Society organizes a national conference of practicing physicians on a categorical disease program the response fills one of the largest hotels in America. The American Cancer Society, with help from the National Cancer Institute, attracted to the Waldorf Astoria in November 1974, over 3,200 physicians interested in improving their own work on behalf of patients. Not only were the latest research results presented in lectures, slides, documents and displays, but questions coming straight from doctors' offices and operating rooms were answered by the best experts the country has to offer.

At the same time several major newspapers, electronic media, specialty magazines and academic journals covered the meeting, questioned scientists, explored news of research developments and wrote stories for their tens of thousands of readers unable to attend the conference.

Educational materials developed for the ACS/NCI Conference on Advances in Cancer Management are still being distributed and, for some time to come, will provide "the" authority for the surgeon, the general practitioner, the radiotherapist and the other specialists who spend almost all of their time treating patients.

As you might imagine, the 14th Annual ACS/NCI Conference on the Detection and Treatment of Early Breast Cancer, held in March, took on special interest this year. For results had begun to flow profusely from the 27 breast cancer detection projects which the Society and the Institute jointly support.

While the 27 ACS/NCI breast cancer detection projects are experimental, and the scientists are at work finding ways to do the screening with less patient exposure to X-rays, women's lives are being saved and, in many cases, cancer is being found before the most invasive type of surgery is required. More than twice the expected number of cases of cancer have actually been found. At the same time the project is finding cancer much sooner than it is generally found. This means, very happily, that those cases found are highly susceptible of effective treatment. Axillary node involvement has been found in about 23 percent of the cases. Usually the rate runs more than twice that percentage.

Patients whose lymph nodes are free of cancer at the time of diagnosis have a 75 percent chance to live for at least 5 years. At present about 65 percent survive 10 years. Women diagnosed only after cancer has reached their lymph nodes, however, have only a 50 percent chance of surviving 5 years or more. Their 10-year survival rate is 25 percent.

So the experiment is helping more women than we anticipated. And it is helping those with cancer more than we expected to be able to help them.

This cooperative project has already proven the relative efficacy of several types of detection procedures in the short run so that the coming years can turn to long-run evaluation. It seems clear that some currently used methods are not useful enough to warrant further investment. This would not have been known definitely had it not been for the concentrated and coordinated studies.

PUTTING RESEARCH TO WORK

One of the fundamental and long-delayed needs of the cancer research and treatment community has been a computerized data reference base available to all who need it. Now the National Cancer Institute, the National Library of Medicine and a number of tie-in institutions are operating "Cancerline," an on-line cancer information system available at 300 terminals in medical schools, research institutions, regional medical libraries and hospitals in the United States and several other countries.

The equipment to tie into the system is all commercially available. Standard telephone lines can be used. A maximum charge of $7.50 per search is made. Offline printouts are mailed to users at 10¢ per page. Line fees for transmission are extra. Information can be tapped 5 days a week.

Cancerline has 16,000 cancer drug abstracts on tap; over 18,000 abstracts of carcinogenesis papers and 6,000 research projects are to be added in 1975. Another 10,000 abstracts are expected to be added annually. Doctors can ask about diseases, symptoms, drugs, other forms of therapy, or find specialists, rare facilities, or locate on-going studies of some form of disease they need to know about.

The same system will be used as a building block for the international cancer research data bank program. But the international program will have other components. Already in operation is the international tumor immunotherapy registry. Other internationalized information links depend on completion of agreements on definitions, terminology, modes of communication, and other common denominators necessary for international functioning. Meetings are already underway to achieve this standardization, based on past work by international societies of cancer centers and researchers.

The International work will involve four subject-oriented centers to stress dissemination of specific subject area data to scientists. Automatic distribution of new data to scientists working in the given areas will be part of the system. Technical bulletins covering recent results will be published from computer printouts.

The American Cancer Society knows that this committee has no intention of enacting appropriations for the National Cancer Institute at the President's budget level.

The chairman in recent years has demonstrated the kind of intelligent leadership that bars such a catastrophic waste of past investments.

You have already heard official testimony that the President's budget for fiscal 1976 would cut the total of research grants to 1,934 from a fiscal 1975 level of 2,522. Fellowships and training would dip $4 million despite the fact that we don't have enough people to read the slides, analyze the X-ray targets, and monitor complex dosages of drugs and patient reactions.

Cancer control contracts would be cut by 24. Research and development contracts would be slashed by 136.

If NCI honored all of its multiyear commitments to research project investigators in fiscal 1976, the President's budget would then allow only 9 percent of the new, competing, approved applications to be funded.

There would be no part of the national cancer program unharmed under the President's budget.

THE CITIZEN'S BUDGET

There have been cries of anguish in recent months that cancer research costs too much, that the money should be spent elsewhere in medicine, or not in medicine at all.

The American Cancer Society has no apologies for supporting the citizen's budget of $898.5 million. Nor should any thoughtful biomedical scientist or administrator apologize. Since the National Institutes of Health was founded it has spent some $25 billion. Historically established death rates have been reduced by research advances. This reduction can be put on charts and it can be measured. This has been done for the years 1944 to 1970. The extended work lives in those years resulted in earnings of $156 billion. That seems a fair return on $25 billion invested, not to mention the humanitarian value attained.

Those 3,292,326 persons whose lives were preserved, 1944 to 1970, by medical advances, paid $20 billion in Federal income and excise taxes alone.

They paid, therefore, in just two forms of taxes, four-fifths of the entire cost of NIH since it began.

As Mr. Benno Schmidt put it, any well-run business ought to spend at least 5 percent on research, and health is a $100 billion industry in the United States. We spend far under $3 billion on research. Mr. Schmidt is Chairman of the President's Cancer Panel and managing partner of J. H. Whitney & Co.

Of that $100 billion, cancer treatment costs possibly $10 to $15 billion and may very well be our most expensive disease. We do know that years lost from the working lives of cancer patients are worth—at median income—more than $17 billion per year.

Instead of apologizing for seeking $898.5 million for fiscal 1976 NCI spending, we should point out that even the $898.5 million doesn't fulfill the national commitment which the President, the Congress, and the American people made to the conquest of cancer in 1971.

The panel of consultants on the Conquest of Cancer recommended, at 1971 prices, that $1 billion be spent on the program in fiscal 1976. The original national cancer plan estimated 1976 costs at $1.035 billion.

Put in context, health research has been neglected in recent years after some years of healthy growth.

From 1965 to 1974 total NIH appropriations went up 79 percent.

From 1965 to 1974 Federal outlays went up 132 percent.

From 1965 to 1974 Federal health outlays went up 513 percent.

What we really need is a catchup period.

So far as cancer research money is concerned, the increase has been significant, but it has not been on the order conceived by American Cancer Society witnesses at hearings when the bill was under consideration, nor in the minds of the 250 nongovernmental scientists who spent days, weeks, and in some cases, months in providing the groundwork for the national cancer plan.

The original idea was to mount a worldwide attack on cancer scaled to resemble the effort put into the development of the atom bomb or the flight to the Moon. Without making a value judgment on the three items being compared the array could be presented this way:

Development of the A-bomb ---------- $6,200,000,000
Plant, $1,400,000,000; administration, $0.6 billion; Army contribution, $2.2 billion; operations, $2.0 billion. Covers construction-to-bomb drop period.

Manned Moonshot ---------- 36,400,000,000
Covers NASA appropriations 1959 to manned Moon landing, July 1969. First 5 years appropriations totaled $4 billion, second 5 years totaled $25 billion.

National cancer program to date ---------- 2,300,000,000
Includes all NCI appropriations, 1971–75

NATIONAL CANCER INSTITUTE FUNDING

(millions of $)

	1968	1969	1970	1971	1972	1973	1974[a]	1975	1975	1976	1977	1978	1979	1980
	Actual Money Obligated			New Law					Authorized Under Extension Law					
Research	$183	$185	$190	$233	$373	$420	$547	$641	$750.0	$830.0	$985.0			
Control	-0-	-0-	-0-	-0-	-0-	5	34	50	53.3	68.5	88.5			
Total NCI	$183	$185	$190	$233	$373	$425	$581	$691	$803.5	$898.5	$1,073.5			
				Panel of Consultants' Recommendations										
				$400	$550	$700	$850	$850	$1,000	$1,150				
				National Cancer Plan Developed by 250 NCI Advisors[b]										
				$230	$378	$492	$460	$850	$852	$1,035	$1,192	$1,202	$1,309	$1,421

a/ Includes $60 mil. of fiscal 1973 money released from impoundment.

b/ Panel consultants recommended $400 mil. in 1972 plus an increase of $100 mil. to $150 mil. per year after that until 1977. Figures for 1978 through 1980 are recent additions to update plan.

The American Cancer Society is well aware that critics have complained bitterly about cancer research robbing funds from other research areas. Sometimes the great beast is the Office of Management and Budget.

Neither is a fair characterization. Here are two charts from data supplied directly by NIH Institute directors in most cases.

The first chart eliminates NCI funding and shows an uninterrupted rise in the total for the rest of NIH and National Institutes of Mental Health funding since 1965. The rate has changed from year to year. But the direction is uniformly up. Cancer money does not appear on this chart.

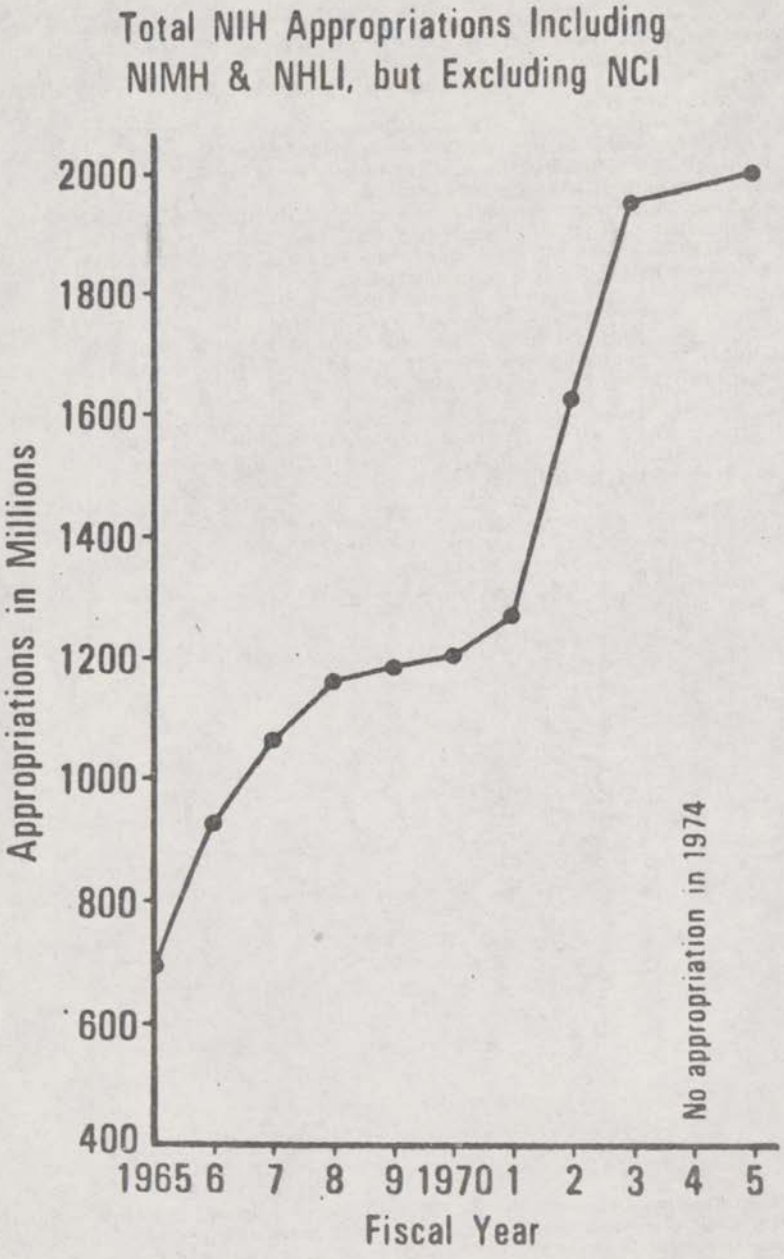


CHART 1

The second chart goes even farther to eliminate those programs where the Congress has placed high priorities. It shows funding at all NIH Institutes excepting NCI and the National Heart and Lung Institute and also eliminates the National Institutes of Mental Health.

All the rest of NIH still shows a continuing upward funding movement. In fact the pace of increase quickens in recent years, a fact this committee is familiar with.

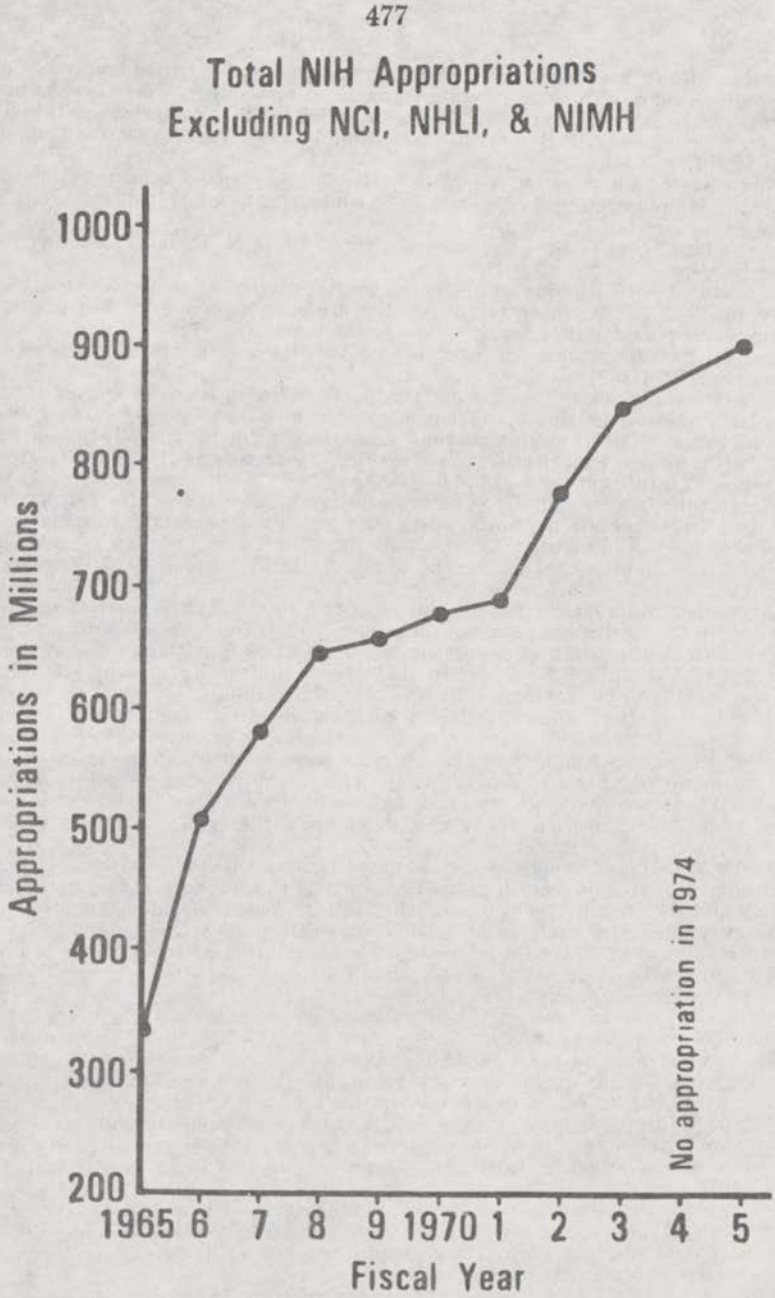


CHART 2

The criticisms that have been thrown at the conquest of cancer program in recent months are not, and this must be emphasized, not a result of observations of how the program has worked.

The criticisms were made before the law of 1971 was passed. The Association of American Medical Colleges made them in 1971 (Conquest of Cancer Act Hearings, March 9, 10; June 10, 1971, U.S. Senate, p. 395). Others made them. Congress in its wisdom decided to proceed with the conquest program.

53-100 O - 75 - 31

It was said in hearings that basic research was insufficiently advanced to provide early progress in therapy under a national cancer plan. Yet there is proof in this testimony of exactly the progress anticipated. It is no exaggeration to say that thousands will live in 1976 who would have died without the plan, and some in 1975 as well.

There have been repeated accusations that the conquest of cancer has decimated basic research by overemphasis of contractual, or applied, research. The facts are otherwise.

In the first years of the conquest program, 1972–74 NCI's total spending went up 58 percent.

Traditional—scientist-initiated—grant project money went up 68 percent.

Again, 1972–74, all grants (traditional, centers, task forces) up 68 percent.

But all contracts in that period went up only 44 percent.

The citizens' budget is not a percentage, across-the-board, adjustment of earlier figures or NCI wish lists.

It is aimed at providing specific products. Community-based cancer control programs and cooperative arrangements would be expanded. Systems for population groups of 1½–3 million persons would be designed for saturation of their area with proper educational and detection programs so that the scope and character of treatment needs could be assayed.

For instance, in this area the program began in fiscal 1975 with six planning and two implementation grants worth $2.4 million. Requests for proposals to expand the work brought in 32 proposals for over a dozen planning grants and a half dozen implementation grants worth $8 million. Some 60 million people would be affected by the expansion.

In fiscal 1976 at least 10 more planning and 10 more implementation grants are needed for saturation programs. The new need is for some $25 millon.

The more continuation of cancer control in fiscal 1976, with no expansion, will cost $45 to $50 million. So the citizens' budget could be justified at $75 million for this work. Our budget table calls for only $67.5 million.

As this committee knows, DES, or diethylstilbestrol, given to prevent miscarriages about 20 years ago is now evidenced in cancer of the cervix of daughters born of the then-pregnant women. There is some evidence that genital organs of sons might be affected as well. Study of this requires $2.3 million in support funds. Where we find such children by examination of medical records their lives might be saved even where they don't know they run the unusually high, DES-induced, risk of cancer.

One of the cancer problems that is mushrooming like an atomic cloud is the environmental risk of certain industries, such as those associated with asbestos, vinyl chloride, taconite, and others. The Nation faces social and industrial disruption if the entire problem is handled by regulation. Science needs to be put at the command of Government so that such regulation as is necessary is fairly and intelligently based. Also, science should lead to education which will make some of the proposed regulation unnecessary.

At least $730,000 is needed for an asbestos effort, a thrust to educate groups susceptible to high exposure.

There must also be psychological studies to show us how to motivate high-exposure populations, including smokers, to take the initiative to prevent cancer.

The ACS/NCI breast cancer detection projects will trend toward demonstration, then educate. It is important that health professionals already in practice get the updating needed to put to work the lessons of the detection demonstration projects. The $750,000 in fiscal 1975 should lead in this work to $1.5 million in fiscal 1976.

At least $500,000 is needed for NCI communications with nongovernment groups such as the American Cancer Society, which are doing so much to make the NCI cancer control program work. The society, itself, is spending more on government cooperative ventures than ever before in its history.

The President's budget would cut cancer control. The waste would be phenomenal. Not only would start-up projects be abandoned before projects could be completed in some cases, NCI would not even have the opportunity to evaluate what it has done in cancer control so far. In a pioneering effort to change the health habits of a nation, to bring communities into programs never before operated, evaluation is essential. To move without it is to proceed blindfolded. Inefficiency would be built in, instead of avoided.

At last $14 million more than in fiscal 1975 is needed to exploit the extremely promising advances in primate and human virology that occurred in 1974 and

1975. The citizens' budget asks only an increase of $12 million even though other basic biology efforts need expanding as well.

NCI estimated last autumn that an additional $41.6 million in cancer carcinogenesis research could be used economically, fiscal year 1976 compared to fiscal year 1975. The citizens' budget asks about one-third less than that. Crucial for the present and future generations is the rapid assay of chemicals entering our lives. NCI has found ways to reduce the per-chemical test costs. These new ways cannot be put to work at the President's budget level with anything like their potential effectiveness.

Public policy decisions are already under debate because of varying interpretations of existing data on cancer incidence and survival. The figures need to be air-tight when large sums hinge on them. NCI has mounted the SEER program for cancer surveillance, epidemiology and end results reporting. With the President's budget some $250,000 to $500,000 in work would be unfunded.

Without the citizens' budget, some $1.1 million in inhalation studies to find less hazardous cigarettes will go undone. The money is urgently needed. A beginning of $100,000 or more should be made on finding chemicals antagonistic and agonistic to nicotine. Such chemicals have been useful in alcohol and narcotic patients. Without the citizens' budget such studies cannot start effectively.

The individual line items requested in the citizens' budget are shown in an accompanying table.

CITIZENS BUDGET FOR THE NATIONAL CANCER INSTITUTE, FISCAL 1976

[In millions of dollars]

	1974 actual	1975 appropriations	Fisca, 1976 President's budget	Citizens suggested budget
Grants:				
Regular research	$115.3	$135.1	$114.6	$167.6
Cancer research centers	92.5	115.8	100.7	155.0
Task forces	10.0	12.0	8.9	18.0
Research career program	1.7	2.0	2.0	5.0
Clinical education		5.0	2.9	9.0
Scientific evaluation	.3	.4	.4	.4
Radiation development program		4.2	2.2	8.0
Total research grants	219.8	274.6	231.8	363.0
Fellowships and training	23.6	22.2	18.2	25.0
Construction	31.7	30.0	17.0	44.0
Grant review	4.6	6.2	6.6	8.3
Direct operations:				
Biology and diagnosis	41.0	51.1	44.1	63.2
Treatment	76.8	82.9	76.2	105.0
Cause and prevention	112.2	122.4	110.0	155.3
Cancer control and rehabilitation	33.8	50.4	45.6	67.5
Program direction; services	14.7	23.4	29.7	35.1
NIH construction	6.4	9.7	5.0	8.0
NIH management fund	16.8	19.1	20.8	24.0
Total[1]	580.8	[2]691.7	605.0	898.5

[1] Columns don't add to totals because of rounding.
[2] $8,000,000 carried over to fiscal 1975; 1976 equals $699,700,000.

Mr. NATCHER. Thank you, Dr. Rosemond. Our chairman had to be away today on a very important matter concerning his district and for that reason he is not here. I know that he would want to extend his best wishes to you, Dr. Rosemond. We are delighted to have you. You are serving in a very important capacity. I say that to you frankly.

As you know, on our subcommittee we have turned down all of the requests for rescissions for NIH. I guess you know that.

Dr. ROSEMOND. I am quite aware of it, sir.

Mr. NATCHER. We sincerely believe on this subcommittee, and this applies to the members on both sides of the aisle generally, that the rescission request for cancer could not be justified. And, Dr. Rosemond, we refused to go along.

Dr. ROSEMOND. I know you did. We appreciate it very much.

Mr. NATCHER. We are delighted to have you with us and thank you very much.

Dr. ROSEMOND. Thank you, sir.

NATIONAL INSTITUTES OF HEALTH

WITNESSES

DR. ROY GODDARD, CHAIRMAN, ASSOCIATION OF PEDIATRIC PULMONARY CENTERS

JACQUELINE ZASLOW, SPECIAL LEGISLATIVE CONSULTANT, ASSOCIATION OF PEDIATRIC PULMONARY CENTERS

Mr. NATCHER. Our next witness is Dr. Roy Goddard, chairman of the Association of Pediatric Pulmonary Centers.

Who do you have with you, Dr. Goddard?

Dr. GODDARD. I have Mrs. Jacqueline Zaslow, our legislative consultant for this organization and I am sure she will be glad to answer questions.

Mr. NATCHER. We are delighted to have both of you appear at this time. Go right ahead.

Dr. GODDARD. I am Dr. Roy F. Goddard, president of the Association of Pediatric Pulmonary Centers and also the medical director of the southwestern regional pediatric pulmonary program, located in Albuquerque, N. Mex. Seated beside me is Mrs. Jacqueline Zaslow, the legislative and program consultant of the Association of Pediatric Pulmonary Centers, who, if the occasion arises, will act as a resource person. I should like to thank this committee for its continued interest and concern for the pediatric pulmonary program and express appreciation in behalf of the millions of children with chronic pulmonary diseases who look to the program for relief.

You just heard from the previous speakers how important it is. I believe in the first testimony Dr. Harmon said others were 31 percent of the total. We fall in the 31 percent.

You heard Mrs. Villines say 30 percent of their group are severely disabled.

We hope to tell you about these children and young adults we think we can prevent from becoming chronically disabled and give them a much better way of living as they grow older.

In testimony over the last few years, we have outlined the magnitude of this problem and have recorded its legislative history. Therefore in the interests of conserving the committee's valuable time, I will confine my remarks today to the current situation. Any other desired documentation will be willingly furnished for the record.

PRESENT PROGRAMMATIC STATUS OF THE PEDIATRIC PULMONARY CENTER PROGRAMS

There are 10 centers across the Nation currently receiving Federal support. Since July 1, 1974, the pediatric pulmonary program has been administered by the Maternal and Child Health Services of the Health Services Administration, DHEW, and funded under the authorization of title V. We have been very comfortable with this arrangement and

would like to see the development of yet stronger ties between the program and M.C.H.S.

A BRIEF LOOK AT THE EXISTING PEDIATRIC PULMONARY CENTERS AND THEIR IMPACT OF PEDIATRIC PULMONARY DISEASE

We think it will be of significant interest to the committee to learn something of the individual progress and accomplishments of these 10 centers in their own regions and communities in recent times.

CALIFORNIA

At the University of California at Irvine, the program, under the direction of Dr. Robert Huxtable, has since its inception, been responsible for training 14 M.D. fellows in pulmonary diseases; providing specialty courses to 190 M.D.'s; offering regular seminars in allergies and intensive training in neonatology to 460 nurses. Although the major impact has been felt in Orange County, many applicants from the Eastern States as well as from outside the United States have been attracted.

As a result, mortality in the county has dropped from 13 per 1,000 live births to 10 per 1,000 live births. Expanded capability in the area of pulmonary function has been developed. Cooperative efforts and shared funding exist between the center, Long Beach Children's Medical Center, and Children's Hospital of Orange County. A contract between the center and the California State Department of Health has been consummated, resulting in financial assistance toward a therapist's salary.

The center has provided a miniresidency program of 1 to 3 months to community physicians. Twice yearly, an 80-hour course combining didactic content and clinical experience in the critical care of the neonate is conducted.

COLORADO

The Pediatric Pulmonary Center, under the direction of Dr. Ernest Cotton, is situated in Denver, at the University of Colorado Medical School. In this more sparsely populated region of the country, the center has strengthened linkages with primary and secondary sources of care within the State and with Wyoming and portions of Montana and Nebraska. Furthermore, excellent cooperative services have been developed between the center and the National Jewish Hospital, the Children's Asthma Research Institute and Hospital, Children's Hospital, and the Fitzsimons Army Hospital.

A unique feature of Colorado's well rounded training program is a 3 week course focused on the family based approach to the care of the high risk infant. It is given four times a year for physician and nurse teams and is always fully subscribed with participants from all over the country. The department of continuing education at the university's nursing school has also adopted this program as part of their curriculum. Nurses attending the program select a child from the Pediatric Pulmonary Center for clinical experience during the study.

Students from the university's medical school are provided with a 6-week rotation through the center to learn the management and care of infants and children with acute and chronic respiratory conditions.

Six fellows trained at the Denver center are now practicing in this specialty area. Neonates comprises 25 percent of the center's patient case load, 200 cystic fibrosis patients are seen on a regular out-patient basis and the remaining 100 or more, suffer from a variety of other pulmonary problems.

DISTRICT OF COLUMBIA

Unlike any other major U.S. city, the Nation's Capital serves more residents from the adjoining States of Maryland and Virginia than it does from its own populace. The Pediatric Pulmonary Center at Georgetown University Medical School is no exception. Under the direction of Dr. Frederic C. Burke, the patient caseload in 1973 was 2,686, out of which very few comparatively, came from the District itself. The training activities of this center use demonstration patients from Washington, Montgomery County, Md., and Fairfax and Arlington Counties in Virginia. Affiliated institutions include D.C. Children's Hospital and Columbia Hospital for Women.

The excellent facilities of Georgetown Medical School attract faculty and students from a wide area across the States, who, because of the catalytic force of its Pediatric Pulmonary Center have opted to rotate through its speciality programs in allergy, immunology, and respiratory disease.

Because of the high quality research potential, the existence of the Pediatric Pulmonary Center has generated sizeable grants from the Heart and Lung Institute for Georgetown University Medical School complex. The center has in effect, stimulated implementation of programs and support from other sources, far beyond the original concept and of an impact far exceeding the sustaining Pediatric Pulmonary Center Federal grant.

HAWAII

The Center in our 50th State is located at Kauikeolani Children's Hospital in Honolulu, which is part of Hawaii University's School of Medicine. Its director is Dr. Sherrill Hammer. Under the aegis of this program, a much needed emergency airlift medical service has come into being, which serves the outreaches of Oahu itself and the outer islands. A highy skilled transport team has been trained, which includes a neonatologist and a trained nurse who fly with their specially devised equipment which includes an incubator. Although medical science has, in a sense, conquered the most virulent aspects of tuberculosis, it is unfortunately, still quite prevalent in the Hawaiian Islands, particularly in rural areas where qualified medical assistance is not ready available. Although the Pediatric Pulmonary Center is not directly involved with the treatment and care of tuberculosis, its existence has made possible lines of communication between the mainland and the outlying islands for physician consultation and the transportation of patients in urgent need of hospitalization.

In the Center itself, over 300 newborns and 700 chronically lung-impaired children have been treated; who, without these facilities, most likely would neither not have survived or whose life potential and quality would have been deteriorated immeasurably. The Center is equipped with the most modern and sophisticated pulmonary ventilating and life-support systems. It is also staffed by highly qualified physicians, nurses and respiratory therapists.

Due to the professional and community training programs being offered at the Center, both to affiliated hospital and individual health practitioners, children are being diagnosed much earlier and referrals have increased. Allied health personnel are receiving up-to-date training in specialized categorical aspects of pulmonary treatment and are thus filling the void and being utilized as physicians' assistants throughout Hawaii.

LOUISIANA

The anchor for this program is primarily based at Tulane University Medical School in New Orleans under the direction of Dr. William Waring, with strong ties with Louisiana State University, both in New Orleans and Shreveport. Its program affiliates are: Charity hospitals in New Orleans, Lafayette, Pineville and Independence; Confederate Memorial, and Baptist and Ochsner Foundation Hospitals and the Touro Infirmary in New Orleans.

The American Thoracic Society of Louisiana, which is the professional service arm of the American Lung Association, cosponsors three nationally advertised training courses on pulmonary diseases annually. The program has attracted physicians from 32 States and two foreign countries. Dr. Bettina Hilman, director of the pediatric pulmonary program's branch at L.S.U. at Shreveport, is the first Fellow trained under the auspices of the program.

The patient caseload of more than 1,000 is mainly referred from within Louisiana, but does include and treat patients from northeastern Texas, southern Mississippi, southern Alabama and the Florida Panhandle.

NEW MEXICO

In New Mexico, the Pediatric Pulmonary Center is located at the El Camino Medical Center, which is affiliated with the University of New Mexico Medical School through Presbyterian Hospital Center in Alburquerque. Our program affects a territory very different to the populated regions of California and its resources. Within the State we serve a total population of a little over 1 million, out of which 19,500 are black, 73,000 are Indian and 2,000 are of Japanese or oriental origin, including Filipinos and Chinese. Outside of Texas and California, we have the largest Spanish-American population in the United States.

In order to cope with the every surmounting problem of chronic pulmonary disease in children, the State only has 30 pediatricians, most of whom are concentrated in Albuquerque itself. As a consequence, the most viable and effective feature of the program is the periodic out-reach community visitation courses we conduct two to four times per year. We set forth with a team of highly qualified personnel, load our equipment into the trucks and take off for the hills. Just last week, in a predominantly Spanish-American community, we had an outstanding attendance of M.D.'s and paramedical personnel for a 1½-day period. These people came from the far reaches of our State and attended this seminar in a small hospital in Las Vegas, N. Mex. Such sessions are frequently held in community libraries, banks and schools. Over 700 medical and paramedical personnel have

been trained in such community visitation programs since their inception.

The on-going training program is conducted at the Southwestern Regional Pediatric Pulmonary Center in El Camino Medical Center and the nearby Anna Kaseman Hospital, which has some of the most up-to-date facilities, in terms of equipment, personnel and space to be found anywhere in New Mexico. Special 1-week seminars conducted over the past few years have attracted participants from Arizona, Nevada, and West Texas. The elevation and atmospheric conditions of New Mexico are conducive to clinical studies in "clean-air" control and advanced technical development of therapeutic equipment. Since the inception of the pediatric pulmonary program, the New Mexico Center has conducted 16 training courses for physicians and health personnel, varying from 3 days to 1 week. The participants have included 100 physicians, 220 nurses and 320 inhalation and physical therapists. I strongly believe that the Federal support of the pediatric pulmonary program in New Mexico has brought about the means of disseminating professional and lay education that could not possibly have been achieved without such educational programs.

NEW YORK

The Pediatric Pulmonary Center program, directed by Dr. Carolyn Denning at Babies Hospital at the Columbia-Presbyterian Medical Center, caters to the needs of a vast metropolis, far exceeding the boundaries of Greater New York. It serves the needs, both clinical, social and researchwise of an extremely homogeneous population, including its nearby hispanic and black communities and extends across the Hudson River into New Jersey and back again to upstate New York.

Outpatients are accepted from birth to approximately 18 years of age, with the exception of cystic fibrosis, who are accepted regardless of age because of the paucity of qualified internists willing and able to assume the highly specialized care necessary for this categorical group.

There has been a tremendous increase in caseload since 1968 when the program was first initiated. This has been attributed to the Center's most effective training and educational program which, in turn, has resulted in earlier identification of problems relating to chronic pulmonary disease in neonates, infants, children and adults.

In 1967–68 30 patients with cystic fibrosis were followed and 325 with other respiratory conditions. Only 15 new patients were diagnosed. In 1974, outpatients numbered 806; 197 of these were new patients diagnosed and subsequently treated or referred by the Center. These dramatic figures alone, indicate the impact that the Federal support of title V programs, and in particular, the Pediatric Pulmonary Center program, is making upon the health of the Nation today and tomorrow's generation of American citizens.

The training program at the New York center is multidisciplinary. The team of specialist-physicians are responsible for developing and establishing guidelines for each area of categorical expertise. The historic background of New York's program reflects the optimum involvement and the utilization of personnel and institutions that can

only emanate from the previously fragmented and multiple-funded tertiary health systems of a great sprawling noncoordinated metropolis. In its early days, the program was based upon the activities of the center at Babies Hospital itself, the cystic fibrosis clinics at Long Island College Hospital in Brooklyn; Long Island Jewish Medical Center; and the Bronx Community Health Centers. Today, because of consolidation of effort, made possible by the centralization of a regional Federal sustaining grant, all these vital elements have been welded into a single, more viable program.

Today the New York Pediatric Pulmonary Center program incorporates into its basic structure, as funded affiliates and cooperating members, Albert Einstein Medical School and Hospital in the Bronx; St. Vincent's in Greenwich Village, and Harlem Hospital. It is also the core consultant for St. Vincent's on Staten Island, and has now been approached, if funds become available, to bring into the chain, a third major medical school of New York, that of NYU through its affiliation with St. Vincent's. The New York Bureau of Handicapped Children, which is also an MCHS title V project, are interested in pooling resources and tripling the output of the New York Pediatric Pulmonary program. The State Crippled Children's program, title XIX administration, and others, and the bureaucracy involved in the implementation of "SSI" find the center in New York a focal point of expertise, as a clearance house and cooperative facility for the implementation of Federal and State programs.

Likewise I am sorry Mr. Flood isn't here today because in Philadelphia there is a regional program he knows about.

The Philadelphia Pediatric Pulmonary program is under the direction of Dr. E. Sewell, and is regional in all its aspects. It includes the Greater Delaware Valley, and uses four tertiary locations as its focal point. These centers are located at Children's Hospital in Philadelphia; Hahnemann Medical School and Hospital; St. Christopher's Hospital for Children; and Jefferson University Hospital. The program itself has six interlocking component parts:

a. Regional neonatal programs in New Jersey, Delaware, and eastern Pennsylvania.

b. School health training and back-up program in Atlantic City, Harrisburg, Wilkes-Barre, and Philadephia schools.

c. Satellite pulmonary clinics in Wilkes-Barre, Wilmington, Harrisburg, and Atlantic City.

d. The four pediatric pulmonary centers to be utilized as back-up resources to children and youth programs and other primary health systems.

e. Physicians preceptorial program.

f. Facilities of Jefferson Medical College and its resources of chronic care at Children's Heart Hospital to be integrated into the program.

In its current implementation, the Pennsylvania program has established priorities in pediatric pulmonary disease as follows:

a. The neonatal area.

b. Children with asthma and recurrent respiratory disease, exhibiting impairment in growth and function.

c. Children with various congenital handicaps or genetic respiratory disorders, such as cystic fibrosis.

d. More effective utilization of services and diminished duplication of effort in this categorical area.

PUERTO RICO

The center is located at the University of Puerto Rico Medical School, under the direction of Dr. Pedro M. Mayol. The comparatively modest grant awarded to this program has had enormous impact in effecting better standards of health care for the children of both Puerto Rico and the Virgin Islands. The training program for physicians, nurses and all allied health personnel, has now been extended to include the health educators of the Puerto Rico Department of Education. This has provided a vehicle for the dissemination of information on preventative medicine throughout the school districts of the island.

The timely establishment of the Puerto Rican Pediatric Pulmonary Center enabled it to exert considerable influence upon the content matter of the new curriculum of the university's medical school. The increase in training medical students in pediatric pulmonary disease has been significant and has now been extended to include interns and pediatric residents at the affiliated San Juan Hospital. Similarly, the program is offered to outreach areas which has resulted in two excellent programs at Cuguas and Mayaguez.

The center, in collaboration with the Medical Association of Community Hospitals and the American Lung Association has conducted joint programs which have brought about more interest and enthusiasm for improving the health care for children with respiratory diseases.

The major pediatric respiratory problem on the island appears to be bronchial asthma, which accounts for 58 percent of total patient visits. Significant data from the records of University Hospital and from its affiliate, Ruiz Soler, indicate the impact the program has had in cutting down hospital admissions while maintaining better quality services through its outpatient department and increased case finding activity.

Date	Pediatric admissions to pneumology section	Consultations	OPD patient visits
1972–73	106	54	4,774
1973–74	103	66	6,938
1974–75	79	102	8,127

The Center personnel comprises a team of multidisciplinary physicians; trained nurses; social worker; nutritionist; respiratory and physical therapists. The modern and spacious facilities include a pulmonary function laboratory and provide laboratory services for sweat testing, allergic skin testing and tuberculin testing. In addition to bronchial asthma, the rest of the patient population is mainly comprised of children with cystic fibrosis, recurrent bronchopulmonary diseases, dirty lung syndrome, primary tuberculosis, and acute pneumonia.

WASHINGTON

This program is located in University of Washington Medical School's Department of Pediatrics and is associated with the Children's Orthopedic Hospital and Medical Center.

The program, under the direction of Dr. David Woodrum, was originally designed to conform to the Washington/Alaska Regional Medical Program Regional Advisory Committee Guidelines. The primary goal and emphasis of the program is educational in nature. It is designed to improve the knowledge and skill of pediatricians and other health professional workers in communities throughout the States of Washington, Alaska, Montana, and Idaho. Intensive short-term courses in pediatric pulmonary disease are conducted at the University of Washington and Children's Orthopedic Hospital for physicians and their support health professionals (respiratory therapists and/or nurses) from all major population centers throughout the State of Washington and in the other States mentioned. Followup visits to the individual communities are then made by members of the project staff.

Continuing education at the practitioner level and at the level of the practical aspects of respiratory care within community hospitals is emphasized. Acceptance of this program is evident in the form of increased and more appropriate patient consultation and referral, interests in studying local environmental problems and involvement by community physicians who have participated in the pediatric pulmonary program in their local communities attempting to improve the care of children with pulmonary disease. In spite of unstable fiscal conditions, the above activities have developed a momentum of their own, as evidenced by continual two-way flow of health professionals coming to the University of Washington Medical School and the Children's Medical Center for short courses in pediatric pulmonary problems and outreach visits by the project staff including physicians, respiratory therapists, social workers and nurse clinicians going to the communities throughout the State.

The program begins with the neonate and the particular problems associated with IRDS and encompasses the entire pediatric age group including patients with asthma and cystic fibrosis, and other chronic respiratory problems. In view of the fiscal insecurity of this program over the past few years, its success in this region is an indicator of the future potential of such a program if more constant dependable funding mechanisms become available.

FINANCIAL STATUS OF THE PEDIATRIC PULMONARY PROGRAMS

These 10 centers have been operating at a total level of $2 million, without any increase over the last 2 years. This sum has neither provided for inflation, which minimally is recognized at 13 percent per year, nor has it enabled program enrichment or expansion, as called for in the M.C.H.S. Report. Please see exhibit A.

Nonetheless, despite economic hardship, the centers have managed to fulfill their mission and meet their obligations. The impact of their operation upon professional and lay communities throughout the

States has generated a network of services, involving State health agencies and private organizations, whose total financial cost far exceeds the $2 million invested in the 10 pediatric pulmonary centers. However, unless the program is sustained by Federal funds most of this will collapse and so much effort will have been in vain.

Universities, medical schools and other similar institutions are equally hard hit by lack of sufficient funds and although the program has demonstrated its value, these institutions cannot carry the burden unaided. But they are able and willing to be cooperative partners with the Government in the promotion of this most worthwhile undertaking. At the present time, the program is forward funded and is operating in this fiscal year on uncommitted section 314(e) 1973 funds which Congress approved to be transferred last year for this purpose. When the fiscal year 1975 appropriation bill was enacted, Congress then directed that $2 million out of the $29 million that was restored to maternal and child health services be utilized for the continued support of the program.

The recommendations contained in the maternal and child health services in-depth review of the pediatric pulmonary program call for a total of 22 centers to be established by 1980 and the aggregate corresponding budget necessary would by then have reached $10 million. In order to achieve this, it is proposed to add two centers to the chain each year. Because of the circumstances mentioned above, the addition of two centers in 1975 was not possible.

In light of this, we respectfully urge this committee to take action that would enable the plan to be implemented by the addition of two more centers in fiscal year 1976. We therefore plead that the sum of $3.6 million be added to the title V appropriation and that Congress direct that it be utilized for support of the pediatric pulmonary program. We fear that unless this is accomplished, the existing 10 centers will not be able to survive beyond June 30, 1976, and thousands of infants and children will be deprived of life supporting services. We believe this comparatively modest investment in the health of children today is an economic measure and one that conforms to austerity levels of governmental spending. If one prorates the cost of this program against the cost to the country of supporting unproductive adults, who in the future, will become disabled and charges of the State through lack of diagnosis in childhood and early preventive medicine measures having been taken, one can readily cycle—to the priority or absolute necessity of continued support for these pediatric pulmonary center programs.

OVERVIEW OF THE MATERIAL AND CHILD HEALTH SERVICES, DHEW

We are appalled that the administration proposes in 1976 to drastically reduce the appropriation for maternal and child health services. This particular Government agency has more than demonstrated its effectiveness and its ability to implement programs for mothers, children, and infants. Furthermore, it is the only existing agency whose expertise in this area extends beyond the Federal level into the regions, States and local communities. The crippled children's services are a very cogent example in this connection and are reflective of MCHS's responsiveness to the equally importannt socio-economic needs of the medically indigent child and his family. We maintain that the ad-

ministration's budget figure of $221 million is absurdly inadequate, especially when compared with the 1975 appropriation which was $294 million. We would like to see MCHS accorded a budget in excess of $340 million.

TITLE V—RESEARCH AND TRAINING

The President's request cuts this appropriation back $7.5 million over the 1975 figure, leaving a paltry $17.5 million for support of those programs authorized by title V of the Social Security Act. These programs, including the pediatric pulmonary center program, would suffer extreme hardship and irreparable damage if this figure is not increased to a more feasible level, which in our estimation should be no less than $34 million.

FORMULA AND PROJECT GRANTS TO THE STATES

In 1975, the $267 million appropriation barely covered these commitments. In most instances the States themselves have overmatched the prescribed formula, for example—figures are approximate:

New York: Federal grant, $1.5 million; State contribution, $21 million.

California: Federal grant, $2 million; State contribution, $15 million.

We, therefore, suggest that any further reduction of budget for State formula grants would be tantamount to phasing out the programs entirely.

PERSONNEL

It has been our privilege to have a close working association with the professional and program staff of MCHS, whom we have found to be highly skilled competent people. The 68 positions restored by Congress last year enabled MCHS to meet their programmatic obligations.

The proposal by the administration to once again, eliminate these positions would render this very viable service branch of the Government helpless to supervise a sizable portion of the programs under its purview.

NATIONAL INSTITUTES OF HEALTH

The Association of Pediatric Pulmonary Centers, along with the Coalition for Health Funding and other responsible groups, is most disturbed at the administration's proposed budget request for NIH, which if approved, would severely truncate research endeavors in the United States today. We are sensitive to this issue on a large scale but also, in a more provincial sense, are deeply concerned about such a cut back in research spending which would affect the progress being made in pediatric pulmonary disease. We regard the pediatric pulmonary center as a most suitable clinical environment to stimulate targeted areas of research; for the provision of patient population for demonstration and controlled studies; as a collaborative unit of cooperative projects with clinical and basic investigators; and as an ideal training ground for the younger researcher whose laboratory activities can be coordinated with clinical application.

The 1975 appropriation for NIH was $2,090,418,000, the President's request suggests an inoperable budget of $1,805,000,000—we join with the health coalition's proposal of a minimum of $2,295,800,000.

Evolving out of this total picture, we would now like to address ourselves to the plight of two of the institutes, that perhaps have the greatest impact on our own categorical area of interest.

A. THE NATIONAL HEART AND LUNG INSTITUTE

President's 1976 request: $292,794,000.
1975 appropriation: $324,130,000.
Coalition 1976 request: $360,000,000.

The 1975 figure authorized for National Heart and Lung Institute was $520 million and although the authorization of the 1972 Heart, Blood, Vessel and Lung Act, will expire on June 30, 1975, very few facets of the expanded program have been implemented through the very restrictive level of funds made available, as below:

1. Grants: The administration budget provides $15 million less than was available in 1975 which would only permit 40 percent of approved grants to be funded. We contend that this is a disservice to the country and a minimum of 60 percent of aproved grants should be funded. In order to achieve this, an additional $14 million would be required, making a round total of $30 million above the 1975 appropriation.

2. Training: Keeping pace with the country's need for more trained investigators indicates a necessity to provide financial incentive for the younger researcher with an economic ability to pursue his career. Therefore, the $20 million proposed by the administration is inadequate. In order to offer at least 2,000 traineeships per year, at $16,000 per year, a minimum of $32 million is needed.

3. Research and demonstration centers: The President's 1976 budget does not provide for any additional centers this fiscal year, although a total of 30 such centers were authorized under the act. We feel that at least $10 million should be appropriated for the establishment of another 6 centers this year.

4. Other programs: Prevention and education: Targeted research: Clinical trials in pulmonary therapy: SCOR programs: Continuing education in emergency services: Pulmonary faculty training grants in conjunction with the heart programs are among the institute's high priority areas.

Based upon the President's request, there is no way that the National Heart and Lung Institute can carry out its mission unless Congress takes action.

B. NATIONAL INSTITUTE OF ARTHRITIS AND METABOLIC AND DIGESTIVE DISEASES

President's 1976 request: $148,404,000.
1975 appropriation: $173,121,000.
Coalition 1976 request: $190,000,000.

The President's request would neutralize NIAMDD's ability to not only properly sustain its ongoing programs, but also render it helpless to comply with recent congressional mandate. This past year two laws were enacted that obligate NIAMDD to expand their arthritis pro-

gram and to initiate another in diabetes. No starts have been made in either direction, nor can they be made under current financial operating levels. Two chairs remain conspicuously vacant, those of the directors for these two new programs and consistently, those of necessary supportive personnel. This frustrating set of circumstances imposes unfair and unrealistic burdens upon the decisionmaking body of this institute.

Chronic obstructive pulmonary disease in children, is in most aspects, similar to the variety of diseases that plague the adult generation, inasmuch as that many of them are attributable to disorders of metabolic origin. Therefore, the challenge presented to NIAMDD is a vast one and cannot be sliced into equilateral pieces of pie. Unfortunately, the word "metabolism" does not conjure up the same dramatic image that the dread words of "cancer" and "heart" instill in the public's mind. Nonetheless, without detracting in any way from the magnitude of the problems faced by the other institutes whose very names are more synonymous with their goals, we maintain that the low profile engendered by NIAMDD masks a high voltage research program of far-reaching boundaries. We believe that it is inclumbent upon those who are concerned with scientific progress for the good of all mankind to provide NIAMDD with sufficient funds to do the job that it is capable of doing.

OTHER INSTITUTES INVOLVED IN CHILDREN'S RESPIRATORY PROBLEMS

There are two other institutes with programs that are vitally concerned with children's respiratory problems. The first of these, the National Institute of Allergy and Infectious Diseases is continuing ongoing programs in these fields as well as concentrating on studies of the body's immunological defenses. We believe they should be supported with a minimum fiscal year 1976 appropriation of $131,300,000 (fiscal year 1975 appropriation was $119,452,000, and the President's 1976 request is $108,700,000).

The National Institute of General Medical Sciences is deeply involved in genetic respiratory disorders such as cystic fibrosis and alpha$_1$ antitrypsin deficiency and we believe should be awarded $206,100,000 for fiscal year 1976 (fiscal year 1975 appropriation was $187,400,000 and President's 1976 request is $161,630,000).

SUMMATION

We recognize that the budgetary recommendations made in this deposition exceed those of the administration for DHEW. We are also cognizant and sensitive of the frustrations of Congress to equate the total picture of the United States economy with its internal and domestic needs. We can only therefore pray that this committee, in its weighty considerations of priorities will take action that will endow future Americans with a sound mind in a sound body, knowing they have done their best for health, welfare, and education.

[The attachments follow:]

EXHIBIT A

THE PEDIATRIC PULMONARY PROGRAM

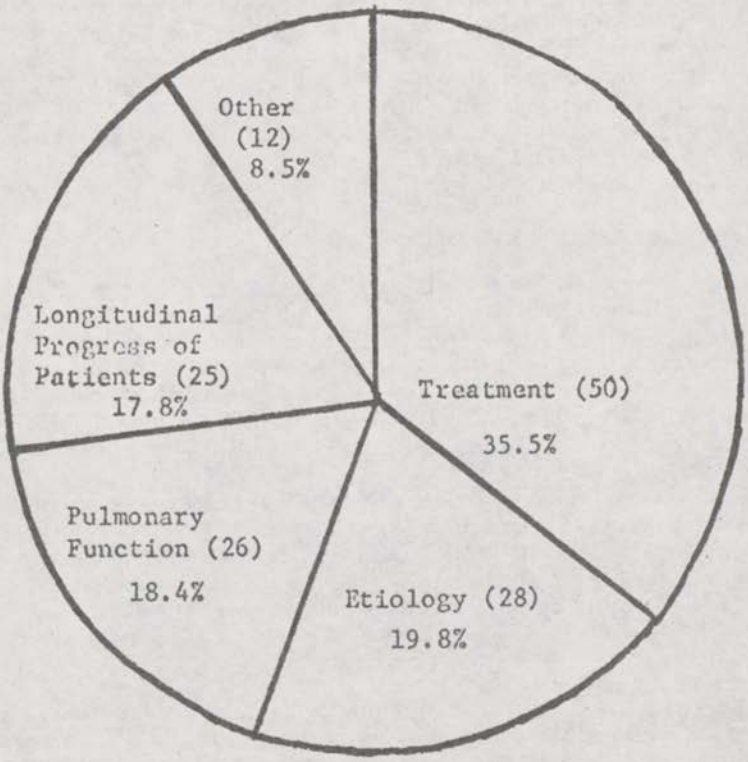
A review to determine the present state of the program and to develop recommendations for future support and direction—Maternal and Child Health Services, Bureau of Community Health Services, Department of Health, Education and Welfare

APPENDIX 12—RESEARCH ACTIVITIES IN THE 10 PEDIATRIC PULMONARY CENTERS

ALL centers have completed research studies.

ALL centers are presently engaged in research activities. The majority of these studies are clinical in nature.

Sample of 141 research studies presently being conducted



ALL centers expect to engage in future research activities including studies concerned with the social-emotional implications of chronic pulmonary diseases in children.

APPENDIX 22—THREE ASPECTS OF PROPOSED EXPANSION OF PEDIATRIC PULMONARY PROGRAM

INCREASE FEDERAL SUPPORT TO EXPAND EXISTING CENTERS

	What additional staff needed to provide comprehensive care and increase training activities	How much—$1,000-000 (100,000 per center)	When—fiscal year 1975
Phase in 2 CF centers (South)	Additional staff needed to provide comprehensive care.	$600,000	Fiscal year 1975.
Phase in 2 CF centers (1 south, 1 north-central.			Fiscal year 1976.
Phase in 2 CF centers (north-central)			Fiscal year 1977.
Phase in 2 CF centers (midwest)			Fiscal year 1978.
Phase in 2 CF centers (east)			Fiscal year 1979.
Phase in 2 CF centers (1 east, 1 west)			Fiscal year 1980.
Strengthen linkages between all centers and related agencies/individuals/programs.	Consultation by CO/RO staffs. Increased screening and service activities.	Federal: 0	Ongoing.

APPENDIX 23—COST OF EXPANSION OF PEDIATRIC PULMONARY PROGRAM (IN MILLIONS)

Fiscal year and item:	
1974: Support 10 existing centers	$2.00
1975: Expand 10 existing centers	3.00
Add 2 new centers	3.60
1976: Add 2 new centers	4.56
1977: Add 2 new centers	5.62
1978: Add 2 new centers	6.68
1979: Add 2 new centers	8.06
1980: Add 2 new centers	9.47

EXHIBIT B

DELEGATE'S LETTER TO THE PRESIDENT

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., December 20, 1974.

HON. GERALD R. FORD,
The White House, Washington, D.C.

DEAR PRESIDENT FORD: Although we recognize the great burdens of your office and are hesitant to bring yet another matter to our attention, nevertheless because of our concern for the health and welfare of over 10 million American children who suffer from chronic pulmonary diseases, we feel we must write to you on behalf of the pediatric pulmonary program.

This program provides treatment for children who suffer the crippling effects of asthma, bronchitis, bronchiectasis and cystic fibrosis. The financial considerations in the continuation of this program are minimal while the services rendered are vital to the lives of these children—and withdrawal of support would have a devastating effect upon the families involved. Currently this program receives support authorized under title V of the Social Security Act which is administered by the Maternal and Child Health Division of the Bureau of Community Health Services, Department of Health, Education, and Welfare. There is a lengthy documented legislative history surrounding this program dating back to 1968, which is readily available should additional details be required.

Diagnosis, treatment, control, and hopefully, one day, a cure, can only be achieved through the maintenance of the pediatric pulmonary center network. There are 10 federally supported centers in the country today, whose expertise, in terms of advanced therapeutic techniques and specialized training facilities are

responsible for the well-being of 30,000 of the 10 million children. We, the undersigned, are fortunate in having such centers in the areas which we represent. These centers are struggling to keep their doors open beyond June 30, 1975. There are also several other qualified facilites in underserviced parts of the country which are ready and willing to assume these responsibilities when support becomes available.

The enclosed summary of a recently prepared report by the maternal and child health professional staff will indicate the enormous dimension of the problem and their recommendations to ameliorate the situation. The current level of funding for these 10 centers is $2 million. In order to continue and expand services, $3.6 million would be required in the 1976 title V appropriations for Sections 503, 504, and 511.

We are cognizant and deeply aware of the need to tighten belts during this uncertain phase of our economic development. It is because of this need for austerity that we urge your consideration of the comparatively small expenditure over the next few years, of less than $1 per afflicted child, which will amount to a considerable savings in the future of tax dollar expenditure due to the preventive care nature of the program. The catastrophic costs of acute episodic hospitalizations, and the stabilization of a large percentage of the Nation's potential manpower, are significant factors in favor of the solidification of the pediatric pulmonary program, an ambulatory preventative service.

Mr. President, on behalf of these seriously ill children, we urge that you review this request—compassionately as a parent, and judiciously as our Chief Executive.

Sincerely,

Hon. J. Bennett Johnston, U.S. Senator; Hon. Lindy (Mrs. Hale) Boggs, Member of Congress; Hon. Alan Cranston, U.S. Senator; Hon. Andres J. Hinshaw, Member of Congress; Hon. Peter H Dominick, U.S. Senator; Hon. William L. Armstrong, Member of Congress; Hon. James P. Johnson, Member of Congress; Hon. Hiram Leong Fong, U.S. Senator; Hon. Spark M. Matsunaga, Member of Congress; Hon. Pete P. Domenici, U.S. Senator; Hon. Manuel Lujan, Jr., Members of Congress; Hon. James L. Buckley, U.S. Senator; Hon. Bella Abzug, Member of Congress; Hon. John M. Murphy, Member of Congress; Hon. Richard S. Schweiker, U.S. Senator; Hon. Lawrence Coughlin, Member of Congress; Hon. Joshua Eilberg, Member of Congress; Hon. Warren G. Magnuson, U.S. Senator; Hon. Joel Pritchard, Member of Congress; Hon. Russell B. Long, U.S. Senator; Hon. F. Edward Hébert, Member of Congress; Hon. John V. Tunney, U.S. Senator; Hon. Charles E. Wiggins, Member of Congress; Hon. Floyd K. Haskell, U.S. Senator; Hon. Donald G. Brotzman, Member of Congress; Hon. Patricia Schroeder, Member of Congress; Hon. Daniel Ken Inouye, U.S. Senator; Hon. Patsy T. Mink, Member of Congress; Hon. Joseph M. Montoya, U.S. Senator; Hon. Jacob K. Javits, U.S. Senator; Hon. Charles B. Rangel, Member of Congress; Hon. Hugh Scott, U.S. Senator; Hon. William A. Barrett, Member of Congress; Hon. William J. Green, Member of Congress; Hon. Jaime Benitez, Resident Commissioner; Hon. Robert N. C. Nix, Member of Congress; Hon. Henry M. Jackson, U.S. Senator; Hon. Brock Adams, Member of Congress; Hon. Herman E. Talmadge, U.S. Senator.

SUMMARY OF THE PEDIATRIC PULMONARY PROGRAM

(A review to determine the present state of the program and to develop recommendations for future support and direction. Prepared by the maternal and child health programs of the Bureau of Community Health Service, Department of Health, Education, and Welfare. Revised September 1974)

This is a report of an indepth review of 10 regional pediatric pulmonary centers that have been under Federal support since 1968. Although funded through fiscal year 1974 by the regional medical programs service, programmatic responsibility was transferred to the Bureau of Community Health Services in July 1973. At that time, it was indicated that a review of the 10 existing centers and the

overall program be undertaken as a base for developing recommendations for future financial support and program direction. A basic conceptual aspect is its identification of the essential elements for pediatric pulmonary disease case and proposed plan of a broad-based health delivery system that links together multiple resources to provide that care. Such a system would be of benefit in the implementation of a national health insurance program.

The report begins with a brief overview of the nature and extent of chronic pulmonary disease in children (CPD). Major conditions in the CPD category are defined, such as asthma, bronchitis, bronchiectasis, and cystic fibrosis, and tabular data presented to describe the magnitude of the problem, in terms of number of children affected; days of school loss and hospitalization; and restricted activity. It is estimated that over 10 million children in the United States suffer from CPD, and of these 10 million, 30,000 are being treated in the 10 funded pediatric pulmonary centers. Other aspects of the problem are also examined, such as the impact on families and the need for teams of medical and allied health personnel with expertise in coping with the diseases. The prevalence of CPD is being further brought to light by the screening programs of titles V and XIS (EPSDT).

Contained in the report is an inventory of existing resources and linkages that could be correlated to expand the services of these 10 centers (see attachment for list), such as MCH and CC programs in the 56 States and political jurisdictions, as well as other qualified private facilities. The report describes the observations and findings of site visits to these centers, made by multidisciplinary review teams composed of MCH personnel and outside experts. Although standards of medical care and teaching are generally of high quality, there are still unmet needs and areas that could be strengthened if adequate funding were available.

There is also a section which deals with the function of an ideal pediatric pulmonary center and which defines minimum acceptable facilities. The report concludes with recommendations for expansion of the center network in suggested geographical areas of high incident rate, and recommendations for enrichment of the 10 federally funded centers. Guidelines of maternal and child health support of pediatric pulmonary centers, authorized under title V, have now been published in the Federal Register.

Please see attachment 2 for proposed timetable and budget.

THE WHITE HOUSE,
Washington, December 24, 1974.

Hon. HIRAM LEONG FONG,
U.S. Senate,
Washington, D.C.

DEAR SENATOR: I wish to acknowledge and thank you for the December 20 letter to the President in which you joined with 38 of your congressional colleagues to express your deep concern over the well-being of the American children who suffer from chronic pulmonary diseases.

You may be assured that your presentation on behalf of increased funding for the pediatric pulmonary program, under title V of the Social Security Act, will be called to the President's attention without delay. In addition, I will make certain that a copy is made available to the appropriate Presidential advisers.

With kind regards,

Sincerely,

PATRICK E. O'DONNELL,
Special Assistant to the President.

Dr. GODDARD. Thank you very much. We will be happy to answer any questions.

Mr. NATCHER. Dr. Goddard, we want to thank you for your appearance before our committee at this time and also we want to thank you for coming. Thank you very much.

WITNESSES

JAMES MITCHELL, ACTING EXECUTIVE VICE PRESIDENT FOR THE INTERNATIONAL ASSOCIATION OF REHABILITATION FACILITIES
CHARLES RICHMAN, DIRECTOR, PRODUCT DEVELOPMENT, INTERNATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. NATCHER. Our next witness is Mr. Ted Hipkins.

Mr. MITCHELL. Mr. Chairman, Mr. Hipkins was unable to come today. As you may know, he was appointed president of the Appalachian Hospitals and will be coming with the International Association of Rehabilitation Facilities.

I am James Mitchell. I have with me Mr. Charles Richman who was responsible for the surveys we took of our member facilities upon which we base our testimony.

Mr. NATCHER. Mr. Richman, we are glad to have you appear at this time. We will be pleased to hear from you.

Mr. MITCHELL. Thank you, Mr. Chairman.

Mr. Chairman, my name is James Mitchell and I am the acting executive vice president of the International Association of Rehabilitation Facilities (IARF). I appreciate this opportunity to present testimony before this committee on the need for appropriations for the support, development, and improvement of rehabilitation facilities. These appropriations are authorized under the provisions of the Rehabilitation Act of 1973 to provide such support under title III of the act. IARF is a private voluntary association representing more than 650 vocational and medical rehabilitation facilities serving over 200,000 handicapped individuals throughout the United States. These rehabilitation facilities are now serving approximately 200,000 handicapped individuals on an annual basis.

Rehabilitation facilities are an essential part of the rehabilitation program and process through providing medical and vocational services to those individuals who are seriously and severely disabled. A wide range of services including medical rehabilitation, work, and personal adjustment, vocational evaluation, sheltered workshop employment, counseling, and placement, psychosocial services, et cetera, are provided within the rehabilitation facilities. Many of these services are supported through purchase of service from community based rehabilitation facilities under section 110 of the Rehabilitation Act. In recent years, approximately 20 percent of all clients served by the State vocational rehabilitation program have been served in rehabilitation facilities and approximately 28 percent of all case service funds were expended for these services.

As private nonprofit community organizations, these facilities do not have direct recourse to taxes in order to meet their capital and operational needs and requirements. In addition, due to the current economic climate, access to local community funds for this purpose has been extremely limited, and in many cases just does not exist. In the past, the Federal Government has played a major role in the establishment and development of rehabilitation facilities in this country. Funds for planning, construction, staffing, training of handicapped clients and expansion and improvement of these facilities have been an integral part of Federal support and service program

under the Rehabilitation Act. However, in the past few years, the executive branch of Government has chosen to ignore many of these facility development and program development needs. It has been falsely assumed that such needs can be met through purchase of services funds alone and that there is not a great need for special consideration and appropriations for facilities under project grants authorized under title III of the act. This has been evidenced by the fact that administration budget request for fiscal year 1976 does not include a request for construction funds and that the request for facility improvement and training services grant moneys reflect a decrease from levels appropriated in the past 3 years.

The steady refusal by the HEW and OMB to include such funds for facilities in the budget is having and will continue to have an adverse effect upon the quality and availability of rehabilitation services. This is true for a variety of reasons. Among these reasons are the increasingly stringent limits on rates of payments for services, the inability of many private nonprofit facilities to compete successfully in the money market for capital investment funds, the effect of the recession on fundraising and subcontracting activities. H.E.W. itself projected the need as being in excess of $300 million for planning, construction, improvement, and initial staffing of rehabilitation facilities ["Rehabilitation Facility Needs in the 70's—A National Summary of the Need for Rehabilitation Facilities, U.S. Department of HEW"]. These projected unmet needs have still not been met today.

We now ask this subcommittee to act in appropriating sufficient sums of money to begin to meet the unmet needs for services to handicapped individuals engaged in rehabilitation programs within rehabilitation facilities. We specifically request that this subcommittee appropriate the following funds: Facility construction grants in the amount of $40 million; initial staffing grants in the amount of $10 million; project planning in the amount of $2 million; training services grants in the amount of $8 million; facility improvement grants in the amount of $15 million; technical assistance grants in the amounts of $1 million and $5 million for capitalization of the mortgage insurance program. These requested sums reflect moneys which will only minimally meet the need to provide for the comprehensive rehabilitation needs of the handicapped served within rehabilitation facilities. Funds for facility construction and development would be particularly helpful in dealing with a number of hardship situations. The following are but a few examples of facilities having an urgent need for such funds:

The Madison Opportunity Center, Inc. of Madison, Wis., is a vocational rehabilitation facility providing transitional and extended workshop employment, work activity programming, adult basic education, occupational therapy, and recreational activities for more than 200 handicapped individuals. Those served currently have a number of disabilities and many are multiply disabled. These individuals are currently being served in two separate facilities, one adapted industrial building constructed in the late 1940's and another constructed in the 1930's. These facilities were not constructed to allow for the special needs of the handicapped and cannot be adapted to allow for barrier free accessibility. In order to meet the target

of serving the more severely disabled, the Madison Opportunity Center is seeking a new 55,000 square foot facility which will require $650,000 in capital funds plus funds for the purchase of land. This facility will be designed to be totally barrier free and will allow for the employment, training, and rehabilitation of the most severely handicapped. Other sources of private and public funds have been sought unsuccessfully. Without such funds, the handicapped in Madison, Wis., will be deprived of acutely needed services.

Almost 3 years ago, Hurricane Agnes devastated the east coast of the United States. Due to this natural disaster, the United Rehabilitation Service Inc. of Wilkes-Barre, Pa., sustained severe structural and flood damage. Today, this comprehensive facility is serving only 200 handicapped individuals from the community although the preflood capacity accomodated 400 individuals. The rest are now at home awaiting services that can assist them in achieving productive lives. Those with the most severe and limiting disabilities including ambulatory disabilities have had to be refused services due to the limitations caused by damage to the physical plant of this facility. In the near future, this facility will be forced to move from its current site. A total of $4 million in construction and development funds will be required to adequately provide the medical, psychological, vocational, speech and hearing, physical therapy, and other comprehensive rehabilitation services needed by the citizens of Wilkes-Barre. Almost every possible avenue of funding has been explored without any success to date. The appropriation of funds under the Rehabilitation Act for construction would provide this facility the resources to rebuild and continue to serve its community.

In mid-May the Harris County Center for the Retarded, Inc. of Houston, Tex., will be celebrating the opening of a nationally unique high rise residence for the mentally retarded and mentally handicapped. This residence will be run like a hotel and some $500,000 of funds under the Developmental Disabilities Services and Facilities Construction Act were utilized to construct this structure. However, these facilities will only provide housing for the severely handicapped involved in the Harris County program. In order to provide an expansion of services and programs for residents, an expansion of the current service facilities will be required. An additional 10,000 square feet will be required in the sheltered workshop to serve an additional 120 severely handicapped individuals so that a total of over 300 individuals can be provided with meaningful employment, activity, and service. It is estimated that $500,000 will be required to meet these essential expansion and renovation needs. Otherwise these individuals who suffer from epilepsy, cerebral palsy, visual handicaps, and the multiple handicapped retarded will be forced to suffer for want of day programing which will make their lives more meaningful and productive.

These are but three examples of uses to which funds appropriated under title III of the act can be applied and of the benefits to the handicapped individuals being served. In order to determine the extent of the need for facility construction, expansion, improvement, and program development, IARF conducted several extensive surveys of the field in March. One survey was conducted by the IARF facilities specialist division and provides information of Federal funding needs in each of seven facility project grant areas. This data was supplied

by the State vocational rehabilitation specialists and supervisors who are responsible for the administration of the rehabilitation facility program on a State level. These individuals are in a position to have knowledge and awareness of the needs for such programs in their own States.

In addition, a second survey of rehabilitation facility operations was undertaken by IARF to determine the financial, capital, operational, and programmatic needs of facilities. More than 300 medical and vocational facilities responded to this survey, and based upon this sample, a consistent pattern of near capacity utilization with an accompanying need for fiscal support was identified. Capital expenditure needs over the next year for building, expansion, renovation, staffing, equipment, operation capital, and wage subsidies apparently cannot be met alone by earned income, fees, donations, or local community funds. From the data accumulated in recent months, a consistent pattern has arisen reflecting the need for facility improvement and development, with the accompaning lack of funds to meet this need. There has been an increased demand for rehabilitation facility services as more severely handicapped individuals are being served and as States proceed rapidly in the process of returning mentally handicapped individuals to the community through deinstitutionalization. The most critical need exists within vocationally oriented facilities where even though case service monies are available, there is a lack of institutional capacity to provide this service.

The immediate capital expenditure requirements of the more than 300 facilities surveyed, which could only be partially met by the funds requested, total more than $200 million. Since this sample represents the needs of no more than 10 percent of the medical and vocational rehabilitation facilities in this country, it is but a tip of the iceberg. The true need is far greater than that sampled. Further, it does not reflect the need for the development of facilities in areas not presently served, which will not be established without some sort of Federal capital assistance.

It is worthy of note that the Federal Government itself is creating the need for capital improvment at the same time that it is providing no help in meeting this need. In addition to the exceptional utilization rate of facilities by the State-Federal rehabilitation program, several other programs have impacted on facilities. The Occupational Safety and Health Act is one program that has created an urgent need for substantial renovation and improvement of facilities to upgrade the safety of the working environment for handicapped individuals employed in them. Similarly, the Wagner-O'Day Act, which has provided new opportunities for the employment of the handicapped, is often constrained in its application by the lack of access to capital on the part of facilities.

I would also like to stress the need to capitalize the Rehabilitation Facilities Insurance Fund authorized under Section 303, Mortgage Insurance for Rehabilitation Facilities, of the Rehabilitation Act of 1973. IARF has repeatedly urged the Rehabilitation Services Administration to activate this program. The facilities survey that I referred to earlier indicates that approximately 100 of the 300 facilities surveyed (or 33 percent) could presently utilize federally insured loans to meet some of this capital improvement needs. This program

is designed to be self-financing and, if properly administered, it will involve no outlay of Federal funds. In authorizing the mortgage insurance program, the Congress provided the same assistance for rehabilitation facilities which is now provided through various agencies to hospitals, nursing homes, group practice clinics, and the like. Regulations for this program have been drafted by HEW but have not been published, presumably because no money has been appropriated. Nonprofit facilities serving the severely disabled have an extremely difficult time borrowing money in the commercial market, if for no other reasons that the lenders fear the prospects of dealing with defaults. A mortgage insurance program would help to eliminate this major obstacle to financing facility operations.

Although this testimony has focused upon appropriation levels for those programs authorized under title III, we would also like to state our support for appropriations under other titles of the act. We strongly urge the authorized funding of basic State grants in the amount of $720 million and innovation and expansion grants in the amount of $42 million. The basic State grant appropriation will allow for the services for State vocational rehabilitation clients at entitlement levels for which the States can provide matching funds. With regards to the innovation and expansion program, the requested level will provide an incentive to the States in developing innovative and improved service programs, especially for the most severely handicapped. Furthermore, we support appropriations in the amounts of $32 million for research and $28 million for training. Each of these ancillary support programs are essential to providing an improved state of the art as supplied by trained professional personnel. Finally, under title III, we request that $5 million be provided for Projects With Industry, which provides one needed mechanism for incorporating handicapped individual into the competitive labor market.

Rehabilitation facilities may vary in the type of services offered or the disability group served, but they are all directed toward the goal of restoring the ability of the handicapped to function gainfully in society. There is a strong trend, supported by IARF, to provide an ever-widening range of services within comprehensive rehabilitation facilities which can provide integrated and coordinated medical and vocational services. Furthermore, facilities continue to be immediately responsive to the service needs of ever greater numbers of severely handicapped individuals. If rehabilitation facilities are to meet the challenge of serving the handicapped fully with the highest quality services, personnel and programs, it is essential that the Federal Government encourage and support their efforts.

In conclusion, I would like to commend this subcommittee for being generally responsive in the past to the service and rehabilitation needs of the handicapped and of rehabilitation services within community-based facilities. I urge that you carefully consider the need to maintain an adequate facility capacity to allow for the delivery of these needed services. I have appended summaries of the survey data referred to in the body of this testimony. Should you have any questions regarding my comments, I would be glad to be responsive.

[The attachments follow:]

[Addendum I]

INTERNATIONAL ASSOCIATION OF REHABILITATION FACILITIES (FACILITIES SPECIALIST DIVISION)

SURVEY OF STATE FUNDING NEEDS—REHABILITATIVE FACILITIES—FISCAL YEAR 1976

In March 1975, IARF conducted a survey through the auspices of its facilities specialist division in order to determine Federal fund requrements for reliabilitation facilities. Facilities supervisors and specialists in each State were contacted and asked to complete a survey inventory indicating the projected needs for funding for facility related projects Estimates of funding needs for each of seven project grant programs authorized under "Title III—Special Federal Responsibilities" of the Rehabilitation Act of 1973 (Public Law 93–112). Respondents were asked to base these requirement estimates upon the assumption that additional appropriations could be made available to meet these needs and not upon current levels.

A total of 40 State vocational rehabilitation agencies responded to the survey. The following represent the aggregate totals of annual estimated dollar requirements:

ESTIMATED FEDERAL FUNDING NEEDS

	Number of grants	Annual requirement
I. Projects with industry (sec. 304(d))	56	$7, 137, 000
II. Projects for vocational training services (sec. 302(b))	70	9, 394, 600
III. Project development grants (sec. 301(d))	96	3, 800, 100
IV. Construction grants (sec. 301(b))	97	42, 756, 000
V. Initial staffing grants (sec. 301(c))	94	13, 419, 116
VI. Facility improvement grants (sec. 302(c))	206	10, 071, 045
VII. Technical assistance (sec. 304(e))	264	1, 578, 500
Total	883	88, 156, 361

[Addendum II]

INTERNATIONAL ASSOCIATION OF REHABILITATION FACILITIES

SUMMARY OF IARF—REHABILITATION FACILITIES OPERATIONS SURVEY

IARF conducted a comprehensive operations survey of its institutional membership during March 1975. The purpose of this survey was to obtain data regarding the need for funds during fiscal year 1976 for facility construction, improvement, and development.

The following is a summary of capital needs of 333 respondents to the survey:

	Requirements
Medical and comprehensive facilities (medical component):	
Capital expenditures over next year	$25, 976, 000
Capital expenditures over next 2 years:	
Expansion and renovation	12, 501, 000
New construction	33, 032, 000
Equipment and materials	10, 156, 000
Total	55, 689, 000
Vocational, psychosocial and comprehensive facilities (vocational component):	
Capital expenditure needs over next year:	
Building	$27, 649, 000
Construction expansion/renovation	68, 188, 000
Staffing	52, 892, 000
Equipment	51, 017, 000
Operating capital	4, 450, 000
Client wage subsidy	2, 019, 000
Total	206, 215, 000

The dollar requirements indicated are those which cannot be met through fees, donations, earned income, or local community funding sources. More than 27 percent of all facilities responding indicate that they occupy buildings that are more than 30 years old and in many cases these structures are not adequate to fully serve the handicapped.

With regard to utilization and client capacity, the following data was obtained from respondents:

Medical and comprehensive facilities (medical component):

	Number of clients
Total client capacity:	
Outpatient	55,135
Inpatient	12,133
Total capacity	67,268
Total clients referred but awaiting service:	
Outpatient	728
Inpatient	843
Total awaiting service	1,571

The ratio of inpatient capacity to those awaiting service indicates the need for a 7-percent increase in service capacity.

	Number of clients
Vocational, psychosocial and comprehensive (vocational component):	
Total client capacity	52,291
Total awaiting service	6,255

The ratio of total client capacity to those referred but awaiting service indicates the need for an overall 12-percent increase in service capacity. A total of 172,860 clients are serviced annually in vocational facilities on a nationwide basis. These facilities report an 85-percent utilization rate. This data clearly indicates that the current utilization of both medical and vocational rehabilitation facilities are exceptionally high and that there is a demonstrated need for expansion to accommodate clients awaiting service.

Certain other selective facility needs were also sampled in the survey. The following is data obtained relative to the projected utilization of mortgage insurance, should it become available under the Rehabilitation Act during fiscal year 1976:

	Number of facilities
Medical and comprehensive facilities (medical component):	
Could utilize mortgage insurance (10 percent)	7
Could not utilize mortgage insurance (90 percent)	62
Total (100 percent)	69
Total mortgage amount to be insured	$5,757,000
Vocational, psychosocial and comprehensive (vocational component):	
Could utilize mortgage insurance (41 percent)	103
Could not utilize mortgage insurance (59 percent)	146
Total (100 percent)	249
Total mortgage amount to be insured	$40,064,000

Mr. NATCHER. Mr. Mitchell, we want to thank you and Mr. Richman for your appearance this morning. Thank you very much, gentlemen.

CHILD HEALTH SERVICES

WITNESSES

DR. ARTHUR SALISBURY, VICE PRESIDENT FOR MEDICAL SERVICES, NATIONAL FOUNDATION—MARCH OF DIMES

CLYDE E. SHOREY, JR., ASSISTANT TO THE PRESIDENT, NATIONAL FOUNDATION—MARCH OF DIMES

Mr. NATCHER. Our next witness is Dr. Arthur Salisbury.

Dr. SALISBURY. With me is Mr. Clyde Shorey, our representative in the Washington area.

Mr. NATCHER. We are glad to have you with us, Mr. Shorey.

Dr. SALISBURY. I am Dr. Arthur J. Salisbury, vice president for medical services of the National Foundation—March of Dimes. I appreciate very much the invitation of this committee to testify in reference to appropriations for maternal and child health services under title V of the Social Security Act.

During a 20-year period, beginning in 1938, the National Foundation—March of Dimes was fully concerned with one disease—poliomyelitis. This period happily came to an end in 1958 when the Salk vaccine had been developed and found effective in preventing that disease.

Thereafter, The National Foundation—March of Dimes turned its resources and energies to another major, but much more complex, problem—the problem of birth defects, which we defined as abnormalities of structure or function present at birth and due to prenatal abnormalities. Birth defects outnumber and outweigh all other health problems of infants and children in our Nation. Each year approximately 210,000 infants are born with abnormalities which will significantly affect their lives and the lives of their families and the society in which they live. But they do not all live. Birth defects cause or are associated with 50 percent or 30,000 of the deaths in the first year of life; 15 million people in this country are living with their lives significantly altered by birth defects.

The National Foundation—March of Dimes is concerned about another and related group. These are the 240,000 infants who are born each year in this country prematurely and smaller than normal. Many of these will die in the first weeks of life but a large proportion will survive with brain damage, mental subnormality and other handicaps. They will survive requiring assistance from the Nation's resources while contributing less to these resources.

The National Foundation—March of Dimes strives to reduce the toll of mortality and morbidity of these damaged babies through programs of research, medical services, health education of the public and education of health professionals. Our efforts are directed toward both prevention and treatment. This work is supported entirely by voluntary contributions from the caring and concerned public.

It is obvious, however, that a voluntary agency can serve primarily in helping to stimulate, initiate and demonstrate the ways of improving and extending health services for mothers and infants. The responsibility for continuing and maintaining these services ad for inaugurating a large portion of new efforts must be met by governmental bodies using tax moneys. We are, therefore, deeply concerned about the levels of appropriation for health services and medical care for mothers and children who are unable to obtain these services because of monetary and other barriers.

For the current fiscal year, the last Congress appropriated $295 million for maternal and child health services under title V. This amount, although it permitted little or no expansion of services, at least prevented the reduction of services which would have been unavoidable had the administration's request for $265 million been accepted by the Congress.

For fiscal year 1976, the administration has requested $212 million. This amount will be totally inadequate because the States, in order to qualify for a share of these funds, must, as is mandated in the

current law, establish new programs in maternal and infant care, intensive care of newborn infants, diagnostic and treatment services for children and youth, dental services for children and family planning services. Meaningful programs cannot be initiated if the Federal share of their cost is set at an unrealistically low level.

The National Foundation—March of Dimes can attest to the fact that current programs for prevention and treatment for mothers and children are clearly not meeting the needs. We receive requests for grants of funds from hospitals, community-based health agencies and from local and State health departments which exceed our fiscal capability by manyfold. Additionally, our chapters are overwhelmed by requests for financial assistance to pay costs of treatment for children with birth defects. This clearly indicates the current inadequacy of the crippled children's program.

This period of questionable economic stability, recession, and mounting unemployment is certainly going to be attended by an increasing need for new and expanded public health services for pregnant women, infants, and children. As more families become unemployed, the financial barrier between them and the availability of preventive and early diagnostic health services will be insurmountable. Women will not seek or obtain prenatal care; immunizations will be neglected; carious teeth will not be treated; the quality of food intake will deteriorate and ill health will result; seemingly minor symptoms will be neglected until major and costly corrective measures are required. The time to curtail public services is surely not when more people are becoming dependent on these services.

In the past few years, medical science and technology have advanced dramatically in the treatment of complications of pregnancy and of abnormalities of newborn infants. Deaths and life-long handicaps are now preventable if this science and technology can be readily available and accessible to every patient who needs them. Now is the time to initiate new efforts toward this end. Now is the time to put these scientific advances to work for the benefit of the individual and the society.

For these reasons, we strongly advocate an increase in funds for maternal and child health services in the next fiscal year. We do this with full realization that there are critical problems in the economy and that governmental spending cannot continue to increase at the rate of recent years. But we are fully convinced that expenditures for maternal and child health services, at this time of mounting need and of increasing capability for saving lives and preventing damage, will benefit the Nation in future years more than any other expenditure the Government can make.

We recommend, therefore, an increase of 10 to 15 percent above current levels in the appropriation for maternal and child health services under title V of the Social Security Act for fiscal year 1976. The total amount appropriated should be approximately $340 million. Increases are most needed in the amounts in the formula grants to the States to enable them to maintain and expand programs of preventive services and early treatment. We recommend funding of the maternal and child health formula grants at a level of approximately $230 million and the formula grants for crippled children's services at $80 million. Research and training programs are also vital and should

receive $25 million. Other specialized and categorically directed activities should have $5 million.

If these amounts are appropriated, this Congress can be confident that it has demonstrated concern for the health of generations of Americans who will follow us. Can there be any more important priority?

Mr. NATCHER. Dr. Salisbury, we want to thank you and Mr. Shorey for appearing before our committee at this time.

Mr. NATCHER. We will hear from Dr. Richard Naeye.

We are glad to have you appear. I believe you are professor and chairman of Milton S. Hershey Medical Center, Pennsylvania State University. A beautiful section of the State, doctor, and we are glad to hear from you.

PENNSYLVANIA STATE UNIVERSITY

WITNESS

DR. RICHARD NAEYE, PROFESSOR AND CHAIRMAN, MILTON S. HERSHEY MEDICAL CENTER

Dr. NAEYE. I appreciate the courtesy of being able to present my testimony to you.

My name is Richard Naeye. I direct research programs dealing with black lung disease and with various disorders in newborn infants at the Pennsylvania State University College of Medicine in Hershey, Pa. Our program is supported by grants and contracts from the National Institutes of Heatlh and I am here to make recommendations for fundings of several of their programs.

President Ford has proposed a fiscal year 1976 budget that would drastically curtail current research and prevent new investigative efforts on a wide range of major health problems. The President has seriously underestimated the value of the research opportunities that lie immediately ahead. Let me be specific about opportunities with which I am personally familiar. More than $1 billion are being spent this year on Federal black lung benefits. At the same time, research into the cause and prevention of the disorder have been markedly curtailed. This decline in research effort is occurring at a time when a breakthrough may be in sight for determining the causes of the disorder. Let me be specific. Aside from free silica, it has never been determined just which components of coal mine dust are toxic. It has long been known that dust in anthracite mines is more toxic than dust from many bituminous mines but we have never fully understood why. Some clues have now appeared. We have a new test-tube analytic system, using living blood cells from miners. In this system, anthracite is more toxic than bituminous dust and higher-rank bituminous dust is more toxic than dust form low-rank specimens. If further studies confirm these findings, we will have a means for testing the toxic properties of specific chemical constituents of mine dust.

Two institutes at the NIH are responsible for research into black lung and other pulmonary disorders. President Ford's recommended budget cuts would preclude new research into black lung disease and reduce current investigative efforts. I recommend a 1976 budget for NHLI and NIOSH at the 1975 levels with upward adjustments for

inflation. This recommendation is modest because I well recognize the deep problems that currently exist in our national economy.

Let me touch on two other major national health problems where breakthrough opportunities may be at hand. Both the public and the Congress have shown a continuing interest in preventing the sudden infant death syndrome, commonly called crib death. This is the most common cause of death between 1 week and 1 year of age in the United States. Investigations at our own and other laboratories this past year have generated strong evidence that the infants have subtle abnormalities in brain function long before death. We think these abnormalities may gradually disappear as the infants grow older. The mechanism of death often appears to be apneic episodes, that is periods when breathing stops during sleep. Important new leads have developed on how these apneic spells might be prevented. The time is at hand when an increased investment in research might soon reduce the death rate from this disorder.

Childhood accidents are another major problem on which we have new information. Such accidents are the leading cause of death between 1 year and 14 years of age. In a large, partially completed, NIH sponsored study it appears that many accidents are a subtle form of child neglect. The same is true for many childhood deaths due to pneumonia. There is real hope for reducing deaths due to accidents and pneumonia in children if we can only find a way to improve the bonding process between mothers and their newborn infants. When this bonding process is inadequate, some mothers subsequently neglect their infants and such neglect leads to the fatal accidents and failure to seek medical care when a child develops pneumonia. The NICHD sponsors major research programs designed to help improve the bonding process between mothers and their newborn infants. We have also found that mother's smoking makes an important contribution to the death of their infants from pneumonia. I doubt that anyone will find a quick solution to mother's smoking.

Finally, I want to report on prospects for reducing perinatal mortality in the United States. Fourteen nations have lower rates than the United States. We at last are discovering just which disease processes are responsible for this excessive perinatal mortality in the United States and we are relating these disease processes to specific factors in pregnancy. We have found that specific factors in pregnancy such as diet, anemia and infections appear responsible for most of the disease processes that lead to the excess deaths. NIH-sponsored research has made these new discoveries possible and I strongly urge that this research momentum be continued by appropriating funds for the NICHD at the 1975 level of $126 million plus the addition of $6 million for a 1976 total of $132 million. This latter total would permit the start of new programs specifically designed to reduce the shocking levels of perinatal mortality which are a disgrace to our health care system.

The past 2–3 years have been an exciting time in many areas of medical research. I hope the Congress will permit the progress to continue.

I thank you very much.

Mr. NATCHER. Dr. Naeve, we certainly appreciate your appearance before our committee.

Our next witness is Dr. John MacQueen, president of the American Academy of Pediatrics. You have with you?

Dr. MACQUEEN. George Degnon.

American Academy of Pediatrics

WITNESSES

DR. JOHN MacQUEEN, PRESIDENT
GEORGE K. DEGNON

Dr. MacQueen. I speak in behalf of the many members of the academy providing services in the MCH and CC programs.

The academy is aware of the importance of those MCH and CC programs to child health and is alarmed at the budget to reduce the support of the programs.

It is the position of the academy that the State programs have been one if not the most successful of the Federal health programs.

Because they are older and well established they do not have the glitter of some of the new programs, but in fact, they are the programs that have initiated the new ideas in maternal and child care and they currently are responsible for the provision of the majority of the health services that have been determined by Congress to be important.

The State CC programs constitute the major health delivery system in the Nation to provide care for the handicapped children.

On this day, throughout the Nation, in every State, there are teams of physicians, nurses, physicial therapists, clinical psychologists, and speech and hearing personnel working together to provide the special coordinated services that are required by the handicapped child. These teams function in hospitals, mobile clinics, and community clinics.

This Federal-State system provides services for approximately 500,000 children each year.

Who are the patients served? They are the palsied, the children with fibrocystic disease, the children with congenital heart disease, the children with rheumatic heart disease. They are the epileptic and children with muscular dystrophy. They are the children with orthopedic problems. They are children with complex problems which need coordinated medical services because there is no other health system in the Nation which provides that care.

A decision to decrease the CC budget would be a national policy decision to decrease the services for these children.

The State MCH programs provide a variety of services. One of the best known are the well-baby clinics that are held in the towns and cities of the Nation. They provide services for children who wouldn't otherwise be served.

These programs provide comprehensive care for high-risk indigent mothers and their babies. Their effectiveness has been demonstrated and there is no doubt that these programs decrease the neonatal death rate in the population they serve. In fact, at this time, no other solution has been proposed to solve this major national problem of the high infant mortality rates in the centers of our cities.

The State MCH programs are now responsible for the children and youth clinics that serve the children who live in the centers of cities. These centers provide a special type of medical care that is required by the children they serve—a type that includes health aids, outreach, health instruction, et cetera. To date, this has been the best solution for the provision of medical care for these children, and the clinics have provided an organization within which pediatricians can work to provide this type of needed care.

It is the policy of the American Academy of Pediatrics that maternity and infant care programs and children and youth programs should be supported.

The Maternal Child Health Services of the Federal Government has initiated and supported new and important methods of providing care for mothers and children. The MCHS initiated and supported the creation of a regionalized system of centers to provide specialized care for high-risk infants.

It is generally accepted that we will not be able to reduce the infant mortality rate much below the 13–14 per 1,000 rate under the best of conditions until we create a system of centers that are staffed and equipped to provide the most modern emergency treatment for the neonate that is born with the complex problems related in maturity.

It is to the credit of the MCHS that they have initiated and continue to provide leadership in the creation of these centers.

The Maternal Child Health Services has been a leader in the field of health manpower. They pioneered the funding of training programs to train pediatric nurse practitioners. Nurses with such training are able to extend health care to more children. There are now some 50 training programs and over 200 such nurses; 23 of these training programs are dependent upon MCHS for support. Reduced funding could remarkably decrease this important manpower program.

The MCHS has been a leader in a number of fields of child care.

It developed the model legislation for State programs for the identification of PKU patients in the maternity nursery and it continues to provide the services needed to care for such children.

It developed and continue to support the regional amputes centers for children with multiple handicaps.

It developed and continues to support the regional cardiac centers for children who live in States where there are not cardiac centers.

MCHS has been heavily involved with conducting clinical research concerning the contemporary problems of mothers and children.

The American Academy of Pediatrics is concerned that in the face of this remarkable record of progress and service to children, the administration has proposed a cut in the MCHS budget with its effect on the State MCHS and CC programs.

The answer to the question, "What would happen if the budget is cut," is quite simple. There would necessarily be equivalent cuts in the services provided by the State program and there would necessarily be equivalent cuts in the national leadership concerning child problems by the Maternal and Child Health Washington office.

One aspect of this problem is acute and requires special note.

For the last several years these programs have functioned on a continuing resolution during the first several months of each fiscal year, until the final Federal budget was determined. This was acceptable in the past when the level of the continuing resolutions was essentially the same as the level of the preceding year.

But if the administration's proposed budget determines the level of the continuing resolution for the coming year, the MCH and CC programs would necessarily function for a matter of several months at essentially one-third less than the 1975 budget. That degree of cut could not be absorbed. There would necessarily be major cutbacks in services and personnel.

The committee is, therefore, requested to recommend that the Congress establish the continuing resolution for the MCHS budget as of July 1, 1975, for the coming year at the fiscal year 1975 level.

Mr. Chairman, we have developed for you a written report which contains our recommended level of funding and we leave these for your consideration.

Mr. NATCHER. We want to thank you for your appearance.

[The report follows:]

RECOMMENDATIONS

Specifically, the academy recommends the following appropriation for fiscal year 1975:

Maternal and child health formula (section 503)	$204,000,000
Section 516 for existing projects	25,000.000
Crippled children's program (section 504)	80,290,000
Research and training	27,960,000
Sudden infant death syndrome	2,750,000
Total for MCH and SIDS	340,000,000

These programs have been the principal manifestation of this Nation's commitment to health care for mothers and children for four decades. Unfortunately, the Federal appropriation indicated for the adequate development of programs throughout the States has not kept pace with indicated needs. In a number of States there are counties with no child health services of any kind; others are dependent on the part-time services of a general public health nurse; some States restrict their child health clinics to infants, or to babies and preschool children because funds do not permit services to school-aged children. The number of prenatal visits has been curtailed by some States because of rising costs of maintaining maternity clinics. However, we are encouraged by the responsiveness of the congressional appropriations committees to these problems, particularly last year.

The $28 million increase requested for formula grants is only a portion of an estimated $100 million required by the States to adequately address the statutory mandate that there be a program of projects in each State. Additionally, the statute requires that by July 1, 1975, States must show that they are making services available to children and mothers in all parts of the State. These requirements are practical, appropriate and, indeed, necessary. Minimum adherence to the statute would increase the number of geographic areas providing health care to mothers and children from 209 to 372, or an additional 163 additional programs among all of the States.

These formula grant programs are humanitarian. They are addressed to reducing infant mortality, lowering and eliminating morbidity among children. Where these programs have been established, infant mortality rates have been cut by as much as 30 and 50 percent.

These formula grant programs are cost effective. Through preventive care they have significantly reduced costly hospitalization among children. Among children served 7.7 percent needed hospitalization in 1968 compared to 2.4 percent last year. They provide a comprehensive scope of necessary medical and health services. It was reported last year that title V projects had a per capita expenditure of $130 per child registered compared to medicaid expenditure of $300 per child. The MCH formula grants are a good investment.

The crippled children's programs represent a coordinated effort within each State to screen and identify children who are crippled or are suffering from conditions which may lead to crippling. Medical, surgical, and other corrective services are provided free to these children, many of whom have multiple conditions. The impact is tremendous for thousands of these young children are spared a lifetime of disability and dependency upon society—and instead they become healthy, wage-earning productive citizens.

But, the crippled children's program is in severe trouble—every State has a long backlog of cases, conditions requiring attention are not included for eligibility, and we are now finding that the scope of programs among the States is being limited and in some instances staff are being terminated.

Concurrently, because these programs are inhibited by funding and manpower shortages from assuming their full responsibility, new categorical programs

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periodically emerge for the care of children with conditions which should be covered by the crippled children's program, some of which are juvenile rheumatoid arthritis, hemophilia, diabetes, lead poisoning, Tay Sachs disease, and sickle cell anemia. With adequate funding for the crippled children's programs, the need for many of these categorical efforts for the younger population might be obviated.

The immunization program of the Center for Disease Control is one other program of particular concern. The academy recommends an appropriation of $12 million so that diseases now preventable by vaccines such as polio, reubeila, measles, diphtheria may no longer curse our children. Immunizations are effective, they are cost beneficial. The CDC program has realized tremendous savings through the consolidated purchase of vaccines for the States, yet unless the immunization program budget is raised to $12 million States have indicated they will be forced to reduce the scope of their programs—thereby needlessly exposing children to these diseases.

Through the annual appropriation process the Congress provides tangible evidence of its priorities. We applaud your efforts in elevating the importance of health care. We recommend that the health care of children emerge as a clear national priority over the next few years.

Mr. NATCHER. Our next witness is Dr. Philip Norman, professor of medicine of the American Academy of Allergy.

We will be pleased to hear from you.

AMERICAN ACADEMY OF ALLERGY

WITNESS

DR. PHILIP NORMAN, PROFESSOR OF MEDICINE

Dr. NORMAN. Mr. Chairman and members of the committee. I am Dr. Philip S. Norman of Baltimore, Md. I am a professor of medicine at the Johns Hopkins University and head of the clinical immunology division of the medical school. I am director of an asthma and allergic diseases center sponsored by Johns Hopkins at the Good Samaritan Hospital in Baltimore. I have served for 4 years on the National Advisory Allergy and Infectious Diseases Council and am president of the American Academy of Allergy, representing some 3,000 physicians who specialize in allergy and immunology.

As a result of the astonishing advances in the basic science of immunology, the more than 35 million sufferers from allergic problems have in sight the means for safe and effective relief from many of their problems. Without atempting to describe in detail the advance in laboratory science, it should be noted that discoveries in the past 10 years have identified the abnormal overproduction of a specific type of antibodies made in the lymph glands of the respiratory tract, gastrointestinal tract, and skin as the derangement in internal body physiology that leads to unnecessary defensive reactions to otherwise harmless substances such as pollens, molds, foods, food additives, insects, animals, and drugs.

These diseases are not trivial and certainly are not "all in the head." They are known to result from a definable disorder of the body's defenses against outside assault from viruses, bacteria, and toxins and result not only in the grave problems of asthma and sudden allergic death, but also in lesser conditions such as eczema, hay fever, and food allergy which are a major cause of absenteeism from work and school. With 35 million people in the United States involved, 8 million of

whom have asthma, a major disease of children, allergies represent a major health problem. Scientific advance has already led to an improved test tube method of diagnosis for pollen, mold, insect, and animal allergy which is now beginning to be offered in the care of patients.

Scientists delving into the mechanism of action of these allergic antibodies have found that they affix themselves to certain cells of the body and when there is a new exposure to one of the allergic substances, there is a rapid release of noxious substances from these cells which, in turn, cause the swelling, itching, wheezing, and sneezing characteristic of allergic reactions. A search for drugs to halt this reaction has led to the development of chromolyn, now used in an inhaled form to prevent asthma but, unforunately, it is ineffective by other routes.

Investigation of the mode of action of injections of extracts of allergenic substances, the shots or "desensitization" used by specialists in allergy show that after a year or more, the production of the antibodies, which confer allergy, is inhibited. Recent investigations of the chemistry of the allergic substances suggests that it may be possible to separate the ability of injections of the substances to inhibit antibody production from their ability to cause allergic reactions. Animal study confirms that one can inhibit these antibodies selectively by injections of chemically modified allergic substances. Human trial of this new method should begin soon.

The Asthma and Allergic Diseases Center program provides the forum for early testing of the applicability of advances such as these for their actual usefulness in the diagnosis and treatment of asthma and other allergic diseases.

I am trying to give the sense that there is rapid progress in the area of allergic diseases which has already given some highly useful results and appears likely to present us with even more astonishing advances in the next decade. Most of this has grown out of Federal support of research through the National Institute of Allergy and Infectious Diseases. There is continuing need for research in a variety of areas:

(1) Identification of allergic substances. Coloring, flavorings, and preservatives in prepared foods are now being recognized as a potential cause of a variety of problems.

(2) The familial nature of allergy. Specific genetic inheritance of the allergic tendency appears likely.

(3) The mode of production of allergic antibodies. Understanding of this process appears likely to lead to methods for inhibition of the process and, thus, amelioration of the allergic problem.

(4) The process of antibody induced release of noxious substances. Drugs under development which interfere with this process could halt an ongoing allergic reaction and, thus, give rapid, although short-term, relief.

Unfortunately, the President's budget provides for only $28,648,000 for the effort of the National Institute of Allergy and Infectious Diseases in allergy and immunology. This is less than $1 per allergic sufferer. A more reasonable figure, one which would allow the exploitation of discoveries made for development of better methods of diagnosis and treatment would be $34 million.

The total budget proposed by the President for the National Institute of Allergy and Infectious Diseases of $108,711,000 is a crippling cutback from the $119,369,000 appropriated last year. A professional judgment indicates that a figure of $133 million is required for the Institute to continue its present rate of high productivity of its various research and demonstrative programs.

Another distressing aspect of the administration's attitude toward NIAID is the consistent cutback year after year in the number of positions available to the Institute. This seriously hampers both its internal research program and the quality of supervision it can give to its extramural granting program. I believe the Congress should turn this trend around and allow the Institute the personnel it needs to carry out its mandate.

I might add I was on a panel of alergists by Barbara Walters on a program of, "Not For Women Only." When I mentioned the expense of not less than a dollar, there was a gasp of incredulity from the audience gathered in the studio.

I appreciate this opportunity to appear before you.

Mr. NATCHER. Dr. Norman, we want to thank you for your appearance. I especially want to call attention to one statement which you made on page 3 as to the identification of substances, color, preservatives. We had that about a week ago, Doctor, before another committee on which I serve which hears the requests for pure food and drug. We stressed the importance with them at that time to make every effort to extend all their investigations concerning the coloring, flavoring preservatives in prepared foods. As you point out in your statement, it is very important.

Doctor, thank you very much.

Our next witness is Dr. Hans Popper, president and dean emeritus of Mount Sinai School of Medicine.

MOUNT SINAI SCHOOL OF MEDICINE

WITNESS

DR. HANS POPPER, PRESIDENT AND DEAN EMERITUS

Mr. NATCHER. Your entire statement will be placed in the record and you may proceed.

Dr. POPPER. This statement deals with four facts. We would like to document the fact that digestive diseases as a whole, including liver disease, represents a rather significant problem. Actually 22 million Americans suffer at one time or another from digestive diseases. Many of these, we realize, do not have the gravity of other diseases but they represent an interference with the quality of life. However, a significant number of these diseases are fatal. In 1969, 167,000 Americans died from diseases primarily related to the digestive tract. We are primarily interested in liver disease. Cirrhosis is one of the few diseases which has increased nationally, particularly in the young adult group, as a more important cause of death.

The second point to which I would like to address myself is the opportunities which at this time exist to do something about these diseases.

With your permission I will start with the area in which I have spent almost all my life: liver diseases. Both acute and chronic liver diseases are attracting more and more interest. I don't have to state to you that viral hepatitis is on the increase. The fact that it is being transmitted by sexual contact, even by kissing, may be a reason that the disease now is on an increase.

Again I don't have to emphasize that alcoholic liver injury is becoming more and more a problem. The problem I would like to emphasize, too, is why alcoholism is to a great extent a psychological problem. Once there was a particular segment of the population that appeared "immune"; there was a study made and it showed that blacks seemed to be protected from alcoholic cirrhosis. The black population I am talking about in Chicago, in the poor forties and fifties, didn't have enough money to buy enough alcohol to damage the liver. This has now been "corrected" in part and now the disease is rising tremendously, as more money is available.

Similarly women once were considered not susceptible by the fact they were just not drinking as much as men. In black women we now have the highest increase of cirrhosis of any people in the Nation.

The third point deals with environmental factors like toxic substances in the surroundings or at work. The liver handles and metabolizes almost all environmental factors. Thus it is the target of many environmental factors leading to its own injury.

We only recently appreciated that liver diseases can be related to socioeconomic standards of the country, as when alcohol becomes more easily available. I would like to emphasize that these diseases are far more prevalent with us than in the underdeveloped parts of the world.

What are the opportunities? That is another point I want to bring to your attention. It is difficult to tell you in detail of the many opportunities which exist immediately or for the long haul. As to liver disease, we are in an exciting time. Hepatitis can now be diagnosed whereas it could not before, readily. I am talking here of viral hepatitis and alcoholic hepatitis. We have now procedures developed where the presence of the disease will be recognized, as well as who is a potential risk and we can now try more successfully to protect the persons suffering and try to develop improved therapy.

With respect to intestinal diseases, we have learned a lot about new hormones in the intestinal trace which were virtually unknown up to about 10 years ago. Now we have discovered and learned about these hormones and how they affect the normal functioning of the digestive system and how they are related to intestinal diseases. These hormones can be produced in pure form. The Institute, the NIAMDD, and the National Advisory Council on which I am serving are now proposing to set up facilities to make these hormones and to distribute them to research workers in the field to clear up the situation regarding many digestive diseases in which they may be involved, as diabetes has been cleared up, when the hormone insulin became available.

You have heard many similar statements before, about research opportunities. I want to close with this last part: My colleagues wish to call to your attention that the budget proposed by the President is lower by $25 million, as you undoubtedly know, than the fiscal level at which the National Institute of Arthritis, Metabolism, and Digestive Diseases, is operating at this time, despite the fact the Institute is

being told by the Congress to enlarge its activities in many fields such as arthritis and diabetes.

We are, therefore, proposing a budget which is larger than the one the President submitted. You have the figures before you in the table entitled "citizens' budget." I am sure that you know more about budgets than I as a scientist could ever attempt to explain to you. I have referred in this budget not only to dollars but also to "slots"—manpower positions. If this institute is to embark on the newly mandated activities it must receive from you additional positions above its current manpower ceiling.

Mr. Chairman, I am very grateful for the opportunity to appear and testify before you.

Thank you.

Mr. NATCHER. Dr. Popper, we appreciate your coming, you have made an excellent statement and we thank you.

[Dr. Popper's prepared statement follows:]

Mr. Chairman and the members of the committee: I appear before you today to speak on behalf of the research and training activities of the National Institute of Arthritis, Metabolism, and Digestive Diseases, and particularly its digestive disease program. My name is Hans Popper, and I am a doctor of medicine, having obtained my degree from the University of Vienna. I also have a Ph. D. degree in pathology from the University of Illinois and four honorary degrees from the universities of Louvain, Bologna, Vienna, and Hanover. I am the recipient of the Julius Friedenwald Medal of the American Gastroenterological Association for outstanding achievement in gastroenterology; the Distinguished Lecture Award, American College of Gastroenterology; National Achievement Award, Digestive Disease Society; and the Distinguished Service Award of the International Association for the Study of Liver Disease. I am consultant physician to the Walter Reed Army Medical Center, the Center for Disease Control, the U.S. Public Health Service. I am a member of the editorial board, "Experimental and Molecular Pathology," and of "Human Pathology," and a former member of the editorial board of "Cancer Research" and former editor for liver, "Gastroenterology." I am past president of both the International and American Associations of the Study of Liver Diseases. I am diplomate of the American Board of Pathology and the American Board of Nutrition and Fellow of the American Medical Association, the College of American Pathologists, and the College of Physicians. I am the author of over 350 publications including several books and monographs. I am a member of the National Advisory Council, National Institute of Arthritis, Metabolism, and Digestive Diseases.

I deem it a privilege to testify before you today on behalf of the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), and for the many scientists and research institutions all over the United States working with research grant support from this Institute. Since the area of digestive diseases is my own field of research, and being a member of its national advisory council, I am quite familiar with the work of this Institute.

Digestive diseases include such well-known disorders as peptic ulcer, regional ileitis, and ulcerative colitis, and encompass many other diseases of the intestinal tract and associated organs about which too little is known. These include cirrhosis of the liver, gallbladder disease, and pancreatitis.

Digestive diseases, which according to recent statistics affect at least 22 million Americans, are among the most common illnesses of this country, ranking second only to diseases of the heart and circulatory system in the number of resultant physician office and house visits. Turning again to these statistics, digestive diseases were the primary cause of death for 167,000 Americans in 1969, the latest year for which statistics are available to me. This means they represent 8.8 percent of all fatalities. In addition, digestive diseases were a contributing cause in another 5 percent of all deaths.

The statistics also indicate that 11 percent of the population has chronic digestive disease. This rises to 35 percent in persons over 65 years of age. Digestive diseases cause 10.5 percent of hospitalizations of less than 30 days in non-Federal hospitals and 13 percent in Veterans' Administration hospitals. In

the military services, 10 to 14 percent of all patients are treated for digestive diseases.

From an economic standpoint, it is important to record that industrial absenteeism of longer than 7 days in 12.5 percent of the instances is caused by digestive diseases. These few figures illustrate the size of the total national problem of digestive diseases. This problem is aggravated by a shortage of specialized manpower, both physicians and paramedical profesisonals. This compares most unfavorably with the figures obtained for other groups of specialists, for instance cardiologists and hematologists, both in practice and as teachers in medical schools.

Turning to specific groups of digestive diseases, I beg indulgence if in view of my own interests I first discuss diseases of the liver. Liver cirrhosis is the fifth most common cause of death in adult males in the United States. In contrast to many other diseases which have been stationary or declining during the past few years, cirrhosis, together with accidents, significantly increased as the cause of death in the past 10 years.

Liver diseases, both acute and chronic, are attracting particular interest for four specific reasons:

(1) The rise in viral hepatitis is brought about by the increased transfer of blood products from person to person, not only by blood transfusions but also by simple contact with blood, not only by the addict who spreads it with his needles but also because body fluids, such as saliva, often contain traces of blood thus producing infection by contact. Viral hepatitis can also be spread through sexual activities. Thus, gradually, the infectivity of the population rises. Both massive fatal necrosis of the liver and chronic hepatitis, potentially terminating in cirrhosis, become more frequent.

(2) Spreading alcohol abuse accounts for the increase of acute and particularly chronic liver diseases. Ironically, improvement of the purchasing power of the lower socioeconomic stratum of the population and changes in the cultural patterns, particularly in the behavior of women, is greatly responsible for these increases. In previous decades, blacks and other minorities have had less access to alcohol for economic reasons. This gave the false impression of relative immunity. At present, the incidence of cirrhosis in them is increasing. Similarly, women were also considered relatively immune to alcoholic liver injury, an "immunity" which simply reflected less drinking and was the result of social patterns. Today, the rise in alcoholic liver injury, including cirrhosis, is most conspicuous in black women. While the behavior and psychiatric problems created by alcoholism entail disturbing social costs, the greatest cost to society and the individual including long-term hospitalization, is derived from chronic liver disease, the sequelae of which are the responsibility of physicians with special concern for digestive diseases.

(3) Various environmental toxins have their first contact in the body with the intestinal tract and the liver, particularly if taken with food. Beside the alcohol abuse, already mentioned, and viral hepatitis in addicts. Liver injuries produced by potent drugs given for legitimate therapeutic reasons have risen conspicuously and the limiting factor for many otherwise useful agents such as effective anesthetics, anticancer drugs, antituberculosis and antihypertensive agents. Moreover, industrial toxic agents have been shown to injure the liver in quite unexpected situations. For instance, liver injuries, both cancerous or fibrotic, resulting in portal hypertension have been observed in workers in plants where vinyl chloride is being polymerized to commonly used plastic. Other types of liver injury result from toxins found in food such as mold-contaminated peanuts. The size of this problem is, at this time, entirely unpredictable. Furthermore, in injuries of many other organs also, the metabolic function of the liver is of key importance in either detoxification or in activation of factors which may become carcinogenic or agents which produce malformation in various body sites.

(4) Only recently did we fully appreciate the significance of the socio-economic status in the incidence of liver and intestinal diseases with the advantaged being at a much higher risk. The causes are not only hygenic elements which determine spread of disease, but more importantly, nutritional inadequacy. As a matter of fact, in addition to frank malnutrition, hidden nutritional deficiencies, more widespread in the disadvantaged population but also found in the affluent, may interfere with the proper metabolism of the liver, causing liver and possibly other diseases. These considerations apply even more to the underfind better ways to control the disease.

Similar examples about significant incidence of other digestive diseases should be presented. For instance, gallstone disease ranks fifth among causes of hospitalization. About 15 million Americans are estimated to have gallstones; in many cases they cause no symptoms while in others they result in debilitating disease. Surgery is the standard treatment and some 375,000 gallbladder operations are performed each year at an average cost of $2,000 each. About 6,000 people die each year because of this surgery—an additional incentive for us to find better ways to control the disease.

Peptic ulcer or its symptoms will strike about 10 percent of all male adults in the United States at some time in their adult lives. About 10 million Americans are estimated to have ulcer symptoms on an intermittent basis and each year about 10,000 Americans die of complications of peptic ulcer. The annual economic loss in the United States due to peptic ulcer alone is estimated at just under $1 billion.

Diseases of the stomach and intestines may afflict persons of any age, but most often affect those in the younger and middle-aged groups at the peak of their most vigorous and productive periods often causing prolonged and expensive hospitalization and countless social and emotional problems. Crohn's disease or regional enteritis, a chronic inflamatory condition of the small intestine, causes severe pain, fever and weight loss, with prolonged periods of hospitalization, and frequently necessitates abdominal surgery involving the removal of affected portions of the intestine. In about half the cases, the disease begins at the age of 20 to 30. Many victims of ulcerative colitis are afflicted with their disorders for years and eventually must undergo extensive surgery. The loss due to digestive disease-related disability and lost income due to premature death has been calculated at 16 billion in 1973. Of all disease categories, digestive diseases rank third in causing economic loss, exceeded only by cardiovascular disease and accidents.

My attempt to present to you the need for additional research and trained manpower to cope with both research and patient care would be academic if we could not point out that research would be able to do something about these needs.

Prevention of the disease is becoming possible in some areas and knowledge of the pathophysiologic mechanism of the disease may permit development of devices to arrest and control the disease.

Permit me to list a few examples of promising opportunities and at the same time point out research achievements based on work by or supported by the National Institute of Arthritis, Metabolism, and Digestive Diseases. Astonishing progress has been made in viral hepatitis in the last years, accelerating indeed in the last few months. This progress followed many frustrating decades of intensive but unsuccessful study. In type B hepatitis, associated with the so-called Australian antigen discovered by sheer serendipity by Dr. Boruch Blumberg formerly of this Institute only a few years ago, the accelerating pace of discovery has brought us near the development of a vaccine, already proven effective in infected chimpanzees. Since we now know that this disease is not only transmitted by blood transfusion but also by contact, the spread of the disease may be arrested. In just the past few weeks, Blumberg presented evidence that hepatitis type B may play an important role in primary cancer of the liver, particularly widespread in underdeveloped countries, which thus would be prevented by a vaccine. Recent studies of the anatomy and localization of the virus and its products, particularly in the liver, may elucidate the mechanism of the chronicity resulting in crippling and life-threatening cirrhosis. Moreover, is has just become possible to identify by practical techniques type A hepatitis. This permits the study of the epidemiology of the disease as the first step in its eradication. The investigations on viral hepatitis and the study of the metabolism of the liver controlling the action of drugs and other environmental factors appears to me to be the most promising area where research achievements should have a rapid effect on improving the Nation's and indeed the world's health.

In still other research, Institute grantees have produced for the first time what seems to be alcoholic hepatitis in baboons by giving them alcohol in combination with an otherwise nutritionally adequate diet. Since alcoholic hepatitis often precedes alcoholic cirrhosis in sum, it will be important to see whether the baboon eventually develop cirrhosis. These and other studies promise to reveal whether alcoholic hepatitis is the link between fatty liver—which is a reversible condition—and cirrhosis—which represents irreversible end-stage damage—as many scientists believe it is. The researchers have also produced

evidence suggesting that alcohol consumed by chronic drinkers might have an injurious effect upon cells of the small intestine strikingly similar to the damage to liver cells which often occurs in alcoholics.

The mechanism of gallstone formation is not established. About 3 years ago, investigators supported by this Institute reported that long-term oral administration of chenodeoxycholic acid—a natural bile acid—can result in dissolution of long-standing cholesterol gallstones—90% of all gallstones in the United States are cholesterol stones.

Consequently, the Institute awarded an initial contract to Cedars-Sinai Medical Center in Los Angeles to supervise and participate in a long-term collaborative clinical study of dissolving gallstone with the aid of chenodeoxycholic acid. The study will run for about 5 years and will ultimately be a multimillion dollar project.

I would like to emphasize that this is the first comprehensive study undertaken to determine the efficiency of a medication for gallstone dissolution and, through additional research, to find out how gallstones are formed and what causes their formation. About 900 patients will be treated at 10 medical centers throughout the country. Panels of distinguished gastroenterologists and researchers all across the United States have been formed to assist. This chemotherapy approach, provided it is proven free of undesirable side effects, may offer an alternative to surgery for many patients and may save million of dollars a year in hospital and related costs.

One of the Institute's main goals is to lessen the toll that peptic ulcers now exact in sickness, deaths, and dollars.

The Institute launched a substantial attack on this problem in April by supporting the establishment of a Peptic Ulcer Center to be operated by the UCLA School of Medicine and the Veteran Administration Wadsworth Hospital Center in Los Angeles. A sizable Institute grant will support this 5-year research effort which involves 20 key investigators with multidisciplinary expertise. The problems cost will run more than $4 million.

Intestinal hormones are an area developed rapidly in the last decade. They have many effects on the body, some of them just in the process of being understood. Just as was the case with other hormones, better known for many years, such as insulin and pituitary hormones, the availability of pure agents is the first step in their rational use and in control of diseases. The Institute has now organized a major effort to obtain such hormones and to provide them to many investigators.

Diarrheic disorders, a widespread curse of mankind, are being fully investigated based on studies of the intestinal membranes. The Institute has in progress an in-depth study of Crohn's disease. 14 research centers across the country are now evaluating the value of drug treatments. Three drugs are being studied to determine their effectiveness to prevent intensification and recurrence of this disease.

Money invested in digestive disease research has borne a rich harvest of fundamental as well as practical information. There is considerable expectation that as this wave of interest and discovery in digestive diseases gains momentum we will be able to replace much of the empiric approach to therapy of digestive disease by rational therapy, based on an improved understanding of the pathophysiology of these disorders.

Because of the numbers of people affected, it seems likely that digestive diseases will continue to be cared for on many levels, as they are now. The research training needs for this category of disease are large. Provision must be made for a continuing supply of motivated individuals for teaching and research so that understanding of digestive diseases continues to grow.

Mr. Chairman, there is no question that awareness of digestive disease as a major health and economic problem has increased. Nor is there any doubt that money invested in digestive diseases research has borne a rich harvest of fundamental as well as practical information. The likelihood that future bright hopes will be realized for digestive disease research is in jeopardy. At a time when we need to push ahead to capitalize on the gains that we have made in the understanding of the physiologic basis of digestive disease, research resources are being threatened. At a time when we should translate our new understanding into more effective patterns of practice at all levels of medical care, funds for training are either reduced or threatened to be phased out.

Intelligent planning for the education and training of manpower for future research in the digestive diseases in obviously desirable, but it is especially different now because of all of the uncertainties of future biomedical research.

The need for manpower trained to care for patients with digestive disease is not at issue because of the overwhelming evidence that digestive disease is a major health problem that affects many millions of people—more than any other category of illness. Although only cancer of the digestive tract and cirrhosis are major "killers", the morbidity and costs of digestive disease are staggering. Hospitalizations for digestive disease outnumber those for heart disease by 5 to 3; hospitalization for peptic ulcer and cholecystitis each outnumber hospitalizations for coronary disease by a similar proportion.

Yet the President has proposed health-research appropriations for the next fiscal year that do not match the research goals we seek to achieve. It appears that $1 of research funds per year is allotted for one patient with digestive disease. Basic research, the foundation upon which all other research rests, and research into the other diseases important to the Nation, are being cut back. The normal research mechanisms of NIH are being supplanted by what can only be described as bureaucratic fiat from a central site in the executive branch—the Office of Management and Budget. Budget managers are now telling health professionals and biomedical researchers what is needed for programs in health research.

The currently proposed administration budget for 1975 means a significant depletion of resources for programs supported by most of the Institutes of the National Institutes of Health. These Institutes, and the extramural programs they support in virtually every medical school, research center, and teaching hospital in the country, will be funded in fiscal 1976 at levels equal to approximately 25–35 percent below several years ago, if one adjusts for inflation and population growth.

More important even than the needs of the individuals directly involved are the requirements of society as a whole. Leaving aside humanistic and even scientific considerations, just on a cost-accounting basis it has been amply proven that the medical research dollar brings itself back 20 times over—and this is not just a figure of speech—in terms of reducing society's burden for medical care, hospitalization, saved working days and years, loss of tax revenue from the disabled, costs of institutionalization or other forms of care for the long-term invalid, etc. This information comes from the "The Dollar Benefits of Biomedical Research: A Cost Analysis." printed not long ago in the Journal of Laboratory of Clinical Medicine.

It should not be forgotten that the NIH cuts are being felt, and will be felt even more severely, in virtually every medical care and research facility in the country and in every medical school. Not only is potential teaching faculty being lost, but there is a very real threat that many if not most schools will be forced to reduce some of their present faculty. New schools are likely to be particularly hard hit.

Eight years ago, the first Conference on Digestive Disease as a National Problem was held in Bethesda, Md., in February 1967. That conference led to the first steps of a coherent Federal program in this important, yet relatively neglected field.

A second national conference was held in Bethesda on May 18, 1973. Approximately 200 participants evaluated the achievements of the preceding 6 years and assessed prospects for further gains in research, teaching, and medical care for those millions of persons suffering from digestive disorders.

I would like to quote from the summary report which contain the findings, conclusions, and recommendations of authorities from universities, government, labor and industry:

"Most current support for research, training, and education in digestive diseases comes from tax funds channeled through the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD).

"All told, the amount of research funds available in proportion to the importance of digestive diseases is much too low. Because support for research in this area has been so limited, there has been little encouragement for young researchers to enter the field."

Now, the administration budget for fiscal year 1976 gives a poor priority to biomedical research. Most of the recent gains originated in work that at its inception seemed far removed from the clinical realm and represented fundamental biomedical research supported by NIH. It would be an incalculable tragedy if the flow of medical progress were to be halted or slowed, as it would certainly be were the administration budget to become the governor of our scientific funding.

Mr. Chairman and members of the committee, I have studied the proposed administration budget. In brief it allots to the NIAMDD about $25 million less for

fiscal year 1976 than this Institute had in fiscal year 1975. This Institute has received cutbacks in funds over the last several years, and the proposed administration budget is nothing short of disastrous. Moreover, because of the annual escalation in the cost of doing biomedical research due to inflationary erosion in the value of the dollar, the proposed administration budget will buy even less in terms of health research than appears on the surface.

I am proposing, instead, a citizen's budget which is a lean, realistic document which would permit this Institute to continue its valuable work for the Nation's most important and disabling chronic diseases. It includes adequate funds for research in all the broad disease areas for which the Institute is responsible including more realistic funds for digestive diseases. In the name of the more than 22 million digestive disease patients all over the country, I urge that you increase the administration budget for fiscal year 1976 along the lines we have recommended.

I also wish to urge you seriously to add to your committee recommendations concerning dollar funds, a strong recommendation to allot to the NIAMDD an additional 25 to 30 positions and to raise the manpower ceiling for the Institute accordingly, to permit it to carry out the various increased mandates which the Congress has given it during this past year. Only in this fashion will this hard-pressed Institute be able to continue and expand its activities in accordance with the dictates of the Congress and the needs of the Nation.

I wish to thank you, in advance, for your considerations of the above and to express my pleasure at the opportunity of testifying here before you today.

FISCAL YEAR 1976 BUDGET PROPOSED BY CITIZENS FOR THE NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES

[Dollar amounts in thousands]

	Positions	1975 estimate	Positions	1976 President's budget	Positions	1976 citizens' proposal
Extramural:						
Research grants		$120,421		$103,546		$148,200
Centers		2,816		2,862		4,000
Fellowships		3,386		4,109		6,200
Training		9,088		235		4,700
Research and development contracts		7,405		6,750		8,500
Total extramural		143,116		117,502		171,600
Direct operations:						
Laboratory and clinical research	432	22,709	432	23,462	479	24,902
Epidemiology, biometry and field studies	18	1,289	18	1,298	18	1,298
Research management and program services	116	6,007	106	6,147	119	6,430
Total, direct operations	566	30,005	556	30,907	616	32,650
Total	566	173,121	556	148,409	616	204,250

Our next witness will be Mr. Jonas Morris, National Council of Community Mental Health Centers.

We will be privileged to hear from you at this time.

Mental Health

WITNESS

JONAS MORRIS, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

Mr. Morris. Mr. Chairman, my name is Jonas Morris and I represent the National Council of Community Mental Health Centers, an organization of nearly 450 programs delivery community mental

health services. Many of these programs have NIMH grants and all of them rely on Federal funds of one type or another.

NCCMHC fully supports the minimum recommendations of the Coalition for Health Funding, but since those are minimum recommendations, we will be recommending, in this presentation, the appropriation of higher levels—levels which we believe are necessary to respond to the demand for both expanded and new services.

We are confident that pending legislation to extend the community mental health center program—H.R. 4925—will be enacted soon; the appropriations we are requesting are to be made pursuant to this legislation. The details of our request are contained in our prepared statement, which we would like to have inserted in the record in its entirety. We are recommending appropriation of $259.7 million for the program for fiscal 1976. The need for funding CMHC programs in fiscal 1976 is acute, for the program has been under severe constraints ever since President Nixon proposed, in early 1973, eliminating Federal support for the program. The grants that have been awarded since then are the result of litigation to release impounded funds. There are now 52 applications totaling $27 million for staffing grants which have been approved but cannot be funded because of lack of money, and they have been waiting in limbo for more than 1 year.

Also, I should point out to you that contained in our recommendation for continuation grants to presently operating community mental health centers are sufficient funds to provide personnel in these centers with a cost-of-living increase—one which the administration has denied.

Attached to our testimony, Mr. Chairman, is a list of the approved but unfunded programs that would be helped by appropriation of the magnitude that we recommend.

Mr. NATCHER. We thank you for your appearance before our committee.

[The statement follows:]

STATEMENT ON THE FISCAL YEAR 1976 APPROPRIATIONS FOR COMMUNITY MENTAL HEALTH CENTERS ON BEHALF OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

(By Jonas V. Morris, Executive Director, NCCMHC)

This statement is presented by the National Council of Community Mental Health Centers (NCCMHC), representing 317 community mental health centers, most of which receive Federal funding under the Community Mental Health Centers Act, and all of which receive Federal funds from one source or another, and another 119 agencies which are in the process of developing CMHC programs or which have a direct interest in community mental health.

Currently, authorizing legislation to extend and revise the Community Mental Health Centers Act is pending in Congress. H.R. 4925 has been reported by the House Interstate and Foreign Commerce Committee, and S. 66 has been passed by the Senate. The appropriation levels suggested in this statement assume that this legislation will be enacted, and further that the authorization levels for fiscal year 1976 will be based upon a compromise beween the current House and Senate figures.

NCCMHC is a member of the Coalition for Health Funding, and fully supports the minimum recommendations recently published by CHF in its booklet, "Appropriations Recommendations for Federal Health Programs Fiscal Year 1976—an Alternative to the President's Proposal."

The minimum recommendations made by CHF are the funds necessary to prevent the deterioration of existing worthwhile programs and thus insure that a proper infrastructure is in place at the time Congress enacts and implements a program of national health insurance. The CHF recommendations are not responsive to the need for services confronting the various health programs. The NCCMHC recommendations presented in this statement are higher than the CHF minimum recommendations because they are designed to respond to the need in the field for more complete community mental health programs.

The need for funding for CMHC's programs in fiscal year 1976 is acute. In 1974, the Congress passed a bill extending the CMHC program (H.R. 14214) but this was later vetoed by the President after the sine die adjournment of the 93d Congress. As a result, no authorizing legislation for fiscal year 1975 has been enacted as of this date, and no new funding has been available for CMHC programs for almost 1 year.

Fifty-two applications for staffing grants were approved during fiscal year 1974, but could not be funded due to lack of money. These applications have now been pending in the approved-unfunded stage for more than 1 year. The total cost of funding these applications would have been $24 million—however, since under the new legislation the programs and requirements which CMHC's must meet in order to receive Federal funding have been changed, it is likely that these applications will have to be revised, and the cost of each grant will be increased. Attached to this statement is a list of approved-unfunded applications, and the amount for which the grant was to be made.

The following table shows the new authorizations in H.R. 4925 and S. 66 for fiscal year 1976, the President's budget request, and the NCCMHC suggested appropriations for the new grant programs authorized by the pending legislation.

FISCAL YEAR 1976 SPENDING ON COMMUNITY MENTAL HEALTH CENTERS

[In millions of dollars]

Program	Authorizations		President's budget	NCCMHC proposed appropriations
	H.R. 4925	S. 66		
Initial operating	50.0	100.0	0	50.0
Conversion	20.0	20.0	0	20.0
Financial distress	15.0	15.0	0	15.0
Consultation and education	10.0	9.0	0	10.0
Planning	3.75	5.0	0	2.0
Facilities	5.0	15.0	0	0
Continuations	(1)	(1)	159.9	172.7
Total	103.75	164.0	159.9	259.7

[1] Such sums as necessary.

INITIAL OPERATING GRANTS

As mentioned above, at the end of fiscal year 1974 there were 52 applications for new staffing grants approved by the National Advisory Mental Health Council which could not be funded due to the lack of funds; 33 of these were for new CMHC's, the remaining 19 were for growth grants.

Under the new legislation now being considered in Congress, only new centers would be eligible for initial operating grants: Growth grants for new services would be funded under a separate authority "conversion grants."

The new legislation also provides funding for a part of the total costs of operating a center, instead of just the costs of staffing, and changes the Federal matching percentages so as to provide higher matching funds in the initial years, and less in the last few years of an 8-year grant. As a result of these changes, the Federal costs for initial grants will increase.

These costs will also be higher because of additional requirements in the new legislation. The five essential services all CMHC's have provided in the past (inpatient, outpatient, partial hospitalization, emergency, and consultation and education) would be expanded to include specialized programs for the elderly and for children (previously funded under pt. F, now repealed), screening of individuals being considered for admission to State mental hospital, followup care of those discharged from State mental hospitals, including the provision of transitional halfway house services for such individuals, and, where these serv-

ices are needed in the catchment area, drug and alcohol abuse programs (previously funded under pts. C and D, now repealed).

As a result, the average initial operating grant will be considerably higher than the average staffing grant has been: NCCMHC estimates $800,000 compared with about $500,000.

NCCMHC therefore suggests an appropriation of $50 million for initial operating grants, enough to fund about 60 new community mental health centers. This would enable the 19 centers which applied for initial grants in fiscal year 1974, but which were not funded, to begin operating and about 41 other new centers to be funded. This would be less than the number of new centers funded in fiscal year 1972—the last year in which the program was funded under normal circumstances (i.e., before the Nixon administration's proposal to terminate a number of Federal health programs). However, we recognize that at this time it is extremely difficult for the Federal Government to commit itself to large expenditures.

CONVERSION GRANTS

The conversion grant is a new authority contained in the legislation now being considered in Congress. It is intended to provide very short term funding to CMHC's funded under the old act so as to enable these centers to expand the services they offer and provide all of the 12 services which would be required under the new legislation.

Conversion grants therefore replace the pt. F children's services grants of the old law and are also designed to provide funding for specialized services for the elderly, and screening services, and followup care (including transitional halfway house services), for those discharged from State institutions. Under the proposed legislation, the existing centers would have only 2 years to make this conversion from the old level of service to the new. Federal funds for this purpose would be available only in fiscal years 1976 and 1977. By that time, any center not meeting the new requirements would lose all its support under this bill. Thus, a center with a staffing grant in its fourth year in fiscal year 1977, but which did not convert to the new level of service, would be ineligible for further continuation staffing or operating grant support in fiscal year 1978. There is therefore great urgency for funding conversion grants.

Since the time period for conversion is so tight, and since there are some 500 existing centers, most of which will need some assistance under this authority, NCCMHC strongly urges the subcommitte to appropriate the full $20 million authorized for this program in fiscal year 1975. In fact, this is clearly insufficient for the need, and substantial assistance will have to be generated by these centers from State or local governments, or other funding sources if they are to meet the new requirements. The Federal dollars will, however, provide an important stimulus for raising these other funds.

FINANCIAL DISTRESS GRANTS

Financial distress grants are also a new authority, and would provide limited support to those centers which have received 8 years of staffing grant support, but which demonstrate they cannot continue to operate without substantial cutbacks in services unless further Federal assistance is provided.

NCCMHC estimates that one-third of the centers losing Federal support will not need any further assistance, as alternative funding will be available for those programs. However, another one-third will probably need some very limited assistance in order to maintain their current levels of service, and the remaining one-third will need substantial assistance to prevent their programs from being seriously curtailed. Those centers in serious financial difficulty report that they will cut back mainly those services for which no alternative third-party funding is available; that is, outpatient and other alternatives to hospitalization. Also, these centers are already finding it extremely difficult to offer services to patients unable to pay and who have no third-party coverage.

Since these programs have already received a substantial Federal investment and particularly since a few more years of financial support might enable many of them to find alternative funding without cutting back services to their community, the financial distress grant mechanism has been initiated. CMHC's can receive only three 1-year financial distress grants under the proposed legislation, and the amount of these grants is generally 90 percent of their last continuation grant.

A total of $15 million would be authorized for financial distress in fiscal year 1976 under the proposed legislation. Of this amount NCCMHC urges appropriation of the full $15 million—sufficient to provide just over half of the 60 centers which will be eligible for financial distress grants in fiscal year 1976 with such grants.

NCCMHC estimates that all of this $15 million is required if these programs are to continue to provide comprehensive services to their community, without regard to ability to pay. We have invested too much in these centers to allow them to disintegrate or cut back services to such an extent that they cease to be a community mental health center as we understand that term.

CONSULTATION AND EDUCATION

Consulation and education grants would be a new authority to fund these important preventive programs in centers which are in their last few years of staffing or operating support, and for centers which have already received a full 8 years of Federal funding.

These grants are intended to insure that all CMHC's give adequate attention to prevention efforts and early detection of mental illness. Only in this way can we really reduce the costs of mental illness to society. The C. & E. grant will enable all centers which have become independent of Federal operating support to continue to fund these programs for which it is often hard for the center to find alternative funding. Moreover, this grant mechanism provides the Federal Government with a means of insuring that all federally assisted CMHC's continue to meet the high standards set in the Federal program, even after their staffing or operating grants run out. No CMHC can receive a consultation and education grant unless it meets all of the requirements in the proposed new legislation.

Finally, C. & E. grants would be available to any entity which meets the requirements of the legislation, except that it does not provide C. & E. services. Thus, State funded programs which now provide many of these services would be encouraged to upgrade their programs to this level of comprehensiveness in order to receive Federal funding for C. & E. services. This would greatly improve the range of services available to those communities which are served by a State program, most of which are not nearly as comprehensive as the Federal programs.

The authorization proposed for C. & E. grants in fiscal year 1976 is only $10 million. Almost 200 centers would be eligible for the C. & E. grants under this bill, 60 of them would be centers which were receiving no other Federal assistance, except perhaps a financial distress grant. It is important to fund C. & E. programs at least in these 60 centers. The formula in the bill provides a capitation payment and a matching incentive payment for funds raised from community agencies serviced by C. & E. programs. In the past, most centers have found it very hard to raise this money, but it is hoped that the Federal grant will provide an incentive to increased collections for C. & E.

To fund these 60 centers will require the full $10 million authorized; and indeed this is, we understand, how the $10 million authorization figure was arrived at. NCCMHC strongly urges that the C. & E. grant program be funded at this level in fiscal year 1976 in order to demonstrate the Federal Government's real commitment to these important cost-effective preventive programs.

PLANNING

Planning grants are authorized as a separate item in the new proposed legislation. Under the old CMHC Act, these funds were available through the regular staffing grant appropriation (up to 5 percent of the appropriation could be used for initiation and development grants). The proposed legislation expands the planning grant authority somewhat, by making both nonpoverty and poverty areas eligible for support, although poverty areas would receive priority. There are now 14 I. & D. grant applications approved but unfunded, which would require $594,000.

NCCMHC recommends that $2 million for planning grants be appropriated, assuming an authorization of $3.25 million.

CONTINUATIONS

The new legislation authorizes continuation of existing staffing grants, or the transfer of existing staffing grants into the new operations grant program, at the percentage matching levels authorized for centers in the same year of operation

as the center which is transferring into the operating grant program. Depending upon how many currently funded centers chose to transfer, and the grant years of such centers (operating grants are funded at a higher rate in early years, and a lower rate in later years) the funds needed for continuation grants under the new legislation may be different from the amount required under the old law.

Moreover, the President's budget request for continuation staffing grants disallows, for the first time ever, any cost-of-living increase factor. Thus, in fact, the continuation grant request submitted by the President represents not only reductions in Federal funds to reflect reduced percentages of support as authorized, but reductions below the amounts authorized due to inflation. In recent years a 5-percent inflation factor has always been built into continuation grants. Although 5 percent is far below the real inflation rate, the administration has now chose to disallow even this much inflation factor.

NCCMHC urges the subcommittee to include funding for continuation grants at a level which would permit at least an 8-percent inflation factor in these grants, and to increase continuation grant appropriations further at a later date if that should be necessary to allow the existing centers to transfer into the operating grant program.

FACILITIES

In view of the current financial situation, and because there are alternative sources for Federal facility assistance, NCCHMC suggests that no money be appropriated for CMHC facility grants in fiscal year 1976. A total of $14 million was made available in fiscal year 1975 through the continuing resolution, yet some of this money may not be used due to insufficient applications for facility projects under this authority unless the funds remain fully available through all of fiscal 1976.

CONCLUSION

NCCMHC suggests an appropriation of $97 million in fiscal year 1976 for new starts, consultation and education, and further assistance to the existing centers (other than continuation grants). The thrust of our proposals is fourfold:

To initiate enough new centers to keep the program moving forward although because of the economic situation new starts would be funded at a level far below the amount needed to reach our goal of nationwide coverage by 1980;

To maintain the quality of the programs which have already received 8 years of Federal funding by providing limited assistance to those in financial distress to insure that they continue to operate as community mental health centers and to provide services to those who cannot pay;

To provide funding for the existing 500 centers to enable them to expand their programs and meet the new definition of a CMHC in the proposed legislation within the 2-year time limit set forth for such conversion under the bills now pending in Congress; and

To initiate the consultation and education grant program in order to demonstrate the Federal Government's commitment to cost-effective preventive programs and to encourage additional funding for these programs from the agencies served.

In some instances, NCCMHC has recommended that the full amount expected to be authorized in the proposed legislation be appropriated. This is because in making these authorizations the committees have been extremely restrictive. Calculations were as to the actual need for funding; that is, the maximum allotment to a center, times the number of centers expected to apply became the amount authorized. Thus, instead of setting broad upper limits on appropriations, the authorizing committees have essentially set out the level of funds they feel should be spent on most of these CMHC grant programs.

The Nation is already well behind schedule for achieving the original goal of this legislation: to fund a CMHC in each catchment area by 1980. It now is very unlikely that we can achieve that goal by 1990 even at the present rate of funding.

Thank you.

CMHC staffing grants recommended for approval but not funded

Center:	Amount
Eastside MHC, Birmingham, Ala	$465,257
Marshall-Jackson, Guntersville, Ala	223,345
Southwest Denver MH Services, Denver, Colo	334,454
Jefferson County MHC, Lakewood, Colo	226,062
Pikes Peake Family Counseling and MHC, Colorado Springs, Colo	817,658
Southern New Castle MHC, New Castle, Del	267,913
South Dade MHC, Miami, Fla	554,423
Marion-Citrus MHC, Ocala, Fla	495,340
Tri-County, MHC, Palatka, Fla	517,500
South Pinellas MHC, St. Petersburg, Fla	600,071
Gulf CMHC, Valparaiso, Fla	495,468
Dalton Area MHC, Dalton, Ga	603,681
North Cobb, MHC, Marietta, Ga	273,651
Floyd CMHC, Rome, Ga	702,308
CMHC of Central Illinois, E. Peoria, Ill	1,078,584
Tri-City Comprehensive CMHC, E. Chicago, Ind	634,337
Lansdowne CCC, Ashland, Ky	343,810
Southern Bluegrass Comp. Care Center, Danville, Ky	421,876
Lake Cumberland, Somerset, Ky	$419,943
Northern Baltimore County CMHC, Towson, Md	483,907
Tufts MHC, Boston, Mass	339,630
Erich Lindemann MHC Government Center, Boston, Mass	67,568
Boston and Commonwealth of Massachusetts Treatment, Training, and Research Center, Boston, Mass	806,216
Franklin County Public Hospital, Greenfield, Mass	562,329
Newton-Wellesley-Weston CMHC, Newton, Mass	587,682
Operation Hope Community MH, Detroit, Mich	577,455
Kirksville College of Osteop. Med., Kirksville, Mo	220,000
South Central Montana Region MHC, Billings, Mont	126,349
CMHC of Atlantic County, Atlantic Area Guidance Center, Atlantic City, N.J	450,000
Monmouth Medical CMHC, Long Branch, N.J	488,194
Riverview CMHC, Red Bank, N.J	554,070
Brookdale Hospital CMHC, Brooklyn, N.Y	1,146,666
Gaston-Lincoln CMHC, Gastonia, N.C	540,000
Wayne County MHC, Goldsboro, N.C	141,591
Pitt County MHC, Greenville, N.C	226,181
Badlands Human Service Center, Dickinson, N. Dak	385,750
Memorial MH and Retardation Center, Mandan, N. Dak	303,930
Southeast Portland Compre. MH System, Portland, Oreg	923,106
Albert Einstein CMHC, Philadelphia, Pa	567,587
Intercommunity Action Inc., Philadelphia, Pa	370,502
Philadelphia Psychiatric Center, Philadelphia, Pa	406,991
West Philadelphia Consortium, Philadelphia, Pa	993,500
Southwest Pittsburgh CMHC, Pittsburgh, Pa	333,542
Divine Providence CMHC, Williamsport, Pa	762,297
York-Chester-Lancaster MHC, Rockhill, S.C	342,221
Spartanburg Area MHC, Spartanburg, S.C	493,160
Harris County MH–MR Center, Houston, Tex	119,983
Bear River MHC, Brigham City, Utah	190,715
Central Utah CMHC, Richfield, Utah	278,676
South County (Mount Vernon) MHC, Fairfax, Va	801,694
Central Comprehensive CMHC., Inc., Clarksburg, W. Va	466,770
Appalachia CMHC, Elkins, W. Va	176,385

Mr. NATCHER. Our next witness will be Dr. George Tarjan.

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WITNESS

DR. GEORGE TARJAN, NATIONAL CONSORTIUM FOR CHILD MENTAL HEALTH SERVICES

Dr. TARJAN. The National Consortium for Child Mental Health Services represents 13 troubled national organizations. There is a pattern of chronic erosion, of endless wearing away on the staffs and agencies delivering help to children, a sequence of events that has continued now for years and comes up once again this year as part of the seemingly endless flank-slashing inroad on the larger arrangements for child mental health care.

On this occasion we speak to the Congress around two major issues. We are concerned about the legislative approach to the children's services in the community mental health center programs; and we are altogether dismayed at what is happening to the training of child mental health professionals, particularly child phychiatrists.

There are 75 million people in the United States below 18 years of age. Theoretically the community mental health center program should be providing for the preventative and interventional needs of a very large percentage of these children.

In fact, only about one-fourth of our young fall within the catchment areas of the existing centers. The moneys made available to the centers for children in 1973 was $20 million; one-fourth of the children in the country in the care of the centers come to about 19 million people and we thus have moneys appropriated to the tune of something in the neighborhood of $1 per child.

It behooves us to look at how many of our children will be in enough trouble to need center help. Our usual statistical convention is that 1 child in 10 is demonstrably disturbed. That describes the child who needs help badly enough, obviously enough, so that the teacher and other students in school have usually made the diagnosis. If we focus only on those who belong to this group, that comes out pretty close to a solid 2 million children in obvious need. Let us underline we are speaking now exclusively for that one-fourth of the population the centers care for. The very largest percentage of these include the rural poor, the inner-city ghetto population, the population in greatest distress. Gentlemen of Congress, you appropriated $10 per child per year for this needy group of identifiably disturbed. That was to cover consultation, crisis intervention, inpatient care, day treatment, and outpatient therapy.

If this figure were multiplied tenfold, it would still fall into the category of a variety of gallows humor. In fact, the initial estimate of 1 in 10 frankly needing care is low, probably by a factor of 3 or 4.

Well, one might say that times are hard and children no doubt must share the privations of society. But it is not enough that the unemployed parents, the economically troubled families will predictably batter more children, neglect more children, and exploit more children this year than they are likely to have done when father and mother were employed and economically more secure? Must the children catch it both from home and from Government? It would seem

that in time of greater privation that this is the moment we should strain to supply families with more child-support services, not less.

But the clincher for us comes this year. This time around we find that there is no enabling legislation so perforce we must address you in potential terms, in the language of "if—then." "If" the enabling legislation is passed "then" please do your best to see to it that children's needs are met. But we find that in a certain sense, this area has already been addressed. The legislative provision for conversion of moneys in a new funding pattern has lumped geriatric health, child mental health, and care for patients getting out of State mental hospitals in an authorization of $20 million for 1976.

This has a fragile ring to it. Such moneys are all too easily targets for later budget trimmings, and diminishments during the heat of markup exchanges. We are concerned because times of institutional change can mean losses as well as progress for children's programs and we would ask you to give this every possible fiber of legislative support that the process allows. This means maximum funding for the conversion moneys.

A somewhat different pattern is visible in manpower manipulations. While fighting a sturdy rearguard action Congress has, in fact, slowly been dragged along by the administration. The mental health manpower budget has been steadily contracting; for example, as of this month child psychiatry training programs the country over are reeling from the recent announcement that the stipends for the bulk of their residents will be discontinued for next year. Many of the best programs, the large university programs, are built on Federal funding. Traditionally these are so organized that they serve poor children in large urban centers. As a result, once again this blow will impact first and most harshly on services to the deprived. Nothing very new or different there. But it is worth noting that there are probably not more than 2,500 practitioners of child psychiatry in the United States today to serve the same 75 million youngsters in the country we noted above. Nonetheless, these programs, stressed and threatened year after year as this subcommittee knows, are once again the focus of attack.

There are a variety of associated mechanisms that serve to lend yeast to the dismantling operation. For one thing the announcement of moneys and policies can be delayed by the Office of Management and Budget to the point that the planning for the ensuing year, program construction, recruitment, and all the associated preparations become well nigh impossible. Then unfilled positions can be cut or frozen. A series of bedevilments is possible—and practiced—that would require congressional watchdogging and legislative mandate to overcome.

The critical issue here is program preservation. When enough delays, enough diminishments, enough niggling-nibbling interferences and subtractions are engaged in, then professionals get depleted, study program directors withdraw, teachers and training supervisors throw up their hands, back off, and give up. Mental health clinicians are not unfamiliar with ambiguity and uncertainty. But it is one thing to experience this with one's clients and patients, it is quite another to know this in the realm of basic sources of supplies and essential program nutriment. The massed threats and frustrations that pile up each year are harrowing and corrosive to morale and to the

general condition of programs the country over. The recent decisions to eliminate stipends for child psychiatry trainees is accompanied by parallel cuts in psychology training and so on for other dimensions of child mental health. Gentlemen, these programs need your help and your continued support.

Mr. NATCHER. Doctor, we want to thank you for your appearance and thank you for an excellent statement.

The committee will adjourn until 10 o'clock Monday morning.

MONDAY, MAY 19, 1975.

SOCIAL SECURITY

WITNESS

HON. BILL BURLISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. FLOOD. We now have the honor and pleasure of having with us our distinguished colleague, Hon. Bill Burlison of the great State of Missouri. He is going to tell us all about social security. That is a good trick whether you do it or not, but I am sure you will try.

Mr. BURLISON. Thank you very much, Mr. Chairman.

Incidentally, this is the first time I have appeared before this subcommittee and I am sort of reluctant to do so on such a minor, insignificant matter, Mr. Chairman, but I feel that it is of great importance to a large segment of the largest populated county in my district. This county is immediately to the south of St. Louis and it has a population of about 110,000 people.

Mr. FLOOD. How far away from the nearest office are you?

Mr. BURLISON. There is a permanent office approximately 10 miles away. Now, let me give you a little of the backdrop on this. In this immediate area, in the north part of Jefferson County, which is immediately adjacent to St. Louis, just across the Meramec River, the boundary line between St. Louis County and my district, there are about 50,000 people who live in three communities that this contact station that I am seeking would serve.

There are three other contact stations in this county. Mind you, in spite of the fact that it has 110,000 people in it, it doesn't have a permanent Social Security office. But it does have these three contact stations. One of them is in a community of about 3,500; the others are in communities of approximately the same size. So we have three communities of approximately 3,500 population each which have a contact station. But in this area that I am speaking of, with a concentrated population of about 50,000 people, there is no contact station.

Now, Mr. Chairman, as I set out in my prepared statement, which is also very brief as I intend to be here, it will require only $1,612; that would be the expenses for this contact station for 1 year. The social security people have spent that much money, I dare say, in arguing with me about providing this contact station. They sent a delegation

over to my office from Baltimore. It just seems sort of ridiculous to argue about such a minor request.

Mr. FLOOD. Where is your regional office?

Mr. BURLISON. The regional office is in St. Louis.

Mr. FLOOD. St. Louis?

Mr. BURLISON. Yes, sir.

I feel that my request is eminently reasonable.

I think they very unfairly and unreasonably are denying my request for a simple contact station that would serve so many of our elderly and disabled people.

Mr. FLOOD. I couldn't have said it any better myself. That is praise from Caesar, you know.

Mr. BURLISON. Thank you, sir.

Mr. FLOOD. Thank you very much.

[The statement follows:]

Mr. Chairman, I am taking this opportunity to submit testimony to the subcommittee on behalf of the residents of Jefferson County, Mo., and particularly the area of Arnold, Barnhart, and Imperial within that county. This locale has a population of over 50,000 people and is a rapidly growing metropolitan area with the proposed developments of two new communities in the immediate future. The 1970 census showed the population of Jefferson County to be 105,248. As you can note in comparison of figures, almost one-half of the county lives in the above mentioned area. It is estimated there will be an increase of more than 40,000 in the next 10-year census period.

There is no existing social security office or contact station to meet the critical needs of the people in the surrounding area. It is necessary that the persons who need the valued counsel of the social security representatives travel approximately 10 miles to the nearest social security office in South St. Louis County. Granted 10 miles is not a great distance, but consider the elderly, disabled, and poor individuals who are seeking assistance.

In the same county we find that the cities of Crystal City, Cedar Hill, and De Soto, having populations of 3,898, 3,600, and 5,984, respectively, do have social security contact stations. In these three offices combined we find 6 personnel and approximately 58 working hours being utilized each month.

The Social Security Administration has argued that a contact station in an area encompassing approximately 50,000 people is not feasible or practicable. We see, however, that in the same county in an area with a population totaling 13,482, we have three such facilities. Since the Arnold, Barnhart, and Imperial area is much more populous than the three cities with established contact stations, I argue that there is very real need for this addition. In an estimate presented to me by the Social Security Administration, they advised that this contact station would cost approximately $31 per weekly visit. This cost estimate includes the salary for one employee at the GS–10 grade level of $14,117 for a 4-hour weekly visit, plus the costs of travel between the station and the employee's permanent duty station. Based on this information, the annual cost on a weekly basis for the contact station in the Arnold area would be $1,612. No allowance is made for space cost at this time as the other three contact stations have donated space and I assume a like arrangement could be obtained for the proposed new contact station.

I urge this distinguished subcommittee to give favorable action on this nominal request for the additional funding necessary to provide this worthwhile and much needed contact station. In the alternative, my request would be that this subcommittee mandate the Social Security Administration to carry out this responsibility with the allocated resources appropriated for the agency.

Thank you, Mr. Chairman, for your courtesy in permitting me this time before this important subcommittee.

COUNSELING SERVICE TO SMALL BUSINESS

WITNESSES

WALTER CHANNING, VICE CHAIRMAN, SERVICE CORPS OF RETIRED EXECUTIVES
JULIUS DAVIDSON, LEGISLATIVE COMMITTEE, SERVICE CORPS OF RETIRED EXECUTIVES

Mr. FLOOD. Mr. Julius Davidson, legislative committee of the Service Corps of Retired Executives.

Mr. DAVIDSON. Yes, sir.

Congressman Flood, Mr. Walter Channing of Farmington, Mich. who is the vice chairman of the National SCORE Council, will present the statement.

Mr. CHANNING. Mr. Chairman, the background of the witnesses appearing this morning is contained in the biographies attached to our statement. I respectfully request that these be included in the published hearings.

Mr. FLOOD. Without objection, that will be done.

[The biographies follow:]

BIOGRAPHY OF WALTER H. CHANNING, VICE CHAIRMAN, SERVICE CORPS OF RETIRED EXECUTIVES (SCORE)

Walter H. Channing was born in Detroit, Mich., and for 32 years, was actively engaged in the retail field.

He is a former chairman and board member of a division of the National Retail Merchants Association of the United tSates; vice president and board member of the Michigan Retailers Association; member of the Greater Detroit Board of Commerce; International Association of Department Stores, Paris, France; and the International Association of Town Planning and Distribution, Brussels, Belgium.

Following his retirement in 1954 as merchandise manager of a major Detroit department store, he served as senior consultant on marketing and retail distribution for the Organization for Economic Cooperation and Development (OECD), Paris, France, and is known in European trade circles for his work with that organization making national surveys, conducting seminars and participating in international conferences.

He has been cited for his contribution to retail distribution in Europe and in 1963 was named honorary president for life of the Chamber of Commerce of Greece in recognition of his efforts in that country. He is the author of numerous papers and articles on retailing and has appeared as guest lecturer at American and European colleges.

He is a retired U.S. Army Reserve officer, a veteran of World War II, a member of the Reserve Officers Association of the United States and American Legion Post No. 1, Paris, France.

Mr. Channing joined SCORE at its inception in 1964, was one of the cofounders and former chairman of the National SCORE Council, and in 1970 received the Presidential SCORE citation. He is presently vice chairman of the council and a member of its executive, legislative affairs, and agency liaison committees.

In 1973, he was named honorary member of Omega chapter of Alpha Sigma Lambda of the Univeristy of Detroit in recognition of outstanding achievement and service to the community.

He is married and resides in Farmington Hills, Mich.

BIOGRAPHY OF JULIUS DAVIDSON, MEMBER OF LEGISLATIVE COMMITTEE, SERVICE CORPS OF RETIRED EXECUTIVES (SCORE)

Julius Davidson, a native of New York City, but since 1936 a resident of Washington, D.C., graduated from Harvard College with an A.B. cum laude, and spent several years pursuing graduate studies at Columbia University's School of Business, Law School, and Graduate School.

His business career includes 5 years of public accounting work in New York City and Minneapolis, Minn., and 12 years as a member of a women's wear manufacturing firm in New York City.

The last 30 years of his working career were spent in the Federal Government, including 7 years as a price controller with OPA and OPS where he directed a nationwide program in the retail and wholesale food distribution fields, and seventeen years as the chief fiscal officer of the Library of Congress.

A dedicated member of SCORE since early in 1966, he is a past chairman of SCORE Chapter One (Washington, D.C.), the recipient of the award for SCORE man of the year in this area, and a Presidential SCORE citation, past member and a cofounder of the National SCORE Council and currently a member of the legislative and budget committees of the National SCORE Council.

He is a member of the American Economic Association, American Statistical Association, Society for Advancement of Management, American Society for Public Administration, and American Library Association.

Mr. CHANNING. Mr. Chairman and members of the subcommittee. Once again, we wish to express our appreciation for the opportunity to appear before you on behalf of over 5,000 members of the Service Corps of Retired Executives (SCORE) and over 2,000 members of the Active Corps of Executives (ACE) throughout the Nation. Our request for more adequate funds with which to provide vitally essential counseling services to small business is made to you under very unusual circumstances. After operating under the dual sponsorship of ACTION and the Small Business Administration for nearly 4 years, we are about to be transferred to the sole sponsorship of the Small Business Administration. In the process, however, we are left with a hopelessly inadequate budget of only $400,000 resulting from estimates planned, prepared, and submitted by ACTION, an agency whose objectives and priorities were far different from those of the SCORE/ACE program and its membership; one which had little understanding of, or sympathy with, SCORE's dedication to the strengthening of the small business community; and one which, regrettably, did not find it convenient to consult with our representatives in the formulation of plans and estimates prior to their presentation to the Office of Management and Budget and to Congress.

To further complicate the situation, the small business community is now confronted with an increasingly serious combination of economic circumstances—recession, inflation, and energy shortages. Small business owners are the weakest elements in our American business structure; the first and hardest to be hit by deteriorating economic conditions. Thus, SCORE/ACE members are being called upon to play an increasingly important role in helping small business owners overcome their difficulties and, thereby, assist in the preservation of our cherished system of free, competitive enterprise.

Big Business can afford paid, professional management counseling, but even during normal times, this is a luxury that small business cannot afford, much less now or in the foreseeable future. Where can the

small business operator turn for management help? The limited Small Business Administration's management assistance staff can hardly search the surface.

In the current economic context, small business is faced with a variety of problems; financing, which, despite any claims to the contrary, is now even tighter for small business than usual; counteracting falling sales; shifting to other lines and other markets; credits and collections; inventory control and liquidation of surplus stocks; production control, particularly when operating with part-time staffs or less than adequate supervision. These and other areas are where SCORE/ACE members, dedicated to one objective only, fit right into the picture.

If SCORE members average as little as 2 hours counseling each week, this would be over 500,000 man-hours a year and priced at $25 an hour, which, incidentally, is far below the going rate for business consultants, the benefit would exceed $12.5 million.

On the overall fiscal front, to the extent that we help keep people in business making a profit, small business is enabled to pay more taxes. It is axiomatic that business is the basic source of tax funds in our society, and any improvement in the profitability of small business serves to reduce our alarming deficit and at the same time does its share in making it possible for the government to finance many necessary social programs.

Along the same line, management assistance provided by our volunteers to Small Business Administration's clients, who either have direct loans or bank loans guaranteed by the Agency, which will in any way improve their chance of success, serves by so much to insure repayment, thereby, improving the fiscal situation.

The failure rate in the United States, particularly distressing to small business, is increasing at a serious rate. For the first quarter of 1974, the failure rate reported by Dun & Bradstreet was 5 percent higher than 1973, while that for 1975, was 30 percent higher than 1973. Whatever help SCORE/ACE volunteers can give to keep small businesses in operation will help to alleviate this situation. In addition, it will lessen the number of employees thrown out of work and reduce the resulting financial losses. According to recent research studies of the Small Business Administration, there are currently over 9 million small business units in the United States, and such business units account for 58 percent of all those employed in the business sector.

SCORE/ACE members make no pretense at solving all economic and social problems. To the extent that each active member makes a contribution, collectively the contribution is a significant one. This is not a case of suggesting Federal funding as the solution to a complex problem. As retired business men and women, we too, are concerned about the mounting deficit. The amount requested is miniscule in comparison with the potential offset to the mounting deficit itself. The benefit cost ratio of the services of SCORE/ACE members, therefore, is of a very high order.

SCORE is an independent, autonomous organization, established in 1964, which now numbers approximately 5,200 retired businessmen and women organized into 260 chapters in all 50 States, the District of Columbia and Puerto Rico. It is represented by a National SCORE Council of all 11 members which is recognized as the voice

of SCORE by the sponsoring agencies. Complementing the SCORE organization is a group of over 2,000 active business executives who are not retired but constitute a body of talent that complement SCORE and act as volunteers in the same manner as SCORE members.

The sole interest of both groups of volunteers is in making management counsel and assistance available to small business owners and prospective small business owners. This is an interest which is closely identified with the Management Assistance Division of the Small Business Administration. Plans are now being developed by the Small Business Administration to intensify its management assistance program in close cooperation with the National SCORE Council. The general plan and objective, with which the National SCORE Council is in full agreement, will be to double the roster of volunteers in the next 2 years and to triple their efforts. ACE, too, will be called upon for greater help. The plans and goals would be highly desirable in normal times, but they are especially appropriate in the current economic context.

I request that this document setting forth the goals and objectives of SBA for SCORE/ACE be included in the published hearings.

Mr. FLOOD. Yes; that will be done without objection.

Mr. CHANNING. Thank you, Mr. Chairman.

[The document follows:]

GOALS AND OBJECTIVES OF THE SMALL BUSINESS ADMINISTRATION FOR THE SCORE/ACE PROGRAM FOR FISCAL YEAR 1976

1. PURPOSE

The purpose of this paper is to outline the need for expanded SCORE/ACE participation in providing counseling services and other SCORE/ACE assistance to small business. This paper has been reviewed by the National SCORE Council's executive committee and the Small Business Administration has carefully considered all of their comments and recommendations. Together with SCORE/ACE volunteers, we are preparing to work closely at the national, regional and district levels to maximize the effectiveness of our management assistance programs.

2. BACGROUND

SCORE/ACE functions now carried out by the ACTION Agency are scheduled to be transferred to SBA on July 1, 1975. We are awaiting issuance of an Executive order. Major preparatory steps are underway so as to minimize problems occasioned by this transfer. SBA is endeavoring to obtain needed personnel and funding support.

The needs of small business today are well known. The requirement to provide management assistance at the earliest possible time is paramount. The current recession intensifies the need for expanding the roles of both SCORE and ACE to meet the growing need for counseling services in the field.

It is appropriate, therefore, for the Small Business Administration to state its objectives regarding the expanding role of SCORE/ACE volunteers and to provide increased administrative and logistic support for the SCORE/ACE program.

3. THE EXPANSION OF THE SCORE/ACE PROGRAM

To carry out the Small Business Administration's program of providing management assistance to small business, the Agency has three general groups of resources:

(*a*) SCORE/ACE volunteers (plus a limited number of volunteers from professional associations).

(*b*) Consulting services from such programs as the academic Small Business Institute and professional consulting services.

(c) Internal SBA resources—management assistance officers.

In reviewing the alternatives for increasing management assistance, it is clear that the Small Business Administration's internal resources are currently limited by funding authorizations. No increase in fiscal year 1976 is anticipated for either contractual services or management assistance resources. Consequently, expanded management assistance programs must depend upon expansion of the SCORE/ACE program and emphasis on providing additional and continuing onsite counseling.

4. NEW EMPHASIS ON SCORE/ACE FIELD COUNSELING

We anticipate that a client will be assigned a counselor upon application to SBA for a loan, particularly a direct loan. This counselor will not only handle the management development plan, but will assist the borrower through his startup period and continue counseling as long as he is needed. It is anticipated that the assigned counselor will also get others involved when a problem arises requiring expertise that he lacked. Such counseling would normally be onsite rather than desk counseling. No attempt to de-emphasize the need for counselors to assist nonborrowers is intended, as the Agency is committed to assist the entire small business community; but by necessity, priorities today must lie with those whose need for management assistant is most urgent. We are striving for greater cooperation from banks to facilitate the earliest possible involement in guaranteed and participation loans. When this occurs, we are in a better position to provide expanding management assistance to all SBA clients. We expect to at least double the roster of the volunteer force within fiscal year 1976. The Agency's top counseling priorities are clients and minorities. In addition to individual counseling, the assignment of new goals also intensifies the need for volunteers in a broad range of the Small Business Administration's training programs for business persons. Workshops, seminars, problem-solving clinics are types of group counseling that will be expanded.

5. SBA ADMINISTRATIVE AND LOGISTIC SUPPORT OF THE SCORE/ACE PROGRAM

To carry out such an expanded program will require additional support from the Small Business Administration to provide for more field visits, recruitment of more volunteers, more executive refresher courses, and some new concepts. The full extent of the program will depend upon several factors including:

(a) An organized effective recruiting program to develop balanced SCORE/ACE chapters with sufficient volunteers to provide the ranges of skills required in each local community.

(b) Assistance through executive refresher courses, to provide the volunteers with the latest techniques and counseling tools as well as information on policies, objectives, and procedures of the Small Business Administration.

(c) A sufficient percentage of volunteers available and interested in providing the expanded indepth onsite field counseling essential to the overall success of the management assistant program in these times.

(d) The fullest cooperation on the part of the Small Business Administration's Central Office and field staff in the matter of administrative, funding and logistic support, including but not limited to professional coordinating staff, clerical help, space, facilities, and prompt and adequate disbursement of out-of-pocket expenses.

Mr. CHANNING. Hampered in the past 4 years in any efforts to further improve the effectiveness of the SCORE/ACE program in achieving its primary goals by lack of funds, by an impractical dual sponsorship, by contradictory objectives, it is our firm conviction that, with the support of thousands of dedicated, talented SCORE/ACE members, we are in a position to make a significant contribution to the American economy, provided we are granted the modest funding that we submit in detail in the attached document.

May I request the document be inserted in full in the published hearing?

Mr. FLOOD. Yes, that may be done.

[The document follows:]

	ACTION budget		NSC budget	
	1976	Transition	1976	Transition
Individual counseling:				
1. Travel over 50 miles	$130,000	$35,000	$208,000	$65,000
2. Travel under 50 mile			312,000	98,000
3. Group counseling (workshops, seminars, etc.)			94,000	24,000
Total counseling activities	130,000	35,000	614,000	187,000
Orientation and training of counselors:				
4. Special meetings for widely scattered counselors			68,000	17,000
5. Orientation and training of new counselors			106,000	27,000
6. Regional SCORE conferences	140,000	80,000	60,000	
7. National SCORE workshop			90,000	90,000
8. Travel of regional SCORE representatives			25,000	6,000
9. National SCORE council quarterly meetings			12,000	4,000
Total orientation and training	140,000	80,000	361,000	144,000
10. Public relations activities			31,000	8,000
Support activities:				
11. Advertising			108,000	27,000
12. Clerical support	50,000	13,000	239,000	60,000
13. Space and facilities			84,000	16,000
Total support activities	50,000	13,000	431,000	103,000
Nonbusiness counseling activities:				
Fixed income counseling	50,000	15,000		
Training and technical assistance	30,000	5,000		
Total nonbusiness counseling activities	80,000	20,000		
Total for SCORE	400,000	148,000	1,437,000	442,000
14. Add estimate for ACE			100,000	34,000
Total estimate	400,000	148,000	1,537,000	476,000

EXPLANATORY NOTES—NATIONAL SCORE COUNCIL AND 1976 ESTIMATES

1. Travel over 50 miles $208,000
2. Travel under 50 miles 312,000

During the next 2 years, the small business community will be critically in need of the management counseling services of SCORE. In cooperation with the SBA, SCORE plans during this time to double its roster of counselors and triple its efforts. Currently, there are about 5,200 members on the SCORE rolls. Our objective will be to increase this number to 7,800 by July 1, 1976, to 8,500 by October 1, 1976, to 10,500 by July 1, 1977, and to 11,000 by October 1, 1977.

In presenting its own budget for fiscal year 1975, SCORE estimated an out-of-pocket travel expense cost of $500,000 for travel over and under 50 miles for individual one-to-one counseling. This was based on an average of 5,000 members and $100 per year for each counselor. Figures secured from the ACTION agency on actual costs through the first 9 months of this fiscal year indicate a total of only $200,000 for the entire fiscal year. The reasons for this discrepancy is obvious in the light of the attitude and conduct of ACTION policymaking officials. In the first place, they created the false impression that SCORE members were affluent and did not expect or need reimbursement of out-of-pocket expenses, in fact, that it was demeaning to ask for such reimbursement. In the second place, knowing full well that the agency would soon run out of their hopelessly inadequate budget of $400,000 for fiscal 1975, instructions were issued to and by the field staff to cut down expenditures. We quote from one such instruction: "I have been advised that funds for travel are getting low for this fiscal year * * * I was asked to advise you that it is suggested that only the most necessary trips should be made." In the light of the major goals and objectives of the SCORE program, helping the small business owner, an instruction of this kind is distinctly counterproductive.

For the coming fiscal year, in cooperation with the SBA, it is planned to intensify our counseling efforts. This means counseling indepth, establishing a more continuous relationship with our clients, and frequeut followups. We also anticipate a considerable increase in the case load. Although the estimate of $100 per SCORE member per year might be considered a reasonable one, the anticipated rapid buildup of the SCORE roster could result in lower utilization of

new members. Accordingly, the out-of-pocket cost per member in fiscal 1976 is estimated at $80 per year. On the assumption that the SCORE roster will average 6,500 during fiscal year 1976, out-of-pocket expenses would come to $520,000, of which 40 percent would be for travel over 50 miles, and 60 percent for travel under 50 miles. For the 3 months transition estimate, based on an average of 8,150 on the SCORE rolls, the cost would come to $163,000, 40 percent for travel over 50 miles and 60 percent for travel under 50 miles.

3. SCORE participation in workshops and seminars for present and prospective small business owners $94,000

This is a highly important steadily increasing activity conducted by SCORE membership. It has considerable importance in pointing out the hazards that face small business. It is estimated that 75 of the 260 chapters will be involved, with a team of four counselors from those chapters traveling varing distances from month to month, much of it during evening hours. It is very essential that these teams not limit themselves to large metropolitan areas, but reach outlying and rural areas as well. This entails preparing the courses, delivering lectures, answering questions, and filing with SBA reports of the results. The cost estimate is based on a modest average of $26 for each trip by each counselor participating.

4. Special meetings for widely scattered counselors $68,000

Not all SORE chapters have large memberships living in close proximity to a central city. Many chapters are small with widely scattered members, and even the larger chapters include members who are far away from chapter headquarters. It is estimated that at least 15 percent of the SCORE roster are too far away to attend monthly chapter meetings and so are deprived of a close working relationship with their colleagues, the SBA staff, and the materials and guides available in SBA offices that are so vital to successful counseling. Such counselors must be brought into meetings at least once a year designed to establish the proper working relationships and to keep them up to date with the most recent rules, regulations, policies, and procedures. To accomplish this would entail a cost of $68,000. This estimate is based on 2 days of per diem and $20 for mileage and parking for each of the approximately 975 scattered SORE members.

5. Orientation and training of new SCORE counselors $106,000

It is expected that during fiscal year 1976, 3,900 new SCORE volunteers will require special orientation and training in the policies and procedures of the SBA, in the operation of SCORE chapters, and in the conduct of SCORE counseling activities. Notwithstanding the unusual technical qualifications of most of the SCORE recruits for counseling on small business problems, unless they receive special orientation and training in the total context of SCORE, the effectiveness of SCORE service is greatly diminished. The figure of 3,900 assumes a turnover of 1,300 because of mortality, morbidity, and advancing age, and an additional 2,600 recruits because of an overall increase in the SCORE roster. Orientation and training property carried out should take at least 1½ days The $106,000 estimate is based on the assumption that two-thirds will be required to travel short distances to the training centers and involve a mileage and parking cost of $6 for each of 2 days, while the remaining one-third will be required not only to travel greater distances, but also to be paid per diem at $25 per day for 1½ days plus $20 for mileage and parking.

6. Regional SCORE conferences $60,000

In recent years, regional SCORE conferences have been held in some, but not all of the 10 geographic regions. SBA has agreed that such conferences are to be held annually in all regions because they are indispensable as a mechanism for orientation of counselors, development of new counseling techniques, and improving program operations. This estimate should cover travel costs of one delegate from each of 260 chapters.

7. National SCORE workshop $90,000

Beginning with the first of the annual sessions in October 1970, the national SCORE council has planned, organized, and conducted annual sessions, increasingly concentrating on workshop techniques where couseling methods, recruiting and orientation procedures, policies, plans and programs of SBA are thoroughly

discussed, explored, and demonstrated. The annual national workshop is the pinnacle of the program for training of SCORE volunteers. The estimate is based on participation of 260 SCORE chapter representatives at a cost of $350 each. The total of the estimate for the national SCORE workshop is included in the transition estimate because it is normally held in October.

8. Travel of regional SCORE representatives $25,000

It is essential that each of the 10 regional representatives comprising the national SCORE council visit each of the chapters in his region at least once a year to review chapter operations, provide advice, apprise members of sources of information and assistance, clarify SBA agency programs, and assist in developing esprit de corps. The estimate is based on a cost of $90 for visits to each of 260 chapters, since most such visits would involve overnight stays and travel to distant points. An additional $1,600 is included to provide travel for the chairman of the national SCORE council mainly to Washington, D.C., for special consultations.

9. National SCORE council quarterly meetings $12,000

The 11-man national SCORE council is authorized by the sponsoring agency to meet quarterly, with the fourth quarter meeting being held at and during the national SCORE workshop. The estimate for the three other quarterly meetings is based on an average of $363.63 per man authorized to travel to these meetings.

10. SCORE public relations activities $31,000

The most effective public relations work, both to inform the public of the availability of SCORE volunteers and to handle small business problems and to recruit the type of men and women suited for such work, makes it necessary for every chapter chairman and every publicity committee chairman to use all possible occasions to spread the word through speeches, lectures, and other contacts. Many chapters are currently handling 10 to 12 such visits per month. Plans for 1976 contemplate intensification of efforts in recruitment, to enable SCORE to fill in gaps in selective fields of expertise, and to inform the small business communities in sparsely settled areas regarding the availability of SCORE counseling services. This estimate is based on one contact per month by one volunteer from each of 260 chapters at a cost of $10 for each such contact.

11. Advertising costs $108,000

We are informed by our members who are expert in the field of advertising and public relations that we cannot and should not depend alone on free advertising granted as a public service. It is essential to bring SCORE's availability to the attention of the general public in a manner that would be of maximum benefit to the small business owners as well as to recruit the type of volunteers required to perform such needed services, then there must be willingness to use paid media. On the assumption that 125 of the small (less than 12 members) chapters require paid media at a cost of $25 per month or $300 per year, the annual cost would be $37,500; similarly, if 135 larger chapters were provided paid advertising in local media on the basis of $450 per year per chapter, the annual cost would be $60,750. The total cost would be $108,000, which would also provide $10,000 for special projects and publicity on a national basis.

12. Clerical staff support $239,000

A modicum of clerical support is a basic necessity if SCORE is not to be severely handicapped in the prosecution of its essential work. It is estimated that a minimum of 8 hours a week will be required for the 135 larger chapters and 8 hours per month for the 125 small chapters. At $3.50 per hour, for part-time work including fringe benefits, $239,000 will be required.

13. Space and facilities $84,000

Space and facilities have become an increasing problem for SCORE chapters, outside of large metropolitan centers where, generally, adequate arrangements are provided in some 69 district offices. As to the remaining 190 chapters, every effort is made to obtain space, desks, equipment, and telephones in chambers of commerce, banks, and other institutions which have been more than generous with SCORE. However, regardless of efforts made, there remain about a quarter of our chapters without facilities for adequate service to small business. Unless SCORE counseling help is to be limited to large metropolitan areas, it is import-

ant that provision be made for all chapters for a minimum of space and facilities. The cost for approximately 65 chapters would come to about $84,000 and would provide an average of 150 square feet for each chapter at an estimated cost of $5 per square foot, $250 for telephone service, and $300 each for an initial investment in desks, chairs, and equipment.

14. Estimate for ACE activities---------- $100,000

ACE, the Active Corps of Executives, is a group of counselors who have not retired but who offer their services as a complement to the SCORE program. ACE represents a body of skills and expertise that contributes a pool of talent to SCORE which fills in gaps in the SCORE roster so that together a more complete service may be offered to the small business community. ACE is not separately organized but generally fits in with the procedures, actvities, and chapter structure of SCORE. With only about 3 percent of the total number of SCORE/ACE cases handled by ACE in fiscal 1975, it is planned to utilize their services to a far greater extent in fiscal year 1976. With increasing utilization, it is expected that reimbursement to ACE members for out-of-pocket expenses for counseling as well as participation in the orientation and public relations programs will increase sharply. Although there are currently over 2,000 members on the ACE roster, it is believed that adding 10 percent to the SCORE estimates for all items except support activities, (which should not change significantly with greater utilization of ACE) would support the separate activities of ACE volunteers.

The total requested for fiscal year 1976 comes to $1,537,000. In relation to the total requests for the ACTION Agency, both domestic and foreign, the amount requested for SCORE/ACE is but ¾ of 1 percent of the total. On the assumption that the SCORE roster will average 6,500 during the year and the ACE roster will average 2,500, this would mean $171 per volunteer per year. What are the funds needed for? For the most part to move volunteers from one place to another so that they may render effective service. Not one penny of this money would be in payment of any services rendered. SCORE and ACE men and women do not want pay. They are truly 100 percent volunteers. However, contrary to some false impressions, they are not on the average an affluent group. During these trying times, they are confronted with the same problems as other fixed-income people. Not only is it proper that they be reimbursed for out-of-pocket expenses, but the continuation of any policy of discouraging volunteers from expecting such reimbursement is self-defeating, since it only serves to discourage recruitment of new members and encourage many desirable members to discontinue their membership; the drain on their limited resources is more than most of them can afford.

Of the total of $1,537,000 requested in our budget, $614,000, or 40 percent, is for out-of-pocket expenses in connection with individual and group counseling activities; $361,000, or 23 percent is for highly essential orientation and training of SCORE/ACE volunteers; $31,000 or 2 percent is for public relations activities conducted by the volunteers themselves; $431,000 or 28 percent is for such support functions as advertising, clerical help, and space and facilities; $100,000 or 7 percent is provided under a separate caption for ACE activities as distinct from SCORE activities.

Mr. Chairman and members of the subcommittee, rather than elaborate further on the details of the budget proposal, we invite your questions on any matters contained therein or on any other points related to the SCORE/ACE program.

Again, may we express our appreciation for this opportunity to be heard.

Mr. Flood. Thank you very much.

Monday, May 19, 1975.

National Heart and Lung Institute

WITNESS

DR. FRANK FINNERTY, JR., PROFESSOR OF MEDICINE, GEORGETOWN UNIVERSITY

Mr. Flood. Dr. Frank Finnerty, professor of medicine, Georgetown University, on the National Heart and Lung Institute.

Dr. Finnerty. I have a prepared statement but I don't seem to have it.

Mr. FLOOD. Do you have a prepared statement?

Dr. FINNERTY. Yes, sir, it will be here.

I am delighted to be here again. I have become an evangelist, I think, instead of a doctor.

Mr. FLOOD. Just so you don't turn your collar around.

Dr. FINNERTY. As you know from previous testimony, high blood pressure, hypertension, is really a wild disease in this country at the present time. Some 23 million people, and some insurance people tell us some 43 million people actually have it.

Now, this is the commonest cause of stroke, of heart failure, of the kidney failure, and particularly applicable in a city such as this, right around here, the commonest cause of death in blacks.

This is a disease, as you know, sir, from previous testimony, that actually has no symptoms, actually has no symptoms until you get a catastrophe and one does not know whether his blood pressure is high or normal or low unless his blood pressure is actually taken.

There's a lot of wives' tales, "I can tell my pressure is high or low" that is just plain foolishness. If there are 23 million or 43 million people, what is horrifying is the fact that 50 percent of them, half of them, don't know they have it, and only 8 percent are under any kind of treatment.

The reason for this is because this disease truly has no symptoms. I am sure in a room such as this some 20 percent of people, one out of five actually has high blood pressure and doesn't know that he has it.

Now, this disease, and we should call it this, really escapes nobody, but there are certain groups of people prone to it.

On a percentage basis it is twice as common in blacks; it is almost twice as common in men, and in those people who have a family history of blood pressure, it is three or four times as common and the worst thing is that it is much more common in the poor than in the rich.

Now, what really needs to be said in plain, simple language, is, there is an actual relationship as between complications and longevity with an actual number. If you take a 35-year-old man whose blood pressure is 160 over 100, I should say 150 over 100, and that is mild, this number will shorten his life expectancy 16.5 years as compared to a man 35 whose blood pressure is 120 over 80.

So there is a real relationship between number and complications.

Now, let's talk a few minutes about just dollars and cents which I will have to read these numbers because I really don't know these by heart.

The annual dollar cost of high blood pressure and its sequelae can be estimated at nearly $20 billion; circulatory problems, the common result of prolonged hypertension, cause 150 million disability days, 3 million hospital admisisons, and 26 million days of hospitalization each year. Of importance to one of the previous people here, social security data indicate that hypertension and its consequences account for the largest single number of disability claims.

Now, that is all the bad things about high blood pressure. Let's talk about the good things. This is not a sickle cell anemia type of disease where you go out and wave a banner and don't do a damn thing. This is a disease simple to diagnose, no needles, no bandages, just a cuff on the arm; it is simple to treat, frequently as simple as taking a pill a day. Eighty percent of these 23 million or 43 million people can truly be protected from the strokes and coronaries and kidney failures by

taking a pill a day. Isn't it better from a dollars and cents standpoint to prevent all the end stage renal disease and pay the millions of dollars for the dialysis unit and this or that?

Mr. FLOOD. You had better define renal disease.

Dr. FINNERTY. Kidney disease or the commonest cause of end stage kidney disease, that situation that puts people in a dialysis unit is high blood pressure. Isn't it more practical and more economical to prevent that from happening by taking a pill a day?

Well, if an effective campaign were to be started off, it is truly realistic that we could prevent 200,000 deaths per year and from a practical standpoint we could reduce the annual death rate in this country by some 10 percent.

Now, as long ago as 1972, our Secretary Richardson, then HEW Secretary, recognized this tremendous toll, what could be done about it. He instituted the national high blood pressure education program.

As you know, this has been going on now for 3 or 4 years. It is designed to really popularize this disease, that everybody, doctors and patients, know about it, but that is all that is happening.

Lots of screening programs, lots of community programs, but lots of people still are screened and don't have the dollars and cents to go to a particular doctor.

In quotation marks, "We will think" States such as down in Florida, they found 24 percent of patients who had been found to have high blood pressure couldn't afford to go to the doctor. What we are saying in plain language is what we need to do is provide some formula grant assistance to the States to support the development of programs which will provide the diagnosis and therapy of this ungodly disease.

Last year the Congress recognized this when you overwhelmingly approved H.R. 14214, the Health Revenue Sharing and Health Services Act. This legislation authorized up to $35 million in 1975 and a like amount in 1976.

Now, despite the fact that the Senate approved this bill by unanimous vote and the House approved it by a vote of 372 to 14, the President pocketed it and shortly after had adjourned. Thus you have had no opportunity to do anything about it.

A provision identical to that in 14214 is curerntly under consideration in this Congress. In fact, final congressional action on it appears to be imminent.

S. 66, incorporating this identical—exactly the same message, has been passed by the Senate. So from a practical standpont, a very realistic standpoint, we feel that if we had or if you would give $35 million to be appropriated to fiscal year 1976 for support of State and local high blood pressure control programs, we could really use what we know.

Sure, it is important to do research and clinical and basic sort of things, but we have the tools right here. If a man were sitting here with high blood pressure, we could simply give him a pill and we would prevent him from the stroke or from the coronary or from the end stage kidney disease.

To me, as a doctor, or a priest, or as anybody, this seems so much more practical than supporting end stage renal disease, not that these people should be killed or shot, but it is so much more practical to prevent it and we can do it.

Thank you, sir.

[The statement follows:]

Mr. Chairman and members of the committee, I am Dr. Frank A. Finnerty, Jr., professor of medicine at Georgetown University Medical School, and chief of cardiovascular research, Georgetown University Medical Division, D.C. General Hospital, here in Washington, D.C. I also serve as a sponsor and director of citizens for the treatment of high blood pressure, a nonprofit educational organization, with headquarters in Chevy Chase, Md.

It is a privilege and a pleasure to appear before this committee to discuss the need for continued and intensified action to control our Nation's health enemy No. 1: high blood pressure.

HIGH BLOOD PRESSURE: HEALTH ENEMY NO. 1

High blood pressure, which is known medically as hypertension, is the leading cause of premature death and disability in our Nation. Undetected and untreatd, it can (and frequently does) lead to stroke, heart attack, heart failure, and kidney failure. Heart attack, stroke, and other cardiovascular diseases account for over 53 percent of all American deaths annually. Several recent research studies have indicated that high blood pressure is the major causative factor in about 75 percent of all strokes, 50 percent of all kidney failure, and over 33 percent of all heart attacks.

Between 23 and 40 million Americans are estimated to have high blood pressure. By any measure, the incidence of hypertension in our Nation is of epidemic proportions.

Since hypertension is usually without symptoms, at least in the early stages of the disease, about half of the persons who have this life-threatening condition are unaware of its presence. Because of this lack of symptoms, or other early warning signs, hypertension has aptly been called the silent disease and the silent killer. Usually, by the time hypertension produces noticeable symptoms, irreversible and serious damage to vital organs has taken place.

No segment of American society is immune to hypertension. Although the high blood pressure epidemic occurs throughout our population, epidemiological studies have shown that some Americans are at relatively higher risk from the disease:

From a percentage point of view, hypertension occurs twice as frequently in black Americans as in whites. In fact, hypertension is the biggest single cause of death among black Americans.

Although women, white and black, tend to have a higher incidence of hypertension, the effects of the disease are far more devastating in men.

Hypertension occurs more frequently in urban communities (20–30 percent of the population) than in rural areas (10–15 percent of the population).

Persons with a family history of hypertension, heart disease, or other cardiovascular conditions are more likely to have high blood pressure than those with no previous family history.

Overweight individuals are more likely to have a dangerously elevated blood pressure, but many persons who are at a normal weight also have the disease.

Hypertension occurs more frequently among persons in lower socio-economic levels.

The risk of serious complications, and reduced life expectancy, has been shown to be directly related to the level of blood pressure elevation. In other words, the higher the blood pressure, the greater the risk of serious complications and premature death. A man at age 35, for example, with a sustained blood pressure averaging 150/100 mm Hg, has a life expectancy which is 16½ years less than that of a man with an average normal blood pressure of 120/80 mm Hg.

I daresay there are few if any of us in this room today who have not seen the tragic consequences of undetected and untreated high blood pressure. We have all seen the silent killer strike down a friend, a relative, or a colleague.

HIGH BLOOD PRESSURE: THE ECONOMIC TOLL

Aside from the human toll of high blood pressure, the economic costs associated with hypertension and its complications are equally devastating:

Circulatory problems, the common result of prolonged hypertension, cause 150 million disability days, 3 million hospital admissions, and 26 million days of hospitalization each year.

An estimated 52 million man-days of productivity are lost annually by American business and industry because of hypertension and its complications.

Social Security data indicate that hypertension and its consequences account for the largest single number of disability claims.

The annual dollar costs of high blood pressure and its sequelae are estimated at nearly $30 million.

HIGH BLOOD PRESSURE: THE CONTROLLABLLE CAUSE OF DEATH AND DISABILITY

Thus far, I've given you the bad news about high blood pressure. Now for the good news:

Hypertension can be easily, painlessly, and inexpensively detected and diagnosed.

Although further research is needed to determine the precise cause or causes of the disease, hypertension can be effectively treated—right now.

Medications have been available for several years which can effectively control dangerous blood pressure elevations, reduce the risk of complications, and lengthen the lives of hypertensive persons.

For about 80 percent of hypertensive Americans, effective treatment may be as simple as a pill a day.

Antihypertensive therapy is, in most cases, uncomplicated and inexpensive. In fact, a number of recent studies suggest that it is far less expensive to control high blood pressure than to wait for a disabling, life-threatening, and very expensive complication to occur.

An effective national campaign to control hypertension could avert at least 200,000 American deaths each year. In other words, our Nation's annual death rate could be reduced by at least 10 percent.

NEED FOR A NATIONAL HIGH BLOOD PRESSURE CONTROL CAMPAIGN

In 1972, then-HEW Secretary Elliott Richardson recognized the tremendous human and economic toll of undetected and untreated hypertension, and the significant savings which could be realized by early detection and treatment. Thus, Secretary Richardson initiated the national high blood pressure education program, a cooperative venture including participation by private, voluntary, and public organizations.

Since its inception in 1972, the national high blood pressure education program has made great progress in increasing public and professional awareness of hypertension as a major threat to health and life. One of the results of this increased awareness has been a proliferation of community high blood pressure screening programs throughout the Nation. These programs have screened many hundreds of thousands of Americans, and referred those with blood pressure elevations to their private physicians for further evaluation and treatment.

It is futile, however, to continue the national campaign against hypertension as merely an educational and screening program. In the absence of a truly comprehensive system of national health insurance, we need to provide assistance to those who cannot gain access to sources of necessary diagnosis and treatment because they cannot afford it.

In many instances, community screening programs have identified suspected hypertensives who have no private physician and cannot afford one, or persons who have a physician but cannot afford the relatively inexpensive costs of diagnostic laboratory procedures and antihypertensive medications. In parts of western Florida, for example, health officials have found that 23 percent of those found with significant blood pressure elevations do not seek further evaluation and treatment because they cannot afford it. Our Nation's recent economic situation, with its attendant unemployment, has only intensified this situation. Hence, we need to provide formula grant assistance to the States, to support the development of programs which will provide diagnosis and antihypertensive therapy for those who currently lack financial ability to obtain these services.

Last year, the Congress recognized this need, when you overwhelmingly approved H.R. 14214, the Health Revenue Sharing and Health Services Act of 1974.

This legislation authorized up to $35 million in fiscal year 1975, and a like amount in fiscal year 1976, to be awarded to the States under the health revenue

sharing provision (section 314(d)) of the Public Health Service Act. These funds were designated for use in screening, detection, diagnosis, prevention, and treatment of hypertension.

Despite the fact that the Senate approved H.R. 14214 by a unanimous vote, and that the House approved it by a vote of 372 to 14, the President pocket-vetoed this bill shortly after the 93d Congress had adjourned. Thus, the legislative branch had no opportunity to respond to the President's action.

A provision identical to that contained in H.R. 14214 is currently under consideration by this Congress. In fact, final congressional action on the Health Revenue Sharing and Health Services Act of 1975 is imminent.

S. 66, incorporating the identical provision of H.R. 14214, passed the Senate overwhelmingly about 1 months ago. H.R. 4925, the House version of this legislation, has cleared the Committee on Interstate and Foreign Commerce and has been officially scheduled for floor action.

It is our recommendation that $35 million be appropriated for fiscal year 1976 for support of State and local high blood pressure control programs.

Although we agree with other witnesses who have appeared before this committee that additional funds should also be appropriated for basic, clinical, and pharmacological research related to hypertension, we strongly believe that we need to do a better job of using the knowledge and resources we already have in the campaign against this disease. The recommendation I have made would, I believe, make a significant contribution to control of the "silent killer."

In summary, our recommendation is: That $35 million be appropriated in formula grants to the States for support of community programs to control hypertension and provide diagnostic and treatment services to persons now unable to afford them.

Mr. FLOOD. Thank you, Doctor.

EXPANSION OF THE JOB CORPS

WITNESSES

ESTHER R. LANDA, NATIONAL PRESIDENT OF THE NATIONAL COUNCIL OF JEWISH WOMEN
BERNICE ZILLY, PRESIDENT, NATIONAL COUNCIL OF CATHOLIC WOMEN
RUTH CLEMENT BOND, MEMBER OF BOARD OF MANAGERS OF CHURCH WOMEN UNITED
DOROTHY R. TALAVERA, ON BEHALF OF AMERICAN GI FORUM WOMEN
DOROTHY SHAED PROCTOR, REPRESENTING THE NATIONAL COUNCIL OF NEGRO WOMEN

Mr. FLOOD. Mrs. Esther R. Landa, national president, National Council of Jewish Women.

Mrs. LANDA. I am Esther R. Landa, national president of the National Council of Jewish Women, an organization with a membership of over 100,000 in local units throughout the country. I appreciate the opportunity of appearing before this committee to register my organization's support of increased appropriations for the Job Corps program.

However, I am also speaking for the members of four other national organizations—the Church Women United, the National Council of Catholic Women, the National Council of Negro Women, and the American GI Forum Women. Together, these organizations have a membership of more than 27 million women of diverse racial, religious, cultural, and economic backgrounds. Together, members of

these organizations have esatblished a coalition, Women in Community Service—a volunteer, nonprofit organization.

Women in Community Service were brought together 10 years ago by a common concern over the mounting problems of America's youth—the school dropouts, the jobless, the delinquents, and the impoverished young people who faced the future with no goals and no hope.

The volunteers of Women in Community Service are currently engaged in a program to recruit and screen young women for the Job Corps, to conduct pre-enrollment orientation training, and to provide support services to young women before, during, and after their training.

As each organization of our coalition has sent a representative to this hearing, each will make a brief statement and submit a full statement for the record. I shall state the consensus of the coalition concerning the Job Corps program as expressed by members of our five constituent organizations at a recent meeting of the national board of directors of Women in Community Service.

In January of this year, the members of WICS coalition indicated their grave concern at the expanding rate of unemployment, especially among young people. At the time the unemployment rate for the Nation as a whole was 8.2 percent; it has since risen to 8.9 percent. For the youth, however, the figure was 20.8 percent and unemployment among black teenagers is reported to be in excess of 40 percent.

To alleviate the plight of the poor and to reduce the economic crisis facing our Nation today, emphasis must be placed on the development of employment opportunities; and, for young people, the Job Corps is one of the more creative and constructive programs in operation.

Yet at a time when unemployment and inflation rates have spiraled to new heights, a time when every program to reduce the unemployment rolls should be at maximum strength, the strength of the Job Corps has been drastically reduced.

The number of Job Corps spaces, of course, is controlled by the budget which dropped from a high of $303.7 million in the second year of Job Corps' operation to a low of $171.1 million this fiscal year. The number of spaces was further reduced by the phenomenal inflation of the past few years. The Consumers' Price Index shows a 55 percent increase from 1967 to 1975.

Our members recognize the budgetary problems the country faces at this time. We realize that one of the first concerns that the Congress must consider is the cost of the program. But how much does a battleship cost? An airplane? How much have we sent to Vietnam?

The value of the Job Corps must be measured against the additional cost of the welfare rolls and the unemployment lines if we do not have a Job Corps. With an increase in either welfare or unemployment costs, the Government loses and the individual is no farther ahead. In Job Corps the individual profits from the training and the Government gains a more responsible citizen and taxpayer.

Our coalition supports, therefore, not only the continuation of the Job Corps but also its immediate expansion to its 1967 strength of 40,000 enrollees and—if unemployment continues at its present rate—to 100,000 enrollees. We urge that funds be appropriated to provide for such expansion.

Under the provisions of the Comprehensive Employment and Training Act of 1973—CEAT—the Secretary of Labor was directed to take steps to achieve an enrollment ratio of 50 percent women enrollees in training in the Job Corps consistent with efficiency, economy, et cetera. At the present time only 27 percent of the enrollees are women. Yet unemployment is more widespread among women than among men. These young women represent an important segment of our future. We urge the increased enrollment of young women in the Job Corps at the earliest possible date as provided in CETA.

In summary, our coalition strongly endorses legislation to expand the Job Corps and to achieve a 50-percent ratio of women enrollees.

I have attached for the record a copy of the bulletin released by the representatives of our coalition at the January 1975 meeting of the board of directors of Women in Community Service.

I respectfully ask that it be made part of the record.

Mr. FLOOD. That may be done.

[The information follows:]

WICS BOARD URGES EXPANSION OF JOB CORPS

The national board of directors of Women in Community Service, in meeting assembled, expressed grave concern for young women in poverty in this period of national crisis.

The phenomenon of rising unemployment and galloping inflation foreshadows great hardships for all segments in our population, but particularly for those already economically deprived.

Some measures under consideration, such as severe reductions in our Federal budget and belt tightening by individual citizens, offer no relief to the poor but rather victimize them even more severely.

To alleviate the plight of the poor and reduce the economic crisis facing our Nation today, emphasis must be placed on the development of employment opportunities. The Comprehensive Employment and Training Act program, signed into law by President Ford recently, is not sufficient to reduce unemployment which is now reaching alarming proportions. The funds appropriated are insufficient to provide employment for our younger workers, especially young women, among whom the rate of unemployment is the highest.

In order to conserve and develop our human resources, the greatest asset this country possesses, we must provide effective and adequate programs. The Job Corps is among the more creative in constructive programs for young people.

We urge our Government to increase greatly the Job Corps program as a means of giving hope to young people to develop their potential.

Mr. FLOOD. Thank you very much.

Mrs. LANDA. Our other representatives are here.

Mr. FLOOD. We would like the names of these other ladies and the organizations they represent in the record. Be sure to put those in.

Mrs. ZILLY. I am representing the National Council of Catholic Women. I am the national president.

[The statement follows:]

STATEMENT IN SUPPORT OF INCREASED APPROPRIATIONS FOR AN EXPANDED JOB CORPS, BY MRS. G. SAM ZILLY

I am Bernice Zilly [Mrs. G. Sam], president of the National Council of Catholic Women, a federation of 10,000 organizations representing some 9 million Catholic women throughout this country.

I speak in support of the statement presented by Mrs. Esther Landa, president of the National Council of Jewish Women, in support of an increased appropriation for an expanded Job Corps.

The National Council of Catholic Women has given active and visible support to disadvantaged young women through our membership in Women in Community

Service, Inc. This interreligious, intercultural, interracial group provides volunteer womanpower to recruit and screen young women in poverty for the human renewal opportunities provided in the Women's Job Corps Centers. Literally thousands of NCCW members have been mobilized to assist these disadvantaged young people in their search for human development.

The National Council of Catholic Women was a founding member of Women in Community Service. We have just celebrated our 10th anniversary, 10 years of gratifying, enriching opportunities for young women and for volunteers.

In this year of 1975, designated as International Women's Year, our attention is augmented in an effort to help young women prepare themselves for a meaningful life.

We urge the increased enrollment, therefore, of young women in the Job Corps at the earliest possible date as provided in CETA.

NCCW endorses legislation to expand the Job Corps and to achieve a 50-percent ratio of women enrollees.

Mrs. FLOOD. Where are you from?

Mrs. ZILLY. Detroit, Mich.

Mrs. BOND. I am Ruth Clement Bond, member of the board of managers of Church Women United, representing our president, Mrs. John Sonnenday. We concur with the statement read.

[The statement follows:]

STATEMENT PRESENTED BY CHURCH WOMEN UNITED, BY MRS. RUTH CLEMENT BOND

I am Mrs. Ruth Clement Bond, member of the board of managers of Church Women United, representing our president, Mrs. John Sonnenday.

Church Women United, an ecumenical lay movement of Protestant, Orthodox and Roman Catholic women, is formally organized in every State and the District of Columbia. More than 2,300 units are active in as many communities throughout the country. Through its own organization, and its 36 related national denominations, Church Women United has channels in practically every community in the country. Their units are located in ghettos, suburbs, small towns, and rural areas.

Church Women United is concerned with problems of racial discrimination and poverty. They are particularly interested in the welfare of young women, especially the teenagers and those in the early twenties who have been overlooked in the numerous programs designed to provide youth with the skills and know-how needed to escape poverty. Church Women United has been involved in such programs as: assignment race; adult basic education; wake-up, speak-up, move-on; the school lunch study and other programs which attack hunger in America.

Our members, through Women in Community Service, have been involved also in the screening, recruiting and support services of young women for the Job Corps. There is no doubt that Job Corps has given new hope to thousands of young women who were out of school, out of work and in impoverished circumstances. It has helped indirectly their families because many of these Corpswomen have finished their high school equivalency, learned a skill or a trade, and have become self-supporting.

At this time of high unemployment and increasing crime in the streets, it is imperative that as many young people as possible be taken off the streets, trained in a skill and given an opportunity to become working members of the community. We assume, of course, that Congress and the administration will be making every effort to reduce the unemployment rate by creating new work opportunities.

We urge, therefore, the continuation and expansion of the Job Corps as a human renewal program to provide opportunity for young people seeking a more productive life.

Mr. FLOOD. Where are you from?

Mrs. BOND. Washington, D.C.

Ms. TALAVERA. I am Dorothy Talavera, Washington, D.C., for American G.I. Forum Women. We concur with the statement and submit a statement of our own for the record.

[The statement follows:]

STATEMENT BY DOROTHY TALAVERA

Ladies and gentlemen, my name is Dorothy R. Talavera. I am the Washington, D.C., liaison for American G.I. Forum Women, an organization of Hispanic women which is very active in the Southwestern United States. I am also the newest member of the WICS national board, having been named to that position only a week ago.

As the other WICS member organizations, American G.I. Forum Women recruit and screen young women from the Hispanic community for Job Corps training. This is done on a volunteer basis. Perhaps even more important is the support and madrina-type advice given by GIFW volunteers to the recruits during their training period. No chart or graph can do justice to this work.

All of the facts on Job Corps have already been said or will soon be said by persons infinitely more qualified than myself to speak on the subject. I would like to tell you what Job Corps means to women who are American citizens of Hispanic heritage.

Hispanic women, Mexican Americans, Puerto Ricans, Cubans, and other Latin Americans, as a group, have the lowest median years of education of any minority group in the country: 9.8 years as compared to 12.3 years for all women. In addition, the median yearly salary for a Hispanic woman in California is $1,800 per annum, according to the California Department of Labor.

Because of their culture, many Hispanas are brought up in an environment where women are discouraged from remunerative work outside of the home. Yet the number of Hispanas who are suddenly thrust in the position of sole support of a family is increasing as a result of death, abandonment, divorce, separation, or because the woman chooses not to marry. The latest Census Bureau statistics say that one out of every seven Hispanic families is headed by a woman. Many Hispanas are simply not prepared educationally, psychologically, or socially for employment.

This is where Job Corps steps into the picture. Job Corps provides a means by which the Hispana can separate herself from an environment which may limit her economic productiveness. At the same time volunteer recruiters sensitive to her strong love and respect for family bonds offer her a chance to grow and become an asset to that family.

Job Corps is a means for readying the Hispana, and the Hispano of course, to compete on an equal level for her place in the American workforce, and to earn self-respect while raising a decent living for her family. Job Corps is not welfare or charity, for as you know the Hispanic pride will not accept charity. This is merely supplying a bootstrap with which the Hispana can pull herself up, an investment which will reap untold dividends.

For these reasons we of the American GI Forum Women support Job Corps and encourage increasing those facilities now available.

I have with me a statement by the president of American GI Forum Women, Ida Acuna of California. I respectfully request that it be made part of the record.

Mrs. PROCTOR. I am Dorothy Shaed Proctor, president of the Washington section, National Council of Negro Women. Today I am representing Dorothy Height, our national president. We heartily endorse the program of Job Corps. We represent 4 million women, and naturally, being one of the concerned minorities, we are very grateful for this opportunity to present these facts to you. I am from Washington, D.C.

[The statement follows:]

TESTIMONY OF DOROTHY SHAED PROCTOR, REPRESENTING THE NATIONAL COUNCIL OF NEGRO WOMEN

Good morning, Mr. Chairman and members of the subcommittee. I am Mrs. Dorothy Shaed Proctor, a member of the Greater Washington, Women in Community Service Board, and president of the National Council of Negro Women, Washington section.

Today I am representing our national president, Miss Dorothy I. Height, who cannot be here.

This morning you have heard the statement of Mrs. Lander, of the National Council of Jewish Women, advocating for the appropriate and full funding of the Job Corps program.

Mrs. Lander has enumerated the kinds of human development services the Job Corps offers young women who have been helped by WICS, and the measurable returns which the Job Corps graduates make to the economy, societal re-enhancement, stabilization of the family, wise, comprehensive, and prudent directing of children, functioning as informed citizens in the governmental processes of the Nation, and now as persons who have been exposed to constructive education, they enrich the human and humane resources of this Nation.

Because of the above facts, and the immeasurable benefits which flow to the Job Corps enrollees and to this Nation, the National Council of Negro Women is proud to be apart of the WICS coalition which is made up of organizations that are committed to young women who are untouched by the benefits of this country.

Organizations that are not only committed but directly involved in the development of the young women. Our efforts of outreach to the community, the recruiting and screening of Job Corps enrollees, and the supportive services provided to Job Corps returnees are evidence of our belief in the essential value of the Job Corps program.

Should this Nation forget or turn away from its untrained, undereducated citizens? I think not. The foregone cannot be the national domestic policy toward young women—the future mothers of America!

Therefore, I urge that the Appropriations Committee recommend to its full committee and to the Congress, that the budget allocation for the Job Corps should be adequate enough to support the existing Job Corps program, and provide slots in Job Corps centers for the large number of potential enrollees who are seeking Job Corps training.

The statement presented by Mrs. Lander has the unreserved support of the National Council of Negro Women.

Mr. Chairman, I thank you and your committee for the opportunity of placing before you the council's position, which we believe would influence your receptiveness of the requested Job Corps budget for fiscal year 1976.

Thank you.

Mrs. LANDA. I would be remiss if I didn't state for the record, then, that I am from Salt Lake City, Utah.

Mrs. ZILLY. Would it be possible to read a statement?

Mr. FLOOD. Not now.

Mrs. ZILLY. Just to say we approve.

Mr. FLOOD. Yes, you made that very clear.

EMERGENCY MEDICAL SERVICES

WITNESSES

JAMES D. MILLS, M.D., A PHYSICIAN FROM ALEXANDRIA, VA.
DR. JOHN P. McDADE, A PHYSICIAN FROM ALEXANDRIA, VA.

Mr. FLOOD. Dr. John P. McDade, Dr. James D. Mills, American College of Emergency Physicians.

Dr. MILLS. Mr. Chairman, I am James D. Mills, a physician from Alexandria, Va.

I have been engaged exclusively in the emergency treatment of the sick and injured for 14 years. I am past president of the American College of Emergency Physicians, and I am currently on its board of directors.

With me, is Dr. John P. McDade, a physician also from Alexandria, Va., and chairman of the college's public policy committee. Dr. McDade serves as chairman of the Alexandria, Va. Emergency Medi-

cal Services Council and on the Metropolitan Washington Emergency Medical Services Council.

Mr. Chairman, we would like to address our comments specifically to Public Law 93–154, the Emergency Medical Services Systems Act of 1973 which is title XII of the Public Health Services Act and section 776 of title VII, the emergency medical services training provisions of the health manpower authorities.

ACEP BACKGROUND

The American College of Emergency Physicians (ACEP) was formed in 1968 by a group of physicians responding to the growing public clamor for improved emergency medical care. ACEP has grown rapidly and now has over 5,800 members whose primary interest is the delivery of emergency medical care.

The primary goal of the college is physician education in emergency medicine and the adequate provision of quality emergency medical services to the American public.

THE NEED FOR EMERGENCY MEDICAL SERVICES

Mr. Chairman, the facts demonstrating the need for emergency medical services programs have been enumerated many times—

100,000 deaths from traumatic injury and heart attack could be prevented each year with improved emergency medical services.

Accidental injury is the leading cause of death among persons from 1 to 38 years of age.

Heart attack is the leading cause of death in the United States; and

5,000 deaths each year from poisoning, drowning, and drug overdoses could be prevented with improved emergency medical services.

I could go on with additional statistics, but believe the benefits of improved emergency medical services can best be stated by experiences of our physician membership, where—

Increased survival rates for neonatal infants;

Reductions in coronary deaths;

Increased poison control center calls with a concurrent decrease in emergency admissions from poisoning; and

Decreases in deaths from automobile accidents.

All have occurred from improved emergency medical services.

EMS SYSTEMS ACT

Public Law 93–154, the Emergency Medical Services Systems Act, was enacted by Congress to meet the demand and need for improved emergency medical services. An EMS system provides for an arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of emergency health care services in an appropriate geographical area. An emergency system must be easily accessible to patients without financial, geographical, or temporal barriers. Communities must demonstrate local support that will continue after Federal assistance has been terminated.

EMS SYSTEMS APPROPRIATIONS

It has been estimated that there may be a need for 400 EMS regional systems in the United States, each serving at least 500,000 people.

If we assume that there is complete and perfect performance by the currently funded 155 projects, we have achieved only 38 percent of our intended goal of providing adequate emergency medical services to the American public.

Naturally, the assumption that all of these projects will be successful is not pragmatic and is unrealistic.

The American College of Emergency Physicians was very active in supporting the development and passage of the EMS Systems Act. We observed the deliberations of the House and Senate in the establishment of the levels of authorization for the program and believe that they are realistic. It has been pointed out that the $185 million over 3 years was considerably less than the American Medical Association's recommendation of $630 million and the thoughtful estimate of Dr. Peter Safer of the Society of Critical Care Medicine of $390 million.

We assume, that Congress enacted successive authorizing spending level increases so that as HEW developed its capabilities to implement the law, and a concurrent greater capability and awareness of communities to develop EMS systems, moneys would be available.

It is difficult for us to understand, when we are beginning to see progress in the development of EMS systems, and the resulting benefits of more effective emergency care, why the administration is proposing reduced budgetory requests.

We recommend, as a minimum, that the appropriations levels for sections 1202, 1203, and 1204, those dealing with feasibility, planning, establishment, operation, expansion and improvement, remain at the same level as fiscal year 1975. We would further endorse an increase over the fiscal year 1975 levels so that communities demonstrating an interest and capability would be able to meet this demand and need—the very reason that Public Law 93–154 was enacted.

I would now like to call on my colleague, Dr. McDade to comment on EMS research and training.

EMS RESEARCH APPROPRIATIONS

Mr. McDade. Mr. Chairman, in establishing research as part of the EMS Systems Act, the Congress requested an applied research program specifically designed to solve the problems faced by EMS systems. Although the general characteristics and components of EMS systems have been clearly outlined in legislation, regulations and guidelines, we can expect and welcome differences in system compositions, priority and acceptance by the community. A stimulating challenge exists to provide targeted research information at the time when it is most needed.

Areas of research that need to be pursued are—

The design of treatment protocols and measures of expected results for the management of emergency conditions.

Evaluation of the effectiveness of new devices, diagnostic measures, and treatment methods.

Policy issues of EMS systems financial support, to name a few.

The administration's request of $2.5 million for fiscal year 1976, a decrease of $2 million from fiscal year 1975 is not sufficient. We understand that this lower level of support will primarily allow only continued funding of ongoing research commitments and not allow any significant new research initiatives.

As you know, the implications of fluctuating research levels creates a situation which hinders total research productivity efforts. One need not be reminded of the difficulties created by turning off, and on, and off the research spigot.

We recommend that section 1205—EMS research be appropriated as a minimum, $4.5 million, the same level of appropriations as fiscal year 1975.

EMS TRAINING APPROPRIATIONS

Our final and most important area of concern is emergency medical services training.

The EMS Systems Act amended title VII of the Public Health Service Act dealing with health manpower adding section 776—"Emergency Medical Services Training." This provision authorizes grants and contracts to educational entities to meet the cost of training programs in the techniques and methods of providing emergency services. Awards have been made for the training of emergency medical technicians-ambulance, emergency medical technicians-advanced emergency medical dispatchers, emergency department nurse training and physician continuing education and training. It was made a single-year authority to conform with the expiration date of the remainder of title VII.

It is our understanding, that the provisions of the continuing resolution, as amended, in effect for fiscal year 1975, do not cover section 776. We further understand, that this omission was inadvertant. No funds have been appropriated therefore, for fiscal year 1975.

Additionally, extension of the authorization of appropriations for this section has been included in legislation extending title VII passed by both the House and Senate last year and reintroduced in both Houses this year. There would appear to be strong evidence of congressional intent to continue support of this program.

In fiscal year 1974, there were over 192 applications requesting over $25.6 million for training under this section. HEW was able to award only 76 of these applications providing training opportunities for over 36,000 people.

With the long deliberations occurring in the authorizing committees on the extension of the health manpower authorities, it appears that a further continuing resolution will be necessary on June 30, 1975.

To correct this legislative omission we strongly recommend to the committee that language be included in this resolution to reinstate section 776, with an appropriation spending level the same as fiscal year 1974.

We further recommend, that when authorizing legislation occurs, $10 million be appropriated for this section. With the unavailability of

funds for the past year, and the unmet training needs that existed prior to its enactment, one can appreciate our concerns and recommendations.

Mr. Chairman, we thank you and the committee for your time and will welcome the opportunity to provide further information on the areas we have discussed, that may be of assistance during your deliberations.

Mr. FLOOD. Thank you.

HEW BUDGET, 1976

WITNESSES

BOYD MARSH, REPRESENTING THE CITY OF CLEVELAND, OHIO, DEPARTMENT OF PUBLIC HEALTH AND WELFARE
DR. NORMAN GREENBERG, MEDICAL DIRECTOR OF THE CHILDHOOD LEAD POISONING CONTROL PROGRAM OF THE CITY OF CHICAGO BOARD OF HEALTH

Mr. FLOOD. Dr. Boyd Marsh, Commissioner of Environmental Health Services, Department of Public Health and Welfare, Cleveland, and Dr. Greenberg, Director of Childhood Lead Paint Poisoning Control Program, Chicago Board of Health.

Dr. MARSH. I certainly appreciate the opportunity to appear before you today and will share my testimony with Dr. Greenberg.

We recognize that the appropriation bill before you is both important and difficult to consider in that it contains funding for the preservation and development of important programs dealing with human resources.

We know that you are under great pressure and that your deliberations are compounded by the current economic atmosphere that prevails from city hall to statehouse and finally to this chamber.

I will today focus upon the need of appropriations for environmental health and sanitation programs, specifically urban rat control and childhood lead poisoning prevention which affect the individual, the family, and the community. Despite the advances of modern medicine, there is serious question as to whether the best medical care, properly delivered to inner-city citizens, has any meaning in face of conditions that breed disease and despair far faster than they can be cured.

The uncertainty created by the lack of funding commitment for essential community health services, such as urban rat control and childhood lead poisoning, is undoubtedly one of the most frustrating aspects of federally funded programs.

To emphasize what I have just stated let's look at a brief funding history and projected future for the urban rat control and childhood lead poisoning programs. In fiscal year 1974 the rat program was funded for $13.1 million while the lead program was allocated $13.4 million. In fiscal year 1975 the rat program funding was stabilized but the lead program funding decreased to $9 million. The proposed fiscal year 1976 budget is suggested to be reduced to $6.6 million for rat control and $3.5 million for lead control programs.

These Federal fund reductions are catastrophic, especially in urban

centers such as Cleveland, where an eroding dollar and decreasing tax base have made it virtually impossible to successfully discharge mandatory responsibilities.

In our lead program during the past 2 years we have tested over 23,000 children and have found about 18 percent of these initially tested children with elevated blood lead levels.

We have also medically treated children and insured that the lead paint hazard in dwellings is reduced.

At the beginning of our rodent control program, some 41 percent of our residential intercity properties had rat problems, while in 1975 19 percent of the properties showed rat problems. We still have a real problem but significant progress has been made. During the time since 1969 the reported rate bites have ranged from a high of 56 to a low of 17.

Cleveland has indeed been fortunate in having received Federal funds for these two programs. Many cities have not. The national need is much greater than the current or proposed level of funding might indicate and I suggest that there needs to be a national commitment to address these needs.

A real concern within the preview of this distinguished committee is the misleading impression often created when programs are continued from 1 fiscal year to the next at the same level.

In such instances the commitment of the Federal Government is not maintained as is implied by the sameness of funding.

In most programs it takes an annual increment of 10 to 15 percent merely to stand still. This Federal appropriation proposal includes examples of the reduction in a national commitment to community health programs. The suggested 50 percent reduction in urban rat control funding and 60-plus-percent reduction in childhood lead poison prevention funding are prime examples.

I would respectfully urge you to make it possible for us to continue our efforts in the promotion of our citizens' health by viewing the appropriations not in light of what we can afford in the traditional sense, but in answer to a more critical question: What will be the ultimate cost to the community and to society if we fail to make an appropriate investment and to take preventive action now?

Thank you.

[The statement follows:]

STATEMENT OF BOYD T. MARSH, M.A., R.S.

Mr. Chairman and members of the committee, I sincerely appreciate this opportunity to appear before you and I extend to you greetings and sincere best wishes from Mayor Ralph J. Perk and the people of Cleveland.

May I say that we recognize that the appropriation bill before you is both important and difficult to consider in that it contains funding for the preservation and development of important programs dealing with human resources.

Those of us working in these fields as well as the people whose lives are directly touched by them, feel very strongly about the levels of Federal appropriations.

We know that you are under great pressure and that your problems are compounded by the current economic atmosphere that prevails from city hall to statehouse and finally to this chamber.

Despite all constraints, I believe that we should act in a manner which reflects the overriding human needs of a nation that must continuously examine the qualitative conditions of society regularly and comprehensively.

I will therefore focus upon the need of appropriations for environmental health and sanitation programs designed to reduce physical and mental disease and social disorder affecting the individual, family, and community health.

Despite the advances of modern medicine, there is serious question as to whether the best medical care, properly delivered to inner-city citizens, has any meaning in face of conditions that breed disease and despair far faster than they can be cured.

The uncertainty created by the lack of funding commitment for essential community health services, such as urban rat control and childhood lead poisoning programs, is undoubtedly one of the most frustrating aspects of Federal aid programs.

To emphasis what I have just stated let's look at a brief funding history and projected future for the urban rat control and childhood lead poisoning programs. In fiscal year 1974 the rat program was funded for $13.1 million while the lead program was allocated $13.4 million. In fiscal year 1975 the rat program was stabilized at $13.1 million but the lead program funding decreased to $9 million. The proposed fiscal year 1976 budget is suggested to be reduced to $6.6 million for rat control and $3.5 million for lead control programs.

These Federal fund reductions are catastrophic, especially in urban centers such as Cleveland, where an eroding dollar and decreasing tax base have made it virtually impossible to successfully discharge mandatory responsibilities.

We find it hard to understand why extensive resources are provided to bail out an aircraft or rail company but the minimal allocated resources to provide the necessary funds to prevent childhood lead poisoning or reduce urban rodent problems are being severely reduced. This is indeed an imbalance in our national effort, in our national priorities, and the most baseless kind of false economics.

The city of Cleveland has been fortunate to have had Federal funds for both the urban rat control and childhood lead poison programs. Cleveland has had critical problems in both areas and with the assistance of Federal funding has moved toward reducing the problems.

For example, in the September 7, 1974 issue of morbidity and mortality weekly reports it is noted that during that reporting quarter Cleveland reported over 15 percent of the children tested with confirmed elevated blood lead levels, and during all of 1974 we tested some 10,000 children with 18 percent initially screened indicating an elevated blood lead level. I might add that our current Federal funding level is about $320,000 with an expected funding level of $200,000 this next project year.

In 1969 a U.S. Public Health Service survey indicated Cleveland as having one of the greatest rat problems in the Nation. In 1974 personnel from the same agency indicated that significant progress had been made in reducing rat infestation rates from 41 percent in 1969 to 19 percent in 1974. During the time since 1969 the reported rat bites have ranged from a high of 56 to a low of 17. Progress has been made but there is a long way to go. I again might add that our current Federal funding level is about $250,000 with an expected funding level of about $200,000 this next project year.

With all of this, Cleveland has been fortunate in having received Federal program funds for these two programs. Many cities have not.

The national need is much greater than the current or proposed level of funding might indicate, and I suggest that there needs to be a national commitment to address these needs.

A real concern within the preview of this distinguished committee is the misleading impression often created when programs are continued from one fiscal year to the next at the same level. In such instances the commitment of the Federal Government is not maintained as is implied by the sameness of funding.

In most programs it takes an increment of 10 to 15 percent merely to stand still. This Federal appropriation proposal includes examples of the reduction in a national commitment to health programs in this Nation. The suggested 50 percent reduction in urban rat control funding and 60-plus-percent reduction in childhood lead poison prevention funding are prime examples.

I would respectfully urge you to make it possible for us to continue our efforts in the promotion of our citizens' health by viewing the appropriations, not in light of what we can afford in the traditional sense, but in answer to a more critical question: what will be the ultimate cost to the community and to society if we fail to make an appropriate investment and to take preventive action now.

Thank you.

Dr. GREENBERG. Thank you for the opportunity to present testimony before the committee. My name is Dr. Norman Greenberg, Medical Director of the Childhood Lead Poisoning Control Program in the city of Chicago Board of Health, and Associate Professor of Psychiatry at the University of Illinois College of Medicine.

Once again we feel compelled to express our concern over the serious problem of childhood lead poisoning.

The Lead-Based Paint Poisoning Prevention Act of 1971 (as amended in 1973) gave us hope of controlling and eventually eliminating this preventable problem; instead, we have little more than the revelation of the depth of the problem.

According to the Center for Disease Control, the component of the Department of Health, Education, and Welfare, responsible for implementing the childhood lead poisoning control programs receiving Federal funds, there are approximately 2.9 million children between the ages of 1 and 6 years seriously at risk of becoming lead poisoned.

Although children can become lead poisoned by exposure to lead from a variety of sources, most of the children at risk live in housing which is deteriorating, and which has peeling paint with a high lead content. As many as 20 percent of very young children who reside in such housing habitually eat flakes of leaded paint, and are therefore in jeopardy of suffering brain damage causing hyperactivity, seizures, retardation, other intellectual damage, and death.

Childhood lead poisoning can exist without obvious symptoms until, even years later, the victim may suffer from serious neurological and psychological damage.

Many communities have no programs whatever and their children are totally at the mercy of prolonged nondetection of their lead poisoning.

In spite of these facts, current efforts to ameliorate such conditions are being thwarted by woefully inadequate and disappearing Federal funding.

Children are continuing to die and become ill unnecessarily.

The Department of Housing and Urban Development is charged with the responsibility of determining the nature and extent of lead paint poisoning problems. But no data is available, since HEW has not developed a data base. The true extent of childhood lead poisining is a mystery.

Today, the administration continues to thwart the effective implementation of the Lead-Based Paint Poisoning Prevention Act by recommending appropriations at the minimal level.

The Congress response to the administration's attitudes has resulted in the appropriation of only a small portion of the amount authorized under the 1973 amendments to the act. Thus, the development of programs at the local level has been greatly impeded.

We urge Congress to redress this decision.

We ask Congress to place elimination of exposure effectively under the medical treatment of lead poisoning: Housing inspection and abatement of lead paint must be considered henceforth an integral part of the health care of lead-exposed children. To accomplish this, we ask Congress to provide funds for the elimination of lead-based paint in dwelling units, with priority for those where children reside who are found to have elevated body lead burdens.

We recommend treating the housing as part of the medical treatment of the child.

We continue to be without adequate knowledge of many aspects of lead paint poisoning. Particularly, we need information on epidemiology, neurotoxicology, more effective means of diagnosis and treatment. It is also essential to have knowledge of long-term effects, specifically, the efforts of low-level exposure to lead on the intelligence and social success of children; on the most appropriate screening and treatment methods, and on the reversibility of lead poisoning.

We ask Congress to continue the biomedical research programs of the Lead-Based Paint Poisoning Prevention Act. None of the moneys authorized and appropriated under the current legislation have been disbursed for research.

Congress needs to appropriate no less than $20 million, a sum which could be effectively administered through existing HEW structure, specifically, the Center for Disease Control.

[The statement follows:]

Once again we feel compelled to express our concern over the serious problem of childhood lead poisoning.

The Lead-Based Paint Poisoning Prevention Act of 1971, as amended in 1973, gave us hope of controlling and eventually eliminating this preventable problem; instead, we have little more than the revelation of the depth of the problem.

According to the Center for Disease Control, the component of the Department of Health, Education, and Welfare responsible for implementing the childhood lead poisoning control health programs receiving Federal funds, there are approximately 2.9 million children between the ages of 1 and 6 years seriously at risk of becoming lead poisoned.

Although children can become lead poisoned by exposure to lead from a variety of sources, most of the children at risk live in housing in which is deteriorating, and which has peeling paint with a high lead content. As many as 20 percent of very young children who reside in such housing habitually eat flakes of leaded paint, and are therefore in jeopardy of suffering brain damage causing hyperactivity, seizures, retardation, other intellectual damage, and death.

Even those whose symptoms seem mild suffer from recurring belly pain, anemia, lethargy, and other nonspecific complaints. Childhood lead poisoning can exist without obvious symptoms until, even years later, the victim may suffer from serious neurological and psychological damage.

Many communities have no programs whatever and their children are totally at the mercy of prolonged nondetection of their lead poisoning.

In spite of these facts, current efforts to emeliorate such conditions are being thwarted by woefully inadequate and disappearing Federal funding, failures of Federal agencies to provide needed planning, program implementation, and support on behalf of children suffering from lead poisoning.

Since the passage of the Lead-Based Paint Poisoning Prevention Act of 1971, a succession of administrations have attempted to block implementation of this legislation. Children are continuing to die and become ill unnecessarily.

The Department of Housing and Urban Development is charged with the responsibility of determining the nature and extent of lead-paint poisoning problems. But no data is available, since HEW has not developed a data base. In the absence of data, we are forced to rely on the National Bureau of Standards' computer-simulation models developed under contract with HUD. The true extent of childhood lead poisoning is a mystery.

At a time when HEW, through its Bureau of Community Environmental Management, was developing a structure and procedure to deal with urban environmental health issues, the administration completely eliminated this Bureau and either eliminated or substantially reduced its programs. In addition, the administration, through such action, has effectively weakened the voice of those health professions who are involved in lead-paint poisoning prevention on the national local level.

Today, the administration continues to thwart the effective implementation of the Lead-Based Paint Poisoning Prevention Act by recommending appropriations at the minimal level, as the following figures demonstrate:

FUNDS AUTHORIZED AND APPROPRIATED

[In millions of dollars]

	1971	1972	1973	1974	1975	1976
(a) Authorized	9.9	16.6	55.0	55	55	55
(b) Recommended appropriations	0	7.5	6.7	9	7	4

The Congress response to the administration's attitudes has resulted in the appropriation of only a small portion of the amount authorized under the 1973 amendments to the act. Thus, the development of programs at the local level has been greatly impeded.

The present act as amended in 1973 would have provided for the progressive establishment of a standard of 0.06 percent by weight of lead in paint. However, the Consumer Product Safety Commission ruled to maintain a level more than nine times this standard, and in doing so, disregarded substantial clinical and expermental evidence as well as the recommendations of the Assistant Secretary of HEW and the Director of the Center for Disease Control.

We urge Congress to redress this decision.

We ask Congress to place elimination of exposure effectively under the medical treatment of lead poisoning: Housing inspection and abatement of lead paint must be considered henceforth an integral part of the health care of lead-exposed children. To accomplish this, we ask Congress to provide funds for the elimination of lead-based paint in dwelling units, with priority for those where children reside who are found to have elevated body lead burdens. Certainly, lead paint must be eliminated from all dwelling units owned, leased, or managed by local public agencies operating with Federal assistance.

We continue to be without adequate knowledge of many aspects of lead-paint poisoning. Particularly, we need information on epidemiology, neurotoxicology, more effective means of diagnosis and treatment. It is also essential to have knowledge of of long term effects, specifically, the effects of low-level exposure to lead on the intelligence and social success of children; on the most appropriate screening and treatment methods, and on the reversibility of lead poisoning.

We ask Congress to continue the biomedical research programs of the Lead-Based Paint Poisoning Prevention Act. None of the moneys authorized and appropriated under the current legislation have been disbursed for research.

As concerned health and community leaders, we must express frustration over the administration's lack of commitment to action on this issue. Urgent domestic health problems such as lead-paint poisoning can no longer be ignored. The American public should expect more from their Government than such tactics as dismissal of staff, failure to collect data, and program cutbacks—all designed to ignore the continuing, critical problem of lead-paint poisoning.

Congress needs to appropriate no less than 25 millions of dollars, a sum which could be effectively administered through existing HEW structure.

Research and Research Training in Microbiology

WITNESS

FRANK E. YOUNG, M.D., PH. D., AMERICAN SOCIETY FOR MICROBIOLOGY

Mr. Flood. Dr. Frank Young, American Society for Microbiology.

Dr. Young. Thank you for the privilege of discussing with you some of the opportunities and needs in research and research training in microbiology. As a member of the Public Affairs Committee of the

American Society of Microbiology, a clinical microbiologist and academician, I have had to deal with some of the recent events that confront our biomedical community. The American Society of Microbiology is composed of 21,000 members who contribute to the applied fields of infectious disease, clinical microbiology, food technology, and industrial applications of microbial actions such a fermentation as exemplified by the wine industry or the manufacture of cheeses. In addition, microbiologists investigate fundamental areas such as genetics, immunology, microbial physiology, virology, oncology and the interactions between a host and its parasites. Today in my role as a citizen witness, I wish to limit my few remarks to the field of medical microbiology and infectious disease.

I am at a loss in coming here trying to talk in a few moments to summarize these vital fields. I feel very much like the statement in Shakespeare, where the actor said, "Out, out, brief candle! life's but a walking shadow, a poor player that struts and frets his hour upon the stage and then is heard no more." I am strutting and fretting a few comments for you and I hope they will be helpful.

Recognizing the importance of research as a mechanism to provide new knowledge that can be subsequently applied through technology to the development of our country's resources and thus prevent disease, the Federal Government initiated a partnership between the academic resources in universities and the National Institutes of Health. This far-sighted program developed science in this country to a position of world leadership. Your subcommittee has already received testimony from the components of the National Institutes of Health and other members of the scientific community. With the advent of legislation to further meet the health needs of our country, the congressional and administrative branches of our Government established far-reaching medicare and medicaid legislation in 1965 that has grown to consume 56 percent of the Federal health budget—increasing from 4.6 billion in 1967 to approximately 18 billion in 1974. While these activities are laudatory, it is essential to maintain and sustain efforts to reduce the human and the economic burden of disease through the prevention of illness.

I believe you have heard a few people this morning stress the need of disease prevention. I find when people are in our hospitals we really fail, unless we can prevent the disease, both the economic and spiritual damage are high.

Quotes from two leaders with different training and perspective may be helpful in illustrating this point.

In 1969 Dr. Marston, director of the National Institutes of Health stated:

> Budget contraints pose another problems for science—that of striking a reasonable balance between the support of basic research and developmental or applied research. We must not forget that most of our insoluble problems can be successfully studied only through free-ranging inquiry of a long term nature. At this point in history the fashionable and glamorous programs tend to be in the area of health service. But it would be a fatal mistake to divert the present inadequate resources supporting medical education into programs directed toward broad societal needs.

More recently, Benno C. Schmidt, Chairman of the President's Cancer panel pointed out:

If any well-run business were spending $100 billion per year on medical care, it would be spending at least 5 percent of that amount on research to reduce those costs. While we cannot go to that level under today's circumstances, sound business judgment requires that we not cut back on the present effort.

It is important to recognize this year the total health budget has come to exceed $100 billion in the United States.

I think one of the most significant advances that we have seen in our lifetime has been the prevention of polio. You have heard this story but possibly a few points need to be emphasized. Dr. Fudenberg calculated the cost and incidence of disability and death and injury due to polio in the period from 1955 to 1961. He estimated that 155,000 cases would occur, and of that, death would be predicted in about 12,500. The lost of income and illness from these individuals would be about $6,389 billion and medical costs alone were $0.327 billion. By comparison, the cost for development of the vaccine was $41 million and the administration of the vaccine $0.11 million. These are quite low, and I have listed a couple of other diseases that show you the savings through the application of research advances to disease.

Another interesting approach is the type of surveillance that we do in upstate New York for streptococcal infections. They, as you know, lead to rheumatic fever, and as the gentleman previously said, some of the problems of hypertension result from kidney involvement that can occur from this disease. It costs approximately, in the County of Monroe, $22.50 to treat a streptococcal pharyngitis. We can diagnose it for about $1.55. Thus, in upstate New York, when 80 percent of the cases actually do not have streptococcal pharyngitis, $1.55 diagnosis is much more economical than a $22.50 treatment.

This brings me to another point. That is, the problems in expanding the need and demand for personnel and research in the field of clinical microbiology. The current health legislation and the newly introduced bill, S. 1737, submitted by Senators Javits and Kennedy, will further stress an already limited manpower pool. Unfortunately, due to the changes and uncertainties introduced by new health services award legislation, the National Institute of Allergy and Infectious Disease was not able to maintain its institutional or university awarded postdoctoral training programs in clinical microbiology. Instead, it is limited to postdoctoral training in venereal disease and allergic diseases. There are fellowships in laboratory medicine available through competitive fellowships for M.D.'s and Ph. D.'s.

There has been an alleged shortage of personnel in microbiology and on the other hand there have been statements that we have a glut of Ph. D.'s.

One antidotal piece of information might be helpful. I recently advertised for a position for an assistant professor in clinical microbiology in our lab. Though nationally advertised I only received four applications for this.

Dr. Peter Allen, chief of the viral diseases branch at the National Institute of Allergy and Infectious Diseases was able to supply me with the name of only one candidate for this position. With the anticipated emphasis on viral causes of disease including cancer and possibly even diabetes, this shortage is significant. Thus we have difficulty in meeting the needs of getting good candidates to fill our positions.

The final background piece of information is that despite the high morbidity and mortality from these diseases our country spends only 32 cents per day of bed disability on research for allergy and infectious disease. I humbly submit that this meager financing is inadequate to meet the demands for applied investigations.

I would like to read the following recommendations on pages 7 and 8 of the statements I prepared.

1. Recognizing the partnership between the Federal Government and the biomedical research community in development of scientific advances in this country and the national resources of biomedical sciences, it is suggested that an advisory committee be established to provide the President with recommendations on science policy, to evaluate ongoing Federal science programs and to inform the Congress about the opportunities and needs of science in our country. It is hoped that such a committee could diminish the continual changes in Federal policy, best exemplified by the "stop-and-go" approach adopted during recent years that has been so destructive to the orderly development of research programs.

While sitting in this chamber this morning I have been impressed with some of the programs you have heard about and the problems of "stop-and-go" in science.

That the National Institutes of Allergy and Infectious Diseases be encouraged to support predoctoral trainees in microbiology and develop postdoctoral training programs to equip Ph. D.'s to contribute to research in the diagnostic and fundamental aspects of clinical microbiology. Such postdoctoral programs should improve the methods used to diagnose and manage microbial infections.

3. That predoctoral education be continued in all fields of basic science as well as the newly created interdisciplinary clusters developed at the National Institute of General Medical Sciences. It is difficult to encompass all training in the interdisciplinary fields of genetics, cell and molecular biology, pharmacological sciences, and systems and integrative biology.

4. Because the cost of medical care is one of the larger aspects of our Federal budget, it is imperative that a significant and constant portion of our health budget be directed to these endeavors. Therefore, I support Mr. Benno Schmidt's proposed investment in research and suggest that at least 5 percent of the total cost for health care be devoted to research.

If in 1949 we had concentrated only on building iron lungs for polio victims and had not supported research, a vaccine would have been developed much more slowly. It is further suggested that at least 10 percent of the total support for research be directed toward training the next generation of scientists. Unfortunately the proposed decrease in the President's budget of $10,741,000 and $25,770,000 for the National Institute of Allergy and Infectious Diseases and the National Institute of General Medical Sciences, respectively, as compared to the 1975 appropriation, would result in severe decreases in both research and research training.

I realize in making these recommendations that there are major constraints on the health budget. However, these research needs are, in my opinion, of utmost importance.

Thank you for your time and consideration.

Mr. FLOOD. Thank you very much.

FRANK E. YOUNG, M.D., Ph.D.

Curriculum vitae

Born: Mineola, New York, September 1, 1931

Union College, Schenectady, New York, 1949-52
M.D. University of the State of New York, Upstate Medical Center, Syracuse, New York, 1956.
Ph.D. Western Reserve University, Cleveland, Ohio, 1962.

1956-57 Intern, University Hospitals, Cleveland, Ohio.

1957-58 Junior Assistant Resident in Pathology, University Hospitals, Western Reserve University.

1958-59 Senior Assistant Resident in Pathology, University Hospitals, Western Reserve University.

1959-60 Resident in Pathology, University Hospitals, Western Reserve University.

1959-62 Predoctoral Fellow in Microbiology, Western Reserve University.

1962 Senior Instructor in Pathology, Western Reserve University.

1962-70 Faculty Research Associate, American Cancer Society.

1962-65 Assistant Professor of Pathology, Western Reserve University.

1963-65 Assistant Pathologist, University Hospitals, Cleveland, Ohio.

1965-68 Associate Member, Departments of Microbiology and Experimental Pathology, Scripps Clinic and Research Foundation, La Jolla, California.

1967-70 Associate Professor of Biology, University of California at San Diego.

1968-70 Member, Departments of Microbiology and Experimental Pathology, Scripps Clinic and Research Foundation, La Jolla, California.

1970- Professor of Microbiology and Chairman, Professor of Pathology and of Radiation Biology and Biophysics, University of Rochester School of Medicine and Dentistry.

1970- Director of Clinical Microbiology Laboratories, Strong Memorial Hospital.

1970- Director of Clinical Microbiology Laboratories, County of Monroe

1974- Pathologist, Strong Memorial Hospital, Rochester, N. Y.

Frank E. Young, M.D., Ph.D.

Memberships:
American Society for Microbiology
Secretary, General Division, 1967-68; Vice Chairman, 1968-69; Chairman, 1969-70
Central New York Branch: Vice President, 1970-71; President, 1971-72
Member, Committee on Public Affairs, 1973-
Member, Annual Meeting Program Committee, 1975
Fellow, American Academy of Microbiology, 1974
American Society for Biological Chemists
American Association of Pathologists and Bacteriologists
American Society for Experimental Pathology
Society for Experimental Biology and Medicine
American Association for the Advancement of Science
Sigma Xi
Alpha Omega Alpha
Editorial Board, Journal of Bacteriology, 1967-73
Infectious Diseases Society of America, 1974-
Member, Subcommittee on the Genus Bacillus, International Committee on Systematic Bacteriology, 1973-

Research interests:
Mechanism of interaction of information containing macromolecules with surface layers of bacterial and animal cells. Two model systems, DNA-mediated transformation and virus infection, are utilized to study the early events involved in alteration of cells by foreign nucleic acid. The primary aim of these studies is to understand more fully the interrelationship of structure and function on a molecular level. In addition, the structure of the cell surface is being analyzed by the investigation of mutants defective in peptidoglycan, teichoic acid, and cytoplasmic membrane synthesis.

Consultantships
National Institute of General Medical Sciences, Microbiology Training Committee, 1972-73

Miles Laboratories, Inc., 1972-

Ad Hoc Consultant for the National Science Foundation and the National Institute of General Medical Sciences of the National Institutes of Health

Ad Hoc Consultant to World Health Organization in the Middle East: Mercury Poisoning Outbreak in Iraq, 1972

Bacteriology and Mycology Study Section, National Institutes of Health, July 1975 - June 1979.

Scientific Advisory Committee for Virology and Cell Biology, American Cancer Society, 1974-78.

FRANK E. YOUNG, M.D., Ph.D.

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Training in Medical Microbiology: Renascence or Retreat

In this issue, we offer the first of a series of articles presented in a seminar under the above title held at the Annual Meeting in May. This seminar, dealing as it does with important professional concerns, was sponsored by the American Academy of Microbiology. Although the Academy addresses itself particularly to professional affairs, such matters must be the concern of all microbiologists. The teaching of microbiology in the medical context is being affected by many adverse influences. Teachers and scientists must be concerned with the trends and must help in reversing those which would discredit and diminish the teaching of microbiology and other science in medical schools as well as the training of microbiologists to meet the growing demands for health care delivery and for progressive medical research. The article that follows and those later in the series will contribute toward progress in the training effort.

Emerging Needs for Personnel in Medical Microbiology

FRANK E. YOUNG

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I hope that this Seminar will provide the opportunity for us to reason together and discuss vigorously the future of our discipline. It is exceedingly important to examine objectively the current opportunities for development of the next generation of scientists who will be involved in medical microbiology. Edward Burger stated in an address to the Public Affairs Committee of the Federation of American Societies for Experimental Biology, "I feel impelled to add that wherever scientific advice is offered it should be unbiased and objective. Advocacy of a point of view or of a particular action tends in the long run only to erode the credibility of scientists as spokesmen for expert judgements." I hope that we can see directions and make plans for the emerging needs in medical microbiology before the decade is past.

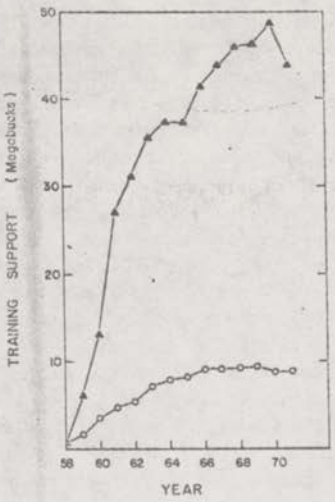
As a discipline, medical microbiology focuses on the host-parasite relationship, including the attributes of the host that are involved in overcoming infection and the traits of the organism that influence pathogenicity. In the 19th and early 20th centuries, emphasis was placed on the major epidemic diseases. Fortunately through improvements in nutrition, sanitation, and research and development of vaccines and chemotherapeutic agents, these diseases have become less pronounced in our country. At the same time, the creation of more sophisticated medical technology has shifted attention to the study of organisms which previously have not been extensively involved in the production of disease, such as anaerobic organisms and opportunistic fungi. These are becoming of even greater importance with the advent of immunosuppression and the increased number of debilitating diseases. Nosocomial infections or diseases that develop after a patient is admitted to a hospital are now recognized as producing significant morbidity and financial burden. According to Sencer, approximately 1.5 million patients a year develop nosocomial infections (2). Of these, 15 thousand die as a direct consequence of these hospital-associated diseases. It is estimated by Sencer that these infections result in a cost of approximately 500 million dollars a year for hospitalization alone. There are also examples of the more classic types of infectious disease, such as gonorrhea, which is currently recognized as a serious epidemic. Social mores, environmental factors, and emerging resistant antibiotic strains combine to aid in the spread of this disease. Finally, it is becoming apparent that the use of antibiotics has not resulted in the eradication of many infectious diseases. Hence, we have turned back the clock to the early thirties and are recognizing again the importance of under-

standing the molecular biology of parasitism. Fortunately, the emphasis of the last two decades on the genetic and biochemical regulation of the microbial cell has provided a partial foundation for these studies. Therefore, with the explosive developments of immunology, we stand on the threshold of an era which I hope will be characterized as the decade of the study of the cellular biology of disease.

To meet this challenge, a number of additional types of microbiologists will be needed. Obviously major activities will continue to be in research and biomedical medical education. A significant problem does exist, however, which will influence training of future medical microbiologists who are interested in parasitism. With emphasis on molecular biology, genetics, and cellular immunology, there has been a relative decrease in the study of pathogenic organisms. Furthermore, because the clinical aspects of microbiology have been abandoned by many medical school departments, we have seen the development of parallel, extensive infectious diseases units in departments of medicine and pediatrics that can provide significant and functional collaboration with microbiologists. Thus, one expanding field of medical microbiology will probably be the development of model systems with pathogenic strains. Particular emphasis will be given to the problems of persistent parasitism and chronic bacterial or viral infections in the immunologically compromised host.

A second and possibly less obvious need is the development of clinical microbiology. In the past this field has been dominated by the clinical pathologist. A number of factors are acting to change this approach to diagnostic microbiology. For instance, the emergence of more sophisticated techniques for rapid diagnosis and the need for detailed knowledge of microbial physiology have made it difficult for the pathologist to keep abreast of these developments. At the same time, the modification of federal and state laws to insist on more quality control in microbiology laboratories may divert the already limited pool of clinical microbiologists into hospital practice. Thus, there will be a shortage of microbiologists who are qualified to participate in clinical research and in developing diagnostic procedures. I wish to emphasize that I am not proposing merely to train managers of clinical laboratories but to direct attention to the investigative aspects of clinical microbiology. Currently there are only a few programs that are aimed at meeting this demand. In such centers, Ph.D.'s with backgrounds in biochemistry, microbiology, biophysics, biology, and genetics and some M.D.'s are exposed to and trained in the challenging field of medical microbiology. Such individuals are essential for developing techniques that will make diagnosis of disease more rapid. As will be shown later, these procedures which are capable of preventing disease are much more humane and economical than the cost of therapy after the individual is compromised by an infectious agent.

The renascence or retreat will be determined in large measure by the capacity to maintain centers of excellence for training in these fields, by the ability to attract and retain highly qualified faculty, and the continued support of the resources of the training centers. The cost of the trainee stipend is only one component in the total development of the educational and research environment. Furthermore, it is probable that many different avenues will be utilized to provide support for these divergent programs. Prior to the 1950's, research and education were predominantly financed by universities, foundations, industry, and local governmental agencies. The unprecedented advance of scientific knowledge and the emergence of leadership of this country in biomedical research were in part based on the Federal Government's commitment to training and research in the biomedical sciences. As shown in Fig. 1, there is a dramatic increase in Federal support for training in the National Institutes of General Medical Sciences (▲) and the National Institute of Allergy and Infectious Disease (○). This support accelerated the training of scientists in this country. Obviously the



Federal Support for Training

continued uncontrolled expansion of this section of the economy would be fiscally intolerable. However, from 1964 this apparent increase has been eroded by inflation. The projected decrease of this significant support for graduate education could produce hardship for many educational centers. The results of these efforts can be seen from preliminary data on the state of 9,909 trainees who have been supported by the National Institute of General Medical Sciences (Table 1). Note that approximately 50% of the trainees are in academic positions today. Most of those in hospital or private practice were in the Pathology Training Program. The preliminary data for Microbiology Trainees are shown in Table 2. Of those who spent six months or longer in the program, 79% have completed or are still in training. Of the 1,081 who have completed the program, approximately 44% are in academic positions and 17% are in postdoctoral fellowships. Only 5% are in hospitals or practice and only 7% in industry. Public service (university faculties, research institutes, governmental health agencies, and continued training in a postdoctoral capacity) accounts for 76% of the trainees.

One might contemplate the effectiveness of these research efforts in another way. The data of Fudenberg show estimated incidence of disability and death from polio (1). Of the projected 155,000 cases (Table 3) in 1955 to 1961, the estimated death and disability are as indicated. Fudenberg calculated the cost of this illness on the basis of income lost during the life of the individual. The loss in income from individuals stricken during this six-year period was 6.389 billion, and medical costs alone were approximately 0.327 billion. By comparison, costs for the development (41 million) and administration of vaccine (0.611 million)

TABLE 1. Status of individuals supported by NIGMS training grants (9,909)

Identifiable positions	Percent
Medical school faculty	24.5
University or college faculty	25.5
Private research institute	2.8
Government health agency	7.0
Military	2.4
Hospital or private practice	7.0
Industry	6.0
Postdoctoral training	15.9
Other	2.9
Unknown	6.0

TABLE 2. Status of trainees in Microbiology (1,081)

Identifiable positions	Percent
Medical school faculty	14
University college faculty	30
Private research institute	6
Government health agency	9
Military	3
Hospital and practice	5
Industry	7
Postdoctoral	17
Other	1
Unknown	8

TABLE 3. Estimated Incidence of Disability and Death from Polio

Degree of disability	Est. incidence
Deaths	12,500
Complete disability	14,300
Marked disability	36,400
Moderate disability	58,100
Slight disability	33,700
Total cases (1955-61)	155,000

were quite low, Parenthetically, it is important to point out that Dr. Enders' work, which was instrumental in permitting the propagation of viruses, was not targeted research. An annual cost analysis of just a few diseases showed savings (in millions per year) as follows: polio, 1,000; measles, 100; viral hepatitis, 100; cytogenetics, 150. I have chosen from these estimates by Fudenberg those diseases or diagnostic contributions which are more closely related to developments in microbiology. The total projected savings is 1.25 billion a year. These figures can be expanded by the data from our own surveillance program for β-hemolytic streptococci. It costs approximately $22.50 to treat a streptococcal pharyngitis in the County of Monroe, whereas it costs only $1.55 to diagnose this disease. In the winter, when we are doing almost 3,000 cultures a week, our rate of positive isolation is only 20%. Thus, almost 80% of the patients could receive a $22.50 treatment instead of a $1.55 diagnosis. Therefore, it is much more appropriate to make the correct diagnosis (which takes 18 hours) than to treat emperically.

In general, it is more economical to prevent microbial disease by developing the procedures which enable the host to ward off the agent than to pay the price in human suffering or dollars after the person has become ill. Unfortunately, our knowledge of the factors which affect host resistance and moderate parasitism by infectious molecular and infectious agents is primitive. Without a sustained thrust to develop these fields, as well as maintaining our research efforts in fundamental nonapplied areas of microbiology, we could jeopardize our progress in controlling infectious diseases.

In conclusion, the challenge facing us is first to determine our manpower needs in emerging areas of medical microbiology, such as in research on pathogenic model systems and research in development and management of diagnostic microbiology. These needs must be balanced by the research and training priorities in other areas of microbiology. Secondly, we must devise the most appropriate methods of support for the training centers. I trust that as a profession we will be able to examine objectively the educational and economic realities in view of fiscal constraints. Our insight and effective leadership will in large part influence the renascence or retreat.

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ASM FOUNDATION

Doris Murray Presents "Blue Spore" to ASM Foundation

The "Blue Spore," an original watercolor painting by Doris Murray, has been presented by the artist to the ASM Foundation. ASM members will remember with pleasure the reproduction of this distinctive work of art on the cover of the September 1972 *ASM News*. Mrs. Murray made the presentation to commemorate the presidency of her husband, R. G. E. Murray, who completed his term as ASM President on 30 June 1973.

The painting now graces the office of Robert A. Day, Managing Editor of ASM, on the sixth floor of the ASM headquarters building. Mrs. Murray's generous gift will be highly prized by members of the Society, members of the Foundation, and ASM headquarters staff.

Support of Workshop Programs

The Directors of the American Society for Microbiology Foundation invite applications for funds to be used to assist in the financing of workshops at the local level. It was previously announced (ASM News 39:3, 1973) that the limited accumulation of funds available now for Foundation programs is to be used to assist workshops, particularly those sponsored by the Local Branches.

An application form for workshop funds is now available and may be obtained by writing to the Professional Services Manager at the Headquarters address. Proposals will be reviewed and evaluated by the Committee on Continuing Education, Marjorie L. Bissett, Chairperson. Approval of awards will then be made, based on the Committee's recommendations, by a committee of Foundation Directors, J. R. Porter, Chairman.

The Branches are urged to take advantage of this availability of funds either to initiate workshop programs at their local meetings or to increase the scope of the programs now being offered.

ABOUT OUR MEMBERS

New Emeritus Members

J. V. Bhat, 407 Chord Road, Block I, Rajajinagar, Bangalore-560010, India.

Francis B. Gordon, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md. 20014.

Awards

Andrew M. Lewis, Jr., Laboratory of Viral Diseases of the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Md., recently received the U.S. Public Health Service Commendation Medal.

Dr. Lewis was honored "for his outstanding research on non-defective adenovirus-SV40 hybrids in laboratory animals which provided basic information on mechanisms of transfer of genetic carcinogenesis in man." Working with viruses which cause tumors in laboratory animals, Dr. Lewis has helped elucidate ways in which viral traits are transmitted through the processes of heredity. Dr. Lewis' work has provided basic information which should prove helpful in the present intense search for viruses causing cancer in man.

Position Changes and Appointments

F. R. Tabita, from Washington State University, Pullman, to the University of Texas at Austin, as Assistant Professor of Microbiology.

John A. Bregnak, from the University of Wisconsin, Madison, to the Department of Microbiology and Public Health, Michigan State University, East Lansing.

Sheldon G. Cohen has been appointed chief of the Allergy and Immunology Branch, Extramural Programs, in the National Institute of Allergy and Infectious Diseases, NIH, Bethesda, Md.

Paul Donaldson, from Northwestern State University of Louisiana at Natchitoches, to Department of Microbiology and Immunology, School of Medicine in Shreveport, Louisiana State University Medical Center.

H. L. Lewis, director of agricultural research at Cotton Incorporated, Raleigh, N.C., has been named a vice-president of the corporation.

Charles Y. Yang has been appointed plant pathologist and head of the Plant Pathology Department of the newly established international research institute, The Asian

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MONDAY, MAY 19, 1975.

D.C. MEDICAL-DENTAL MANPOWER ACT OF 1970

WITNESSES

DR. SEYMOUR ALPERT, GEORGE WASHINGTON UNIVERSITY
REV. BYRON COLLINS, SPECIAL ASSISTANT FOR FEDERAL RELATIONS, GEORGETOWN UNIVERSITY
MARY DORIS RUGGERE, GEORGETOWN UNIVERSITY
PETER BASCH, GEORGETOWN UNIVERSITY
CABLER BERGSCHNEIDER, PEORIA, ILL.

Mr. FLOOD. Dr. Seymour Alpert, George Washington University, Rev. Byron Collins, Special Assistant for Federal Relations, Georgetown University.

Rev. COLLINS. Good morning. With us are students from George Washington and Georgetown University together with Dr. Alpert. We would like to file for the record our statement and make a brief presentation of our needs.

I would like to ask the students to introduce themselves, if that is agreeable, and tell you where they are from.

Mr. FLOOD. Yes.

Miss RUGGERE. My name is Mary Doris Ruggere. I am a senior medical student and class president at Georgetown. I am a resident of Luzerne County, Pa.

Mr. BASCH. My name is Peter Basch. I am a first year student at George Washington Medical School. I am president of my class and chairman of our medical student council. I am from Hartford, Conn.

Mr. BERGSCHNEIDER. My name is Cabler Bergschneider. I am a junior student and I am a resident of Peoria, Ill.

Rev. COLLINS. First we would like to thank this committee for the support of the medical and dental schools in the District of Columbia for the past years. The request before you is for continuation of this. Our basic request is for $5,000 per medical student enrolled at our schools and $3,000 per dental student. The reason the students are here is that this has a very critical meaning to them. Their tuition has been raised, the medical school tuition from $3,500 to $5,000 for this coming year.

The tuition for the dental students has been raised from $3,300 to $4,400. This is the amount of money that they must come up with. If we are unable to persuade the necessity of our demand to the committee, the students themselves will have to come up with the funds that would not be available which would increase their present $5,000 for medical students to $10,000 for this coming year and the dental students from $4,400 to $7,400.

Now the request for the funds is based on about a 6 percent increase of our budgets from last year. We have carefully and systematically, with the presidents of both schools, cut the budget to as low a level as reasonably we can to still maintain quality education. So I think this is the sum of our presentation. If there are any questions that you have, we would be delighted to try to answer them.

Mr. FLOOD. We thank you very much.

[Complete statement follows:]

GEORGE WASHINGTON UNIVERSITY,
SCHOOL OF MEDICINE,
GEORGETOWN UNIVERSITY,
SCHOOLS OF MEDICINE AND DENTISTRY,
Washington, D.C., May 15, 1975.

Hon. DANIEL J. FLOOD,
Chairman, Subcommittee on Labor-HEW Appropriations, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN FLOOD: Attached is testimony and supporting exhibits supplied by the medical schools at George Washington and Georgetown Universities and the dental school at Gergetown University. This testimony and exhibits are submitted for May 19th hearings before your Committee regarding consideration of fiscal year 1976 appropriations under the District of Columbia Medical-Dental Manpower Act of 1970 as amended.

T. BYRON COLLINS, S.J.,
Special Assistant to the President,
Georgetown University.
SEYMOUR ALPERT, M.D.,
Vice President,
George Washington University.

Congressman Flood, Congressman Michel and committee members, I am Fr. T. Byron Collins, S.J., special assistant to the president of Georgetown University. With me is Seymour Alpert, M.D., vice president of George Washington University.

It is a pleasure to appear before your committee to present an appropriations request for fiscal year 1976 for the schools of medicine at Georgetown and George Washington Universities and the school of dentistry at Georgetown University. The specific item should be included in the Health Resources Administration Federal Budget. The legislation under which this item has been authorized is called the District of Columbia Medical and Dental Manpower Act as amended Public Law 93-389). This is the last year we will be appearing under this act as its expiration date is June 30, 1976.

In order to meet our operating costs, to maintain the excellence of our programs throughout the metropolitan area of the District of Columbia and to provide for our increased student body, the schools of medicine at Georgetown and George Washington Universities request up to $5,000 under the authority of this act for each full-time medical student enrolled. Likewise, the Georgetown University School of Dentistry requests up to $3,000 per full-time dental student. The total amount we are seeking is $9,050,000. The specific allocation to the individual schools is as follows:

Fiscal year 1976:	
George Washington University School of Medicine ($5,000×610 students)	$3, 050, 000
Georgetown University School of Medicine ($5,000×840 students)	4, 200, 000
Georgetown University School of Dentistry ($3,000×600 students)	1, 800, 000
Total	9, 050, 000

We turn to Congress for financial support primarily for two reasons:

1. Since our schools are located in the District of Columbia, Congress, in effect, becomes our "State legislature" and we look to Congress for the support that the majority of States are providing their private medical schools. A recent study shows that the average amount of aid that States give to their medical schools exceeds by over $700 the maximum funding level of $5,000 per full-time student that we can obtain under the D.C. Medical-Dental Manpower Act.

2. Our schools are a national resource, not only because 47 States are represented in our student bodies, but, more importantly, because we are located in the District of Columbia and provide substantial health manpower resources to the Federal Government in the District of Columbia metropolitan area.

The amount requested for 1976 is an increase of $1,550,000 over the amount requested last fiscal year. The 1975 amount is in the process of being awarded

by the Secretary of HEW after considerable assistance from your committee. The basic reason for this requested increase for fiscal year 1976 results from expiration of the Federal physician augmentation program (PAP). In order to meet a national need for the education of increased numbers of physicians, Georgetown University in 1970 applied for and received a PAP award from the Department of Health, Education, and Welfare.

This award was for the maximum 5-year period (1971 through 1975). Under this program, Georgetown did successfully serve the country by practically doubling the enrollment in its school of medicine. In May of this year, Georgetown will graduate more than 200 medical students. However, this PAP support program expires June 30, 1975. HEW has not requested the extension of the legislative authority for PAP nor has Congress initiated renewal.

Because of this PAP award during fiscal year 1975, Georgetown did not request the full amount authorized under the D.C. Medical-Dental Manpower Act (Public Law 93-389). The termination of the PAP program accounts in large measure for the necessity to increase the total amount of money requested for fiscal year 1976 under Public Law 93-389. However, this request remains within the authorization limits of $5,000 per medical student and $3,000 per dental student.

In addition to our request under this legislation, which is essential for the continued operation of the schools in fiscal 1976, the medical schools are increasing their tuition charges substantially from the present $3,500 for the current academic year to $5,000 for the academic year starting in the fall of 1975. The dental school has increased its tuition charges from $3,200 for this present year to $4,400 as of September 1975. These increased tuition charges mean that both Georgetown and George Washington Universities are among the highest of any private medical and dental schools in the country in the expensiveness of their tuition levels.

Tuition increases of this overall magnitude have been necessary even though we have done our utmost to curtail expenses for fiscal year 1976. Although we have developed a no-growth budget for fiscal year 1976, an increase in expenses of approximately 7 percent is still necessary because of the effects of inflation on the costs of supplies and services and the necessity for a salary increase in order to retain and attract competent people and enable them to cope with a higher cost of living. The details of the budget are shown on the attached exhibits. The amount raised by the tuition increase coupled with the additional financial support provided by the Medical-Dental Manpower Act will assist in meeting the increased expenses shown in the attached budgets.

As one way of showing the success of our efforts to control costs, a recent Institutional Profile System Ranking Report published in February 1974 by the Association of American Medical College (AAMC) shows that, of 92 medical schools submitting data, Georgetown ranked 90th and George Washington ranked 92d in regular operating expenditures per undergraduate medical student—among the three medical schools having the lowest operating expenditures in the United States.

Georgetown and George Washington Universities have requested the Secretary of Health, Education and Welfare to include necessary funds for the Medical-Dental Manpower Act of the District of Columbia. The Secretary responded that financial distress funds were available to us under the health manpower legislation. Distress funding available for all medical and dental schools in the United States for fiscal year 1976 is $5 million—a sum inadequate for the Nation's needs. As this committee knows from our past experience, the financial distress funds in fiscal year 1974 were increased as an emergency measure specifically to provide funds to meet the operating costs at the medical schools of Georgetown and George Washington Universities and the dental school at Georgetown. The Medical-Dental Manpower Act of the District of Columbia was enacted so that it would not be necessary to use the vehicle of the financial distress section of the health manpower legislation. We attach the exhibits to the Secretary and his response.

We have appreciated the opportunity to appear before you.

T. Bryon Collins, S.J.,
Special Assistant to the President,
Georgetown University.
Seymour Alpert, M.D.,
Vice President,
George Washington University.

GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, AND GEORGETOWN UNIVERSIY SCHOOLS OF MEDICINE AND DENISRY

REQUEST FOR APPROPRIATIONS UNDER THE DISTRICT OF COLUMBIA MEDICAL-DENTAL MANPOWER ACT OF 1970 (AS AMENDED)

Purpose of legislation.—The act provides emergency funds to meet the operational costs of the medical schools in the District of Columbia at George Washington University and Georgetown University and the dental school at Georgetown University.

History and background.—The bill, originally passed as Public Law 91–650, authorized funds to meet the critical operational costs of these schools. On August 24, 1974, a 2-year extension of the bill was approved and became Public Law 93–389. This act enables appropriations for the years ending June 30, 1975 and June 30, 1976. Due to the impetus of this law, the Secretary of Health, Education and Welfare has for 4 years given grants to keep these schools open. There are almost 11,000 graduates of these schools practicing in all 50 States and the District of Columbia. The present classes of these schools number over 1,900 students representing 47 States and the District of Columbia.

Method.—By authorizing the Secretary of Health, Education and Welfare to provide funds to the schools of up to a maximum of $5,000 per year for each medical student and up to $3,000 per year for each dental student in accordance with the demonstrated financial need of the schools. The total amount requested for fiscal year 1976 is $9,050,000.

Similar support given by the States.—A majority of the 50 States currently provide financial assistance to private medical schools. The average State support is in excess of $5,700 per student. Dental school programs are similar. (Please see the attached list for more detail.)

Howard University.—Howard University presently receives operational funds from the Department of Health, Education and Welfare.

Necessity for these funds to meet operational costs.—The School of Medicine at George Washington University and the Schools of Medicine and Dentistry at Georgetown University cannot remain in operation without the funds to be appropriated under the authority of this legislation. There are 14 area hospitals directly dependent on the staffs and programs of the dental school at Georgetown University and the medical schools of George Washington University and Georgetown University.

T. BRYON COLLINS, S.J.,
Special Assistant to the President,
Georgetown University.
SEYMOUR ALPERT, M.D.,
Vice President,
George Washington University.

GEOGRAPHIC DISTRIBUTION OF CURRENT STUDENTS (1974-75) ATTENDING THE GEORGETOWN UNIVERSITY SCHOOLS OF MEDICINE OR DENTISTRY AND THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE. ALSO, GRADUATES IN PRACTICE.

FEBRUARY 1975

STATE	CURRENT STUDENTS	GRADUATES IN PRACTICE	TYPE OF SCHOOL PUBLIC	PRIVATE	STATE SUPPORT OF PRIVATE IN-STATE MEDICAL SCHOOL OR REGIONAL MEDICAL SCHOOL
ALABAMA	4	45	2	-	Southern Reg. $2750 per student
ALASKA	0	10	-	-	Western Reg. $5000 per student
ARIZONA	11	80	1	-	Western Reg. $5000 per student
ARKANSAS	0	5	1	-	
CALIFORNIA	181	910	5	3	$12000 per additional student
COLORADO	4	65	1	-	
CONNECTICUT	93	508	1	1	
DELAWARE	8	44	-	-	$8000 per student
DIST. OF COL.	72	892	1	2	D.C. Med.-Dent. Act & HEW funds
FLORIDA	36	376	2	1	$8000-10000; S. Reg. $2750/stu.
GEORGIA	8	71	1	1	Southern Reg. $2750 per student
HAWAII	4	32	1	-	
IDAHO	5	38	-	-	Western Reg. $5000 per student
ILLINOIS	18	105	2	5	$6000 to $7000
INDIANA	6	47	1	-	
IOWA	1	21	1	-	
KANSAS	5	18	1	-	
KENTUCKY	1	32	2	-	Subsidy by Negotiation
LOUISIANA	2	27	2	1	Southern Reg. $2750 per student
MAINE	1	60	-	-	New Eng. Reg. $5000 per student
MARYLAND	204	1,234	1	1	Neg. Yearly; S. Reg. $2750/stu.
MASSACHUSETTS	143	637	1	3	New England Reg. $5000 per stu.
MICHIGAN	13	106	3	-	
MINNESOTA	3	44	2	1	$8000 per Minn. student
MISSISSIPPI	1	12	1	-	Southern Reg. $2750 per student
MISSOURI	8	37	2	2	Legislation Pending
MONTANA	4	15	-	-	Western Reg. $5000 per student
NEBRASKA	0	3	1	1	Legislation Pending
NEVADA	7	30	-	-	Western Reg. $5000 per student
NEW HAMPSHIRE	12	57	-	1	$5000
NEW JERSEY	219	950	2	-	
NEW MEXICO	5	33	1	-	
NEW YORK	472	1,723	4	8	$3000 to $6000
NORTH CAROLINA	8	131	1	2	$5000/NC stu.; S. Reg. $2750/stu.
NORTH DAKOTA	6	10	1	-	
OHIO	31	193	2	2	$5400 per student (approximately)
OKLAHOMA	5	26	1	-	
OREGON	2	43	1	-	
PENNSYLVANIA	100	641	2	5	$4400 to $7465
RHODE ISLAND	17	183	-	1	$600,000 Spec. Grant; NE Reg. $5000
SOUTH CAROLINA	2	56	1	-	
SOUTH DAKOTA	4	8	1	-	
TENNESSEE	9	31	1	2	Negotiated; S.Reg. $2750 per stu.
TEXAS	10	119	5	1	$17,282
UTAH	38	102	1	-	
VERMONT	7	23	1	-	
VIRGINIA	95	729	2	1	Southern Reg. $2750 per student
WASHINGTON	24	109	1	-	
WEST VIRGINIA	2	39	1	-	
WISCONSIN	8	54	1	1	$4950 per student
WYOMING	1	10	-	-	Western Reg. $5000 per student
TOTALS	1,930	10,775	66	46	

PROJECTED TUITION RATES FOR U.S. MEDICAL SCHOOLS
FOR 1975-76 SCHOOL YEAR
(Listed Alphabetically by State)

NOTE: Resident tuition listed first; then non-resident.

NOTE: Figures current as of February, 1975.

STATE	NAME OF SCHOOL	TUITION
AL	Univ. of Alabama	$1,600; $3,200
AL	Univ. of Southern Alabama	$675; $1,875
AZ	Univ. of Arizona	$1,050; $2,300
AR	Univ. of Arkansas	$1,300; $2,600
CA	Univ. of California, Davis School of Medicine	$670; $2,170
CA	Univ. of California, Irvine Cal. College of Medicine	$892; $2,392
CA	Univ. of California, Los Angeles School of Medicine	$684; $2,184
CA	Univ. of California, San Diego School of Medicine	$700; $2,200
CA	Univ. of California, San Francisco School of Medicine	$720; $2,200
CA	Loma Linda University School of Medicine	$3,800; $3,800
CA	Univ. of Southern California School of Medicine	$3,580; $3,580
CA	Stanford University School of Medicine	$4,000; $4,000
CO	Univ. of Colorado School of Medicine	$1,092; $4,369
CT	Univ. of Connecticut School of Medicine	$950; $1,850
CT	Yale University School of Medicine	$4,100; $4,100
DC	Georgetown University School of Medicine	$5,000; $5,000
DC	George Washington University School of Med.& Health Sciences	$5,000; $5,000
DC	Howard University College of Medicine	$1,500; $1,500
FL	Univ. of Florida College of Medicine	$1,050; $2,250
FL	Univ. of Miami School of Medicine	$2,660; $2,660
FL	Univ. of Southern Florida College of Medicine	$1,050; $2,250
GA	Emory University School of Medicine	$3,100; $3,100
GA	Medical College of Georgia School of Medicine	$1,050; $2,100
HI	Univ. of Hawaii School of Medicine	$700; $1,750
IL	Univ. of Health Sciences The Chicago Medical School	$4,000; $4,000
IL	The Univ. of Chicago, The Pritzker School of Medicine	$4,000; $4,500
IL	Univ. of Illinois School of Medicine	$900; $1,875
IL	Loyola Univ. of Chicago, Stritch School of Medicine	$4,200; $4,200
IL	Northwestern University Medical School	$3,800; $3,800
IL	Rush Med.Col.of Rush Univ.Rush-Presb.-St.Luke's Med.Center	$1,200; $1,200
IL	Southern Illinois Univ. School of Medicine	$642; $1,926
IN	Indiana University School of Medicine	$1,050; $2,200
IA	The University of Iowa College of Medicine	$1,200; $2,500
KS	Univ. of Kansas School of Medicine	$1,050; $2,050
KY	Univ. of Kentucky College of Medicine	$900; $1,800
KY	Univ. of Louisville School of Med.,Health Sciences Center	$1,225; $2,150
LA	Louisiana State Univ. School of Medicine, New Orleans	$800; $2,300
LA	Louisiana State Univ.Med.Center,School of Med.,Shreveport	$800; $2,000
LA	Tulane University School of Medicine	$3,500; $3,500
MD	The Johns Hopkins University School of Medicine	$3,400; $3,400
MD	Univ. of Maryland School of Medicine	$1,500; $3,000
MA	Boston University School of Medicine	$4,900; $4,900
MA	Harvard Medical School	$3,250; $3,250
MA	The University of Massachusetts Medical School	$600; $600

STATE	NAME OF SCHOOL	TUITION
MA	Tufts University School of Medicine	$3,950; $3,950
MI	Michigan State University College of Human Medicine	$816; $1,836
MI	The University of Michigan Medical School	$1,600; $3,200
MI	Wayne State University School of Medicine	$1,554; $3,180
MN	Mayo Medical School	$2,300; $3,500
MN	Univ. of Minnesota-Duluth, School of Medicine	$1,410; $3,150
MN	Univ. of Minnesota-Minneapolis Medical School	$1,920; $4,242
MS	Univ. of Mississippi School of Medicine	$864; $1,464
MO	Univ. of Missouri-Columbia School of Medicine	$730; $1,810
MO	The University of Missouri-Kansas City School of Medicine	$724; $1,944
MO	St. Louis University School of Medicine	$3,100; $3,100
MO	Washington University School of Medicine	$3,100; $3,100
NE	Creighton University School of Medicine	$3,600; $3,600
NE	Univ. of Nebraska College of Medicine	$960; $1,920
NV	Univ. of Nevada, Reno, School of Medical Sciences	$2,000; $7,000
NH	Dartmouth Medical School (New Hampshire)	$4,895(years 1& 2) $5,340(years 3& 4)
NJ	College of Med.&Dent.of N.J., New Jersey Medical School	$1,750; $3,000
NJ	College of Med.&Dent.of N.J., Rutgers Medical School	$1,200; $1,800
NM	The Univ. of New Mexico School of Medicine	$630; $1,500
NY	The Albany Medical College of Union University	$3,000; $3,000
NY	Albert Einstein College of Medicine of Yeshiva Univ.	$3,750; $3,750
NY	Columbia Univ., College of Physicians and Surgeons	$3,750; $3,750
NY	Cornell University Medical College	$4,000; $4,000
NY	Mt. Sinai School of Medicine of the CUNY	$3,300; $3,300
NY	New York Medical College	$4,000; $4,000
NY	New York University School of Medicine	$3,350; $3,350
NY	The University of Rochester School of Medicine & Dentistry	$3,275; $3,275
NY	State Univ. of New York at Buffalo School of Medicine	$1,650; $2,050
NY	State Univ. of New York, Downstate Med.Ctr.Col. of Med.	$1,600; $2,000
NY	State Univ. of New York at Stony Brook Health Sc.Ctr.S.of M.	$1,600; $2,000
NY	State Univ. of New York,Upstate Med.Ctr. College of Med.	$1,600; $2,000
NC	The Bowman Gray School of Medicine of Wake Forest Univ.	$2,750; $2,750
NC	Duke University School of Medicine	$3,400; $3,400
NC	The University of North Carolina School of Medicine	$670; $2,300
ND	Univ. of North Dakota School of Medicine	$1,000; $2,000
OH	Case Western Reserve University School of Medicine	$3,000; $3,000
OH	Univ. of Cincinnati College of Medicine (Cin.)$1,200-(Ohio)	$1,350; $2,250
OH	Medical College of Ohio at Toledo	$1,200; $1,650
OH	The Ohio State University College of Medicine	$1,280; $2,680
OK	Univ. of Oklahoma College of Medicine	$765; $1,669
OR	Univ. of Oregon Medical School	$948; $2,073
PA	The Hahnemann Medical College of Philadelphia	$3,725; $3,725
PA	Jefferson Medical College of Thomas Jefferson University	$3,500; $3,500
PA	The Medical College of Pennsylvania	$3,300; $3,300
PA	The Pa.St.Univ.Col.of Med.The Milton S.Hershey Med.Center	$1,500; $3,000
PA	University of Pennsylvania School of Medicine	$3,730; $3,730
PA	University of Pittsburgh School of Medicine	$1,300; $2,600
PA	Temple University School of Medicine	$1,500; $3,000
PR	Univ. of Puerto Rico School of Medicine	$570; $570
RI	Brown University Program in Medicine	$3,500; $3,500
SC	Medical Univ. of South Carolina College of Medicine	$720; $1,460
SD	The University of South Dakota School of Medicine	$1,150; $2,600
TN	Meharry Medical College School of Medicine	$2,175; $2,175
TN	Univ. of Tennessee College of Medicine	$1,364; $2,836

STATE	NAME OF SCHOOL	TUITION
TN	Vanderbilt University School of Medicine(Tenn.)	$2,800; $2,800
TX	Baylor College of Medicine	$400; $2,800
TX	Texas Technological University School of Medicine	$400; $1,200
TX	Univ. of Texas, Medical Branch at Galveston School of Med.	$400; $1,200
TX	Univ. of Texas, Medical School at Houston	$300; $900
TX	Univ. of Texas Health Science Ctr. at San Antonio Med. School	$400; $1,200
TX	Univ. of Texas Health Sci.Ctr.at Dallas SW Medical School	$300; $900
UT	Univ. of Utah College of Medicine	$850; $1,450
VT	Univ. of Vermont College of Medicine	$1,450; $3,150
VA	Eastern Virginia Medical School	$3,500; $4,500
VA	Med.College of Virginia S.of M.of Va.Commonwealth Univ.	$1,296; $2,536
VA	Univ. of Virginia School of Medicine	$900; $2,200
WA	Univ. of Washington School of Medicine	$1,120; $2,452
WV	West Virginia University School of Medicine	$543; $1,379
WI	The Medical College of Wisconsin	$2,700; $2,700
WI	Univ. of Wisconsin Medical School	$1,500; $3,200

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Washington, D.C. 20037 / (202) 331-0200

The University Hospital
901 Twenty-third Street, N.W.

DOCUMENTATION OF INCREASES IN THE NUMBER OF STUDENTS AND INCREASES IN HEALTH MANPOWER SERVICES TO THE METROPOLITAN AREA OF THE DISTRICT OF COLUMBIA BY THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER SINCE THE PASSAGE OF THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT(P.L. 91-650) IN 1970

The George Washington University Medical Center continues to demonstrate its valuableness as a health care resource for the populace of the greater Washington metropolitan area.

Service provided to Washington area residents was recently analyzed. This analysis of geographical location for patients who were hospitalized at the George Washington University Medical Center showed that 51.94% of the patients resided within the District of Columbia; 30.27% in Maryland, 14.92% in Virginia and 2.85% lived elsewhere. The number of hospitalizations at G.W.U.M.C. has remained at approximately 20,000 over the past five years despite a reduction in the number of available beds. Thus the length of hospital stay for all episodes of care has been reduced.

Recognition of the fine health care available at George Washington University Medical Center can be documented by the increasing number of patient visits to the Out-Patient Service areas. The number of Emergency Room visits has increased by an overwhelming 75.8% since 1968. In fact, from 1968 to 1972 there was an increase of approximately 2,500 visits for each year in this time period. In 1974 the emergency room visits exceeded 1973 visits by 3,500. Based on this growth rate, it could be expected that in 1975 the emergency room at G.W.U.M.C. would provide service to about 48,000 patients. Looking forward to 1976 and the increased number of tourists for the Bicentennial Celebration, it would be reasonable to expect a tremendous volume of emergency room visits since the George Washington University Medical Center is the only hospital with an emergency room located in the historic Monumental area of the Nation's Capital.

Out-patient clinical areas have also shown significant service growth. Out-patient visits in 1974 rose by 5,590 over the 107,572 recorded patient visits in 1973. For the first part of 1975 a record-breaking number of 58,012 visits have already been serviced in the out-patient areas.

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The Health Maintenance Organization which began offering service in June of 1972 with an enrollment of 1800 subscribers has grown to 5,100 members in January, 1975. The Health Plan was opened to Federal employees in 1974. This new element of members added 2,200 subscribers to the Health Maintenance Organization. In addition, the number of members in the Blue Cross-Blue Shield category rose from 500 in 1973 to nearly 2,300 members presently enrolled.

One of the areas in which the George Washington University Medical Center led the nation in offering an alternative health care resource was in the area of In-and-Out Surgery. From 1970 through 1975, a total of 60,537 procedures were performed in the In-and-Out Surgery area of G.W.U.M.C. For the 1974 calendar year, there was an average of 37 procedures done each day for a total of 13,390 surgical procedures performed in the In-and-Out Surgery area of the George Washington University Medical Center.

It would be certain that the George Washington University Medical Center will continue to offer innovative and timely methods of health care delivery to the population of the greater Washington metropolitan area.

1. CORONARY PREVENTION PROJECT. The Coronary Prevention Project (CPP), a collaborative effort with the National Heart and Lung Institute, provides free cholesterol and blood pressure screening for men and women between the ages of 30 and 59. Since 1973 the Project has been cooperating with local businesses, news media and municipal and federal agencies to make these screenings available to the largest possible number of people. To date, nearly 16,000 individuals have been screened. CPP recently took its program to Congress with two weeks of tesing for House and Senate members and their staffs as well as other Capital building employees. WMAL donated the use of its television studios for the CPP's first community-wide screening and provided substantial air time to tell the public about the program. The Coronary Prevention Project is also participating in a major nationwide study of cholesterol and heart disease with 11 other medical centers throughout the U.S. and Canada. The study's purpose is to determine the value of lowering cholesterol in the prevention of heart attack which claims twice as many lives each year as cancer. Those who have their cholesterol checked and are found to have an elevated level are eligible to participate in a further free medical program coordinated by the Coronary Prevention Project.

   CONTACT: Dr. John LaRosa
   Director
   Coronary Prevention Project
   331-6746

2. PAP TEST PROGRAM. This year 12,000 American women will die of uterine cancer; about 43,000 cases are diagnosed annually. The Pap test, a simple painless procedure, signals the presence of cancer at a stage when it can be most easily treated. "No woman need die of cervical cancer if it is diagnosed in time," says Dr. Larry McGowan, Director of the Division of Gynecologic Oncology which is offering free Paptests to women in the metropolitan area. A special effort is being made to contact women between the ages of 20 and 25 and sexually active younger women since data indicate a casual relationship between uterine cancer and early sexual activity. The program is supported with the aid of funding from the Alexander and Margaret Stewart Trust Fund.

   CONTACT: Dr. Larry McGowan
   Director
   Division of Gynecologic Oncology
   331-6357

3. HOME CARE PROGRAM. Through this program the home care needs of the cancer patient are met by a team composed of nurse practitioners, enterstomal therapists, social service workers and public health nurses. The team assesses the patient's needs whether he or she is in the hospital, doctor's office or home and offers a complete and comprehensive program of post-hospital care and follow-up. Every attempt is made to facilitate early discharge of the hospitalized patient, permit the advanced cancer patient to spend the greatest period of time at home in a familiar environment, and provide emotional support to patients and their families as they cope with the problems associated with the disease. The staff coordinates the patient's medical

care with the physician, nursing staff, therapists and social and community agencies. In addition, the Medical Center operates a mobile van to transport patients to and from therapy daily. There is no charege for the services of the home care team; substantial financial support is provided by the Alexander and Margaret Stewart Trust Fund. Through this program, costly health resources are conserved. The program has been operating since 1971 and is staffed to care for 25 patients at any given time.

CONTACT: Mary Silverman
Director
Home Care Program
331-6755

4. CORONARY CARE SYSTEM. The Division of Cardiology has developed one of the most advanced coronary care systems on the east coast. In the past several years, the staff has applied new techniques to save patients who heretofore would have died from cardiogenic shock. New instrumentation, new technology and new clinical use of physiological principles mean that patients are alive today who four years ago would not have survived. The Coronary Care Unit, a sophisticated facility to care for the acutely-ill cardiac patient, has implemented new therapeutic approaches which permit the staff to personalize each patient's care. A computer system monitors literally every heart beat in a much more efficient manner than was ever before possible. The computer has recently been used to analyze rhythm disorders when the patient leaves the CCU to go to the Progressive Coronary Care Unit (PCCU). Although the PCCU patient is no longer confined to bed and is free to move about, his or her condition requires continued close scrutiny by the medical and nursing staff before discharge can occur. "Telemetry" has been introduced to monitor the heart rhythms of these patients as they sit in their room or walk about the halls. Patients wear portable transmitters which send out heartrate signals to the nursing station; here, the signals appear on a television-like screen and are printed on ECG strips. If the rate varies from the patient's norm, the telemetry device sounds an alarm and graphs the rhythm on paper for evaluation. With the introduction of telemetry, the specially-monitored CCU beds are freed for the persons requiring intensive care. The CCU has an unusually high success rate; 90% of the patients are eventually transferred to the PCCU for rehabilitation. The staff of the PCCU attempts to meet the psychological needs of patients as well as their medical needs. Patients are not made to feel like invalids but are ambulated as soon as feasible; they are educated about their disease and learn what they can do to prevent future illness; specially trained nurses assist the patient in coping with fears which may be an important factor in rehabilitation. The CCU and PCCU are important learning environments for medical students and other allied health professionals studying in the School of Medicine and Health Sciences.

CONTACT: Dr. George Kelser
Director
Division of Cardiology
331-6644

5. REHABILITATION RESEARCH AND TRAINING CENTER. The Rehabilitation Research and Training Center at GWU is staffed by a multidisciplinary team capable of designing and implementing new methodology and techniques. These techniques improve the delivery of medical and vocational rehabilitation to patients who are disabled and impaired by physical and/or emotional disorders. The core programs of the Center are in the areas of vocational rehabilitation, cardiopulmonary disease, psychosocial problems and neurologic disorders. Research programs develop as a result of needs perceived in patient care and client services both within the Medical Center and within the city, state and regional agencies; research utilization, in turn, modifies patient care and affects training procedures and the delivery of patient services in the field. The Center receives funding from the Department of Health,Education and Welfare.

CONTACT: Dr. John Naughton
Director and Dean
for Academic Affairs
331-6501

6. OBSTETRICS CLINIC FOR METHADONE MOTHERS. With the support of a private foundation, up to 40 mothers who are on methadone treatment receive routine prenatal care. The staff of the obstetrics clinic makes special efforts to assure optimal nutrition of the mother and developing infant. Reviews of smoking, alcohol, multiple drug abuse and toxic exposures are obtained. One of the objectives of the Clinic is to learn more about the effect of methadone treatment in pregnancy on infant development.

CONTACT: Dr. Allan Weingold
Chairman, Department
of Obstetrics and
Gynecology
331-2771

7. DRUG ABUSE PROGRAM. In recognition of the magnitude of the problem of heroin addiction in the city, the Community Care Center in 1971 established a methadone maintainance program for young multiple drug abusers. With the decline of narcotics abuse as a major problem, the program in 1973 was converted to a Poly Drug Abuse Pilot Project funded by the National Institute of Mental Health. Patients are withdrawn from sedatives, stimulants and narcotics in the hospital environment and entered into a day care program. Their health maintainance is provided by the Community Care Center.

CONTACT: Dr. Earl Sutherland
Director, Drug Abuse
Program
331-6189

8. COMMUNITY CARE CENTER. In 1970 the Community Care Center was organized to serve the medical needs of the 50,000 residents of D.C. Area Nine, adjacent to the University Campus. Patients have access to the full range of medical specialties in the ambulatory care setting and at University Hospital as well as the diagnostic and therapeutic resources of the Medical

Center. Preventive medical care is provided by teams composed of a physician social worker, medical students, nurse practitioner and physician's assistant. At the time of the formation of the University's health maintenance organization, a new concept in team structure was developed within the Community Care Center. One of the teams was enlarged to include both pediatricians and internists in addition to the other members of the team, and the unit assumed responsibility for the care of families of three or more persons enrolled in the HMO. This health care delivery system constitutes the core of experience for graduate trainees and medical students specializing in primary care and family medicine.

CONTACT: Dr. Steven Schroeder
Director, HMO
331-6369

9. GEORGE WASHINGTON UNIVERSITY HEALTH PLAN. The George Washington University Health Plan is a prepaid health maintenance program which strives to avoid costly hospitalizations and illnesses by keeping enrollees well through a regular program of medical care. The plan offers preventive medicine, emergency treatment, full hospitalization and all the diagnostic and therapeutic resources of the University's Medical Center at a fixed annual fee. For the past three years, the plan has been able to provide 2000 medicaid enrollees of the Distric of Columbia with high quality medical care at lower costs than under the regular Medicaid fee-for-service system. Recently the plan was offered as an alternative to groups enrolled with Blue Cross/Blue Shield in the metropolitan area,and in January, 1975 the federal employees became eligible to enroll through an umbrella corporation. This corporation was created jointly by GWU and Georgetown University's Health Plan. There are presently 5100 persons enrolled in the GWU Health Plan. Their health maintenance care is provided by the Community Care Center where a strong emphasis is placed on family and preventive medicine. The GW plan was organized in 1972 with the assistance of a special projects grant from the Department of Health, Education and Welfare.

CONTACT: Dr. Steven Schroeder
Director, HMO
331-6369

10. LOW VISION CLINIC. The Low Vision Clinic is the metropolitan area's only specialized treatment center to assist the visually handicapped with prescribed optical aids intended to improve visual acuity in daily living and at work. Clinic help is available to patients handicapped by imparied vision resulting from glaucoma or congenital defects which do not respond to standard methods used to correct visual impairment. Opthalmic care is coordinated where necessary with rehabilitation efforts of the Vocational Rehabilitation Administration to find employment for the patient.

CONTACT: Dr. Mansour Armaly
Chairman, Department of
Ophthalmology
331-6701

11. FOOD SANITATION PROGRAM. In 1974 the City Council took action to require the supervisory personnel in the food preparation areas of the city's food service establishments to be certified in the principles of food sanitation. The Department of Epidemiology and Environmental Health designed a course to prepare these individuals for certification. Until recently, this has been the only educational program of its kind in the city. To date, nearly 600 people have attended the classes.

CONTACT: Dr. Jack Millar
Chairman, Department
of Epidemiology
331-6117

12. IN AND OUT SURGERY. The in and out surgical unit at GWU Hospital, established in 1966, was one of the first in the country to offer one-day care for patients undergoing minor surgical procedures. This program not only saves the patient the cost of an overnight hospital stay but also frees beds for patients who have more urgent medical needs. In 1972 alone, in and out srugery saved 14 beds which would have cost $214,000; the Government Accounting Office estimated a savings nationally of at least $270 million by increased use of the system. In the past five years, over 60,000 procedures have been performed in the in and out surgical suites at GWUH.

CONTACT: Dr. Charles Coakley
Chairman, Department
of Anesthesiology
331-6138

13. OUT-PATIENT CLINICS. The specialized clinics of the Medical Center's Ambulatory Care Division recorded over 103,000 patient visits last year and in the first part of 1975 a record-breaking 58,012 visits occurred. Much of this health care is provided for the medical indigent residents of the District of Columbia. While the majority of the care is partially reimbursed by federal and commercial health insurance programs, the Ambulatory Care Division has an annual deficit for non-reimbursed indigent services.

CONTACT: Dr. Calvin Klopp
Medical Director of
Ambulatory Care Division
331-6591

14. CONTINUING MEDICAL EDUCATION. The George Washington University Medical Center is committed to providing continuing medical education for the physicians of the Washington metropolitan area. A program of review courses, speakers and demonstrations are available to keep doctors up to date on the most recent advances in medical care. Over 1000 physicians participate in the clinical teaching environment at the Medical Center, where they provide and receive educational stimulation. Through affiliations with other inner city and suburban hospitals, the educational mission of the University is further extended to the community.

CONTACT: Dr. Dennis O'Leary
Associate Dean for
Professional Services
331-6224

15. FLORENCE CRITTENDEN HOME. The staff of the Separtment of Obstetrics and Gynecology provides at no charge maternal and obstetrical care for the residents of the Florence Crittenden Home for unwed mothers. A weekly prenatal and post-partum clinic is conducted at the Home. The division of Laboratory Medicine performs any clinical laboratory work which may be necessary. Babies are delivered at University Hospital under the care of the obstetreical staff, and the infants' medical care is provided by highly skilled neonatologists.

CONTACT: Dr. Allan Weingold
Chairman, Department
of Obstetrics and
Gynecology
331-6357

16. SICKLE CELL DISEASE CLINIC. Approximately 60,000 persons in the city suffer from sickle cell disease, an inherited disorder of the blood for which there is presently no cure. The Division of Hematology conducts an active screening program and collaborates with the municipal and community agencies to educate the public about the medical and social aspects of the disease.

CONTACT: Dr. Wallace Jensen
Chairman, Department
of Medicine
331-6841

17. CLINICAL SCHOLARS PROGRAM. The Robert Wood Johnson Foundation has selected George Washington University as one of 11 institutions in the country to conduct a post M.D. trqining program to develop vitally needed manpower at a leadership level to help guide the nation in the creation of a better health care delivery system. The program began with six scholars and will grow to 12 over a three-year period. Collaboration between the Medical Center, Law Center, School of Business Administration and the Graduate School of Arts and Sciences is involved. Instruction is largely non-classroom in character and often utilizes the voluntary services of the private and federal institutions which guide the nation's health policies.

CONTACT: Dr. John Naughton
Dean for Academic Affairs
331-6501

18. As the demand for medical care grows, physicians increasingly turn to paraprofessionals to provide many medical and health maintenance services. The Department of Health Care Sciences has developed degree granting programs to educate and train physician-extenders such as nurse practitioners and physicians' assistants. The Family Nurse Practitioner program prepares registered nurses to function in an expanded role in collaboration with physicians in delivering primary health care. Now completing its first year, the program has graduated 20 practitioners and helped to place them in jobs in the community. The physicians' assistant program is specifically designed to train assistants who practice family medicine and primary care. Both programs have received funding from federal agencies which are attempting to infuse more allied health personnel into the health care system. Training programs are also available for radiology technicians, medical

53-100 O - 75 - 38

technologists and inhalation therapists. The nurse anesthesists for three of the city's hospitals are also trained at the Medical Center. University Hospital is the clinical campus for the Burdick School to train nurses' aids and operating room technicians.

CONTACT: Dr. Michael McCalley
Associate Dean for
Allied Health
331-6725

19. EMERGENCY MEDICAL CARE. Registering nearly 50,000 patient visits this fiscal year, the GWU Hospital continues to be the principal emergency medical facility serving the downtown business and tourist areas. Despite the pressure of increased patient visits which occur when other emergency rooms in the city close, the GWU emergency room has been able to consistently keep its doors open to the public and, only in rare circumstances, request that D.C. Fire Department ambulances be routed away from GWU. As the closest hospital to the historical monument section of the city, we are making preparations to provide most of the emergency care for the millions who will visit Washington during the nation's bicentennial celebration. The Medical Center continues to serve as the principal provider of emergency care during civil unrest and large public events such as Human Kindness Day when the ER treated the majority of those injured at the gathering. The D.C. Medical Society has designated the GWU emergency facility as one of the city's rape crisis centers to provide psychiatric care as well as medical treatment for rape victims. The Emergency Room is an important training site for the entire range of medical professionals including medical students, nurse practitioners and physicians' assistants. Through the University's affiliations with nursing education programs at Catholic and American Universities, Marymount College and the Burdick School, training in emergency medicine is provided for over 1,000 prospective RN's and LPN's. The unit was recently recognized by the Health Facilities Planning Council as the outstanding emergency room in the Washington metropolitan area.

CONTACT: Dr. Thomas Piemme, Director
Department of Health
Care Sciences
331-6723

20. OVARIAN CANCER STUDY CENTER. The Division of Gynecologic Cancer has been appointed by the National Cancer Institute as the regional center for a national epidemiologic study of primary cancer of the ovary. All primary ovarian cancer patients identified by the pathology departments of the hospitals in the metropolitan area and/or reported to the Regional Cancer Registry are eligible for the study. The primary objective is to assess the personal and medical histories of these patients to determine what factors have a high association with ovarian cancer. Patients are directly interviewed by the staff of the Center. It is estimated that over 300 cases will be evaluated in the next three years. Biostatistical and epidemiological analysis of the data will be conducted and provided to the Department of Health, Education and Welfare.

21. EMI SCANNER. GW's new EMI scanner, fourth in the U.S., is considered one of the most revolutionary advances in radiology. The sophisticated, computerized X-ray unit permits radiologists to detect abnormalities in brain tissue through a painless, non-invasive technique. Patients with minor symptoms of brain disorders can be evaluated while disease is in its early stages. Since its installation in January 1974 nearly 5,000 EMI scans have been provided. The new device continues to serve the needs of the entire Washington medical community while saving patients money and sparing them the pain and discomfort associated with conventional techniques for diagnosing brain disorders.

CONTACT: Dr. S. David Rockoff, Chairman
Department of Radiology
331-6281

22. RADIATION THERAPY CENTER. The Radiation Therapy Center at the George Washington University is an important treatemen and research facility for the care of cancer patients. The Center has the only electron beam linear accelerator in the metropolitan area. This unit is used to treat cancer over large areas of the body by utilizing an innovative technique which spares healthy tissue. The unit has proven to be highly effective in the treatment of cancers of the breast, head and neck. In cooperation with the Naval Research Laboratories, GWU operates the only neutron bear therapy program on the East coast. There are only three such programs in the world. The Center has the only program in the metropolitan area to perform radiologically controled, highly selective lung biopsies to diagnose lung cancer without the use of surgical techniques. The Center's Division of Nuclear Medicine treats over 600 new cancer patients each year; last year alone the Division registered 5,000 camera images and performed 2,000 in vitro tests. . A considerable amount of research is conducted in the Center with the support of the Department of Health, Education & Welfare.

CONTACT: Dr. S. David Rockoff,
Chairman, Department of
Radiology
331-6281

23. JOB DEVELOPMENT LABORATORY. The Job Development Laboratory is devoted to increasing the employment and placement of severely handicapped persons while enhancing their capacity to perform a wider range of tasks. In particular, the staff of the Laboratory has special expertise in developing jobs for the severely disabled in the information processing industry. The Laboratory has been quite successful at designing simple, low cost adaptations of work environments that enable severely disabled individuals to be employed in occupations such as mail clerks, inventory analysts, supply clerks, typists, key punch operators and Xerox operators. Several rehabilitation facilities are setting up microfilming operations with the help of the staff; these operations will subsequently train and employ physically handicapped persons. A program has been designed to provide foreign visitors with the most recent information regarding training in the fields of computer programming, remote data entry and statistical analysis for physically disabled persons. Orientation sessions for potential employers of the handicapped

in the Washington area have been conducted, as well as classes for vocational rehabilitation counselors to provide them with the most complete and up to date information on the physical and psychological aspects of substantially disabled persons. The staff participates actively at national and international gatherings to disseminate information regarding job opportunities for the home-bound and non-home bound severely disabled. The staff has discovered that the lack of adequate transportation to the job site is a substantial stumbling-block to employment for the handicapped. Attempts have been made to provide transportation via funding from the Urban Mass Transit Authority.

CONTACT: Dr. John Naughton,
Dean for Academic Affairs
331-6501

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

Exhibit I

DOCUMENTATION OF INCREASES IN STUDENT ENROLLMENT IN THE SCHOOL OF MEDICINE
SINCE THE PASSAGE OF THE DISTRICT OF COLUMBIA
MEDICAL AND DENTAL MANPOWER ACT OF 1970 (P.L. 91-650)

	Year	Total Enrollment	Enrollment of D.C. Students	Enrollment of Maryland Students	Enrollment of Virginia Students
School of Medicine					
	1969-70	432	17	61	18
	1974-75	589	30	89	33
	Percentage Increase	36%	76%	46%	83%

May, 1975

THE GEORGE WASHINGTON UNIVERSITY
School of Medicine and Health Sciences
Approved Budget Fiscal Year 1976

	Approved Budget 1975-76
CURRENT REVENUES:	
TUITION AND FEES:	
Medical Students	$ 3,000,000
Physician Assistant Students	294,000
Allied Health	280,000
University Credit	150,000
Application Fees	221,000
Miscellaneous Fees	$ 6,000
TOTAL TUITION AND FEES	$ 3,951,000
PATIENT CARE:	
Health Maintenance Organization	$ 563,000
Community Care	60,000
TOTAL PATIENT CARE	$ 623,000
SPONSORED RESEARCH PROGRAMS:	
Direct	$ 5,300,000
Net Recovery of Indirect Costs	1,166,000
TOTAL SPONSORED RESEARCH	$ 6,466,000
EDUCATION AND DEVELOPMENT	$ 550,000
H.E.W. CAPITATION GRANT	785,000
MEDICAL AND DENTAL ACT, D.C. PUBLIC LAW 91-650	
INVESTMENTS	100,000
STUDENT AID	135,000
OTHER:	
Gifts & Miscellaneous	80,000
Faculty Affiliation	90,000
TOTAL CURRENT REVENUES	$12,760,000

	Approved Budget 1975-76
CURRENT EXPENSES:	
INSTRUCTION:	
Clinical Sciences	$ 2,185,298
Basic Sciences	1,689,557
Allied Health	270,161
TOTAL INSTRUCTION	$ 4,145,016
PATIENT CARE:	
Clinical Sciences - HMO	$ 480,872
SPONSORED PROGRAM RESEARCH	$ 5,300,000
EDUCATION AND DEVELOPMENT	550,000
LIBRARY	353,964
STUDENT AID	135,000
ADMINISTRATIVE AND SUPPORT:	
Direct	888,908
Medical Center Administration	996,600
University Allocations	741,205
TOTAL ADMINISTRATIVE AND SUPPORT	$ 2,626,713
OPERATION AND MAINTENANCE	$ 2,238,435
TOTAL CURRENT EXPENSES	$15,830,000
NET OPERATING DEFICIT	$(3,050,000)

Chairman Flood, Mr. Michel, and members of the subcommittee, I am Peter Basch, president of the second year class and chairman of the medical student council at George Washington University. I appear today representing intense student concern over the funding of the D.C. Health Manpower Act.

As Father Collins has indicated, the financial situation has already made it necessary to increase medical student tuition to $5,000 for the coming year. What you may not realize is that even at the present tuition levels, nearly 60 percent of students at the George Washington Medical School are dependent upon some sort of financial aid, primarily in the form of loans. The average educational debt ranges from over $4,000 for freshmen to more than $10,000 for a graduating senior.

At the same time that direct Federal funding to medical schools is being cut back, significant sources of financial aid to medical students are also being phased out. This is a reflection of growing congressional discontent with the responsiveness of medical educators to health-manpower problems and probably foreshadows the passage of legislation which would drastically alter the funding of medical education. In the meantime, this transition in national health care policy is catching students at George Washington and Georgetown in the middle. We are hopeful that as the District government moves ahead in the next year under home rule that they will be able to assist as in cushioning the impact of this transition.

At its national meeting in March, the American Medical Student Association, recognizing the unique position of the medical schools in the District of Columbia, passed a resolution supporting our request for appropriations.

I would finally like to emphasize that the population of students entering medical school is changing. The motivation to become a doctor is no longer the hope of a high income and professional status. Over half of the students at George Washington are planning careers in primary care medicine (family practice, general medicine, pediatrics). In a recent survey, 55 percent said that they would be willing to practice is an underserved area of the country in the National Health Service Corps if positions were made available. Yet the availability of of such programs depends on the passage of new health-manpower legislation. If tuition syrockets before this legislation is passed to provide alternatives, our students will be required either to discontinue their medical studies or turn to high-interest loan organizations for support. With phenomenal debts to pay off, they would be forced into the higher-paying specialty practices, a prospect undesirable to the students as well as the American public.

PETER BASCH,
Chairman, Medical Student Council,
George Washington University.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C. March 12, 1975.

MATTHEW F. MCNULTY, Jr., Sc. D.,
Chancellor, The Medical Center, Georgetown University,
Washington, D.C.

DEAR DR. MCNULTY: Thank you for your letter of January 23 to Dr. Charles Edwards, also signed by Dr. James J. Feffer, requesting funds for fiscal year 1976 under Public Law 93-389. Please excuse my delay in repaying.

The Department's budget request to Congress for fiscal year 1976 did not request funds under the D.C. Medical and Dental Manpower Assistance Act of 1970, as amended by Public Law 93-389, due to the policy of fiscal restraint taken by the administration.

You are aware that we have proposed to Congress an extension of the financial distress authority contained in section 773 of title VII of the Public Health Service Act to assist health professions schools that have fiscal deficits. Also, that the Department has requested in the President's 1976 budget $5 million to assist schools in financial distress. We believe that the extension and funding of the financial distress authority for all schools is preferable to an approach that makes funds available for individual recipients.

You are to be commended for taking the difficult step of increasing tuition to generate the income required by your medical education program. We believe that similar action will be necessary at other schools.

Sincerely yours,

THEODORE COOPER, M.D.,
Acting Assistant Secretary for Health.

GEORGE WASHINGTON UNIVERSITY,
SCHOOL OF MEDICINE,
GEORGETOWN UNIVERSITY,
SCHOOLS OF MEDICINE AND DENTISTRY,
Washington, D.C., January 28, 1975.

CHARLES C. EDWARDS, M.D.,
Assistant Secretary, Health, Department of Health, Education, and Welfare, Washington, D.C.

DEAR DR. EDWARDS: In accordance with the provisions of Public Law 93-389, we request funds from the Federal budget for fiscal year 1976.

Under Public Law 93-389 Congress can appropriate an annnal amount of up to $5,000 for each medical student at the George Washington University and the Georgetown University Schools of Medicine and up to $3,000 for each dental student at the Georgetown University School of Dentistry.

These three schools continue to need these state-like operating funds urgently to meet both the ongoing educational programs and the mandate for increased health manpower service to the metropolitan area of the District of Columbia. The amount requested for the George Washington School of Medicine is $3,050,000, $5,000 times 610 students. The amount of the request for Georgetown University School of Medicine is $4,200,000, $5,000 times 840 students. The amount requested for Georgetown University School of Dentistry is $1,800,000, $3,000 times 600 students. The total for all schools is $9,050,000. This amount is essential to enable the schools to continue in operation.

In making this request we report the continued valiant efforts at "self-help" by these schools of medicine and dentistry. An increase in tuition from $3,500 to $5,000 per medical student and an increase from $3,200 to $4,000 per dental student will start in September 1975 as a method of institutional self-responsibility. According to present investigations, these tuition increases of 38 percent and 56 percent result in tuition charges for 4-year programs of medicine and dentistry that are at the highest tuition levels in the country.

The funds from the above two sources are vitally necessary for the financial stability of these three schools.

Sincerely,

MATTHEW F. MCNULTY, JR., SC. D.,
Chancellor, The Medical Center, Georgetown University.
JAMES J. FEFFER, M.D.,
Vice President for Medical Affairs, George Washington University.

ATTACHMENT 1

GEORGETOWN UNIVERSITY MEDICAL CENTER—DOCUMENTATION OF INCREASES IN THE NUMBER OF STUDENTS AND INCREASES IN HEALTH MANPOWER SERVICES TO THE METROPOLITAN AREA OF THE DISTRICT OF COLUMBIA BY GEORGETOWN UNIVERSITY MEDICAL CENTER SINCE THE PASSAGE OF THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT (PUBLIC LAW 91-650) IN 1970

Georgetown University Medical Center is involved in both health care education and service programs which are critical to the health care system of the metropolitan area of the District of Columbia.

Since the passage of the District of Columbia Medical and Dental Manpower Act in 1970, the student enrollment in the medical and dental schools at Georgetown University Medical Center has increased by a total of 55 percent, while the number of students enrolled from the District of Columbia, Maryland, and Virginia has increased by 78 percent, the greatest increase of 125 percent is in the number of District of Columbia students enrolled. (See exhibit I.)

The faculty physicians and dentists, house staff, students, and administration of Georgetown University Medical Center are dedicated to serving the health care needs of the community of the metropolitan area of the District of Columbia. In this dedication their efforts stretch far beyond the walls of the Georgetown University Medical Center.

Faculty physicians, house staff, and students from the school of medicine serve the community at the District of Columbia General Hospital, Arlington Hospital, and Fairfax Hospital. A strong affiliation exists with the Washington

Veterans Administration Hospital. We also have staff and programs at the Hospital for Sick Children, Columbia Hospital for Women, Providence Hospital, and Sibley Hospital in addition to the Army and Navy Hospitals and the National Institutes of Health. The school of medicine faculty, house staff, and students serve actively in the District of Columbia community mental health program.

The School of Dentistry with its students and professors is a major source for dental care in the District of Columbia. In 1971 the School of Dentistry opened a new clinic building with a greatly increased capacity in order to meet the challenge of increased dental care need in the District of Columbia.

In addition to the dental services at Georgetown University Medical Center, the School of Dentistry is involved in a large dental program at D.C. General Hospital. More than 100 4-year students from the School of Dentistry rotate through D.C. General Hospital under the supervision of faculty from Georgetown, together with the supplementary health care provided by interns and residents from the dental school advanced specialty program in oral surgery. The school also has programs at the Veterans Administration Hospital and at Childrens Hospital.

A detailed description of the Georgetown University Medical Center's health education and health service programs to the metropolitan area of the District of Columbia is provided in exhibit II attached.

EXHIBIT 1

GEORGETOWN UNIVERSITY MEDICAL CENTER

DOCUMENTATION OF INCREASES IN STUDENT ENROLLMENT IN THE SCHOOLS OF MEDICINE AND DENTISTRY SINCE THE PASSAGE OF THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT OF 1970 (PUBLIC LAW 91-650) MAY, 1975

School and year	Total enrollment	Enrollment of D.C. students	Enrollment of Maryland students	Enrollment of Virginia students
School of medicine:				
1969–70	473	15	48	11
1974–75	809	30	83	28
School of dentistry:				
1969–70	406	5	28	19
1974–75	557	15	34	34

EXHIBIT II

DOCUMENTATION OF GEORGETOWN UNIVERSITY MEDICAL CENTER'S HEALTH EDUCATION AND SERVICE PROGRAMS TO THE METROPOLITAN AREA OF THE DISTRICT OF COLUMBIA

1. Psychiatric walk-in clinic. Providing immediate attention to those in a crisis, this clinic in the Department of Psychiatry is staffed by faculty, social workers, residents, and students of the Medical Center. No appointments are necessary and patients are seen within an hour. The clinic aims at heading off serious emotional breakdowns at the time of a problem and offers each patient up to six visits for crisis intervention services. After this time referral for further treatment is made if necessary. Twenty percent of the people who come to the walk-in clinic are treated definitively within the six visits. A fee of $10 a visit is charged if the patient is able to pay. The clinic, which offers emotional first aid to hundreds of people a year from all walks of life, all social and economic backgrounds, and all ages, was the first one established in the Washington metropolitan area. It was started in 1964. A variety of problems are handled and patients hear of the clinic through media reports, friends and family, referrals by health professionals or clergy, and social workers. There were almost 2,000 patient visits to the clinic last year. Most of these were District of Columbia residents. Extending crisis intervention further, the walk-in clinic is now working with outreach teams in area "A" of the city to reach people who need help. Area "A" contains a cross section of the population with a total of 140,000 to 150,000 people. A new back-up facility, the Mental Health Care Unit for in-patient referrals, was recently opened at Georgetown University Hospital.

2. Nurse-midwifery. The first six graduates of a nurse-midwifery education program at Georgetown University School of Nursing received their certificates in November, 1974. The program, funded by the Department of Health, Education, and Welfare, for area nurses, is the only one of its kind in the Washington, D.C. area and one of the few in the nation. Experience in nurse-midwifery under this program is provided at D.C. General Hospital, Georgetown University Hospital, the Greater Southeast Community Hospital and Prince George's County Health Department. Nurse-midwives, as members of the obstetrical health care team, work to bring quality care to mother and child, lowering infant mortality rates in the management of uncomplicated births. The Georgetown program is aimed particularly at the alarming infant mortality rate in Washington's inner city. Working with a physician consultant, the nurse-midwives are involved in prenatal care, labor, delivery, post delivery, and family counseling.

3. The university-affiliated program for child development is an interdisciplinary training center serving the developmentally disabled child and his family. Such children have difficulty with normal development including such problems as mental retardation, cerebral palsy, epilepsy, autism, and specific learning disabilities. The disciplines of psychology, pediatrics, communication disorders, nutrition, genetics, instructional technology, psychiatry, special education, dentistry, community services, social work, physical therapy, occupational therapy, and neurology work together as a team to provide both a diagnostic and treatment service to these children. Along with this, special interdisciplinary preschool and infant stimulation programs are available. Training graduate students in the various disciplines is one of the primary goals of the program, but there is also a major community outreach effort to train persons who are actively involved in providing care. Particular emphasis here is on such people as day care center and Head Start workers, and personnel in institutions, who are responsible for the day-to-day education or caretaking of children with developmental problems. Through the Department of Pediatrics, the center offers a course on "Developmental Disabilities: an Interdisciplinary Approach" at the graduate and undergraduate level.

4. Children's kidney disease prevention center. The department of pediatrics for the past 8 years has been operating a screening, diagnostic, and treatment center for children with kidney disease from the Washington metropolitan area and surrounding communities. The program was established to answer the needs in the community of significant numbers of children suffering from chronic and fatal kidney disease. No child is turned away from this vital service. The center was established in 1966 with the support of the National Insttiutes of Health and continues now with help from the National Kidney Foundation and funds raised by the Potomac Women's Club. A main objective is to identify and treat children who have kidney disease as early as possible. Physicians also receive speciality training under the program. Outpatient visits to the center number around 1,300 yearly. In 1973 the center expanded and initiated a dialysis (artificial kidney) and kidney transplant program. Children with any type of kidney disorder now can receive the complete, specialized care their case requires at the Georgetown Center.

5. Home care program for cancer patients. A team of physician, nurse and social worker from the Medical Center cares for the advanced cancer patient in his home, giving the patient more time to be with his family and saving him from the spiraling cost of hospitalization. No charges are made to the patient for these services which offer excellent medical care. Medicines, supplies and hospital equipment are also provided. The program has been in operation from Georgetown University Hospital for 25 years, supported by a private trust fund. 2,960 days of home care were provided last year. One member from the medical team visits the patient each week, and the total team visits once every 3 or 4 weeks. The doctor provides medical follow-up; the nurse teaches the family nursing care; and the social worker provides counseling to the patient and his family in coping with death and dying. The program can take care of 20 patients at any one time.

6. Georgetown University Community Health Plan, Inc. The Georgetown University Community Health Plan (GUCHP) is a prepaid group practice health maintenance organization offering services to a broad cross-section of people in the Washington metropolitan area. The plan is designed to offer enrollees a full array of comprehensive health services with easy access through medical centers located near their homes. The plan is family oriented with a strong emphasis on preventive medicine. GUCHP is currently operating through three locations: Reston, Va.; Edgewood Terrace in Northeast Washington; and Kensington,

Montgomery County, Md. In addition, the services are available at the three locations on a fee-for-service basis to nonenrolled patients. The GUCHP facility at the Edgewood Terrace location has contracted with the D.C. Department of Human Resources to provide medical benefits to 2,000 D.C. medicaid recipients. GUCHP also enrolls the "near-poor" at the Edgewood Terrace site through a Family Health Center Program funded by HEW. Starting on January 1, 1975, Federal employees are eligible to enroll in GUCHP through University affiliated health plans, an umbrella corporation recently created jointly by GUCHP and the George Washington University Health Plan. There are presently 4,400 persons enrolled in GUCHP.

7. Cleft palate center. The Georgetown center has been the only facility of its kind in the Washington, D.C., area for more than two decades. Both adults and children suffering from this congenital deformity. which is a falure of the palate and lip to form properly, are evaluated, treated and rehabilitated regardless of their ability to pay. The defect which occurs in one of every 750 live births severely impairs speech and affects swallowing action and appearance. The necessary long-range treatment involving many dental and medical specialities is offered at Georgetown to patients from the metropolitan area and from West Virginia, Virginia, Delaware, and Maryland. The center, which works closely with families, stresses that proper treatment can enable patients to lead a normal life and prevent psychological problems. Treatment includes careful nursing care in early life, education of parents, and plastic surgery over a period of years. It also involves speech therapy, psychological and psychiatric support, and prosthodontic treatment such as speech aid prostheses. Further backup is provided by pediatricians. ear-nose-throat specialists, orthodontists, oral surgeons, pedodontists (specialists in children's dentistry), and social workers.

8. Breast cancer screening program. Working closely with five local units of the American Cancer Society, Georgetown University Medical Center operates a free breast cancer screening center for women in the Washington metropolitan area. Using the most advanced methods of detection, the project will screen a total of 10,000 women between the ages of 35 and 75. The project is aimed at saving lives by detecting breast cancer early in women who do not yet have any symptoms. The Georgetown centers uses multiple screening techniques, including physical examination, mammography or xerography, soft tissue X-ray, and thermography, measuring skin temperature. The 5-year project arranges for women having negative results to return annually for further examinations and careful followup. Women found to have breast cancer are referred to their doctors for immediate treatment. The new Georgetown project, one of 27 in the country, is also developing education and training programs. It is supported by the National Cancer Institute and the American Cancer Society.

9. Intensive care nursery. Georgetown plays a leadership role in preventing mortality and morbidity in newborn infants. One such program involves the GU Hospital's intensive care nursery, which provides constant monitoring and mental care for infants during their first critical hours of life. This unit has helped lower the death rate of babies at the hospital to 6 per 1,000 live births, compared to the national rate of 18 per 1,000. Recently Mrs. Julie Nixon Eisenhower cut the ribbon to open new streamlined facilities for newborn infants at the hospital which has more than doubled the size of the intensive care nursery. The new nurseries offer the most advanced comprehensive care for high-risk infants. Georgetown University Hospital is a regional center where many medical disciplines contribute to the care of high-risk mother and child, combining prenatal delivery, and postnatal care. The expanded nurseries will be able to care for up to 2,000 high-risk deliveries a year. They provide a total of 53 infant beds. The 29 beds for sick babies include the large intensive care unit of 14 isolettes, 3 isolation beds, and 12 beds for intermediate care. There are an additional 24 beds for healthy babies.

10. GU at head start centers. A community services team from Georgetown's Department of Pediatrics has been working with community Head Start centers throughout the District of Columbia to identify and help preschoolers who have problems that interfere with the learning process. This includes emotional, educational, and social disabilities as well as mental retardation or physical handicaps. The program, funded by the Department of Health, Education, and Welfare, involves 600 children ages 3 to 6. It aims to reach them at an early age before they enter the public school system. The Georgetown team of experts in child development and special education visits each center several days a week,

working with teachers and parents to develop individual programs for children that need them. The problems are defined, programs implemented and followed up. Stress is placed on working with a child's strengths and interests to overcome his weaknesses. The key in how to work with a child best is to determine his individual "learning style." Such information can then be transferred for use by his future teachers. Every effort is made to work out programs within the school setting to keep the child in the mainstream and not isolate him. The Georgetown team has been visiting 12 Head Start centers in Anacostia, 13 capital Head Start centers, and 4 centers in Arlington, Va.

11. Ask the doctor. This public service program is part of Opinion Line. Every 2 weeks a faculty member of the school of medicine or the school of dentistry participates on the program. The faculty discuss a topic in their respective fields, then answer questions from listeners. Station WUST offers the University an opportunity to perform an important service for its listeners in the Washington community.

12. The area A community mental health center. The area A community mental health center serves one of the four geographic areas of the District of Columbia and is sponsored jointly by the Georgetown Department of Psychiatry and the D.C. Department of Human Resources. Comprehensive mental health services are provided for 140,000 people of varied socio-economic levels. The bulk of the emergency and outpatient services is provided at Georgetown University Hospital. The Day Hospital, located in the Georgetown area, has an average of 35 patients in active treatment. The Youth Service facility, which is one block from Georgetown Hospital, includes a day treatment school, outpatient diagnostic and treatment services, a drug clinic, and school consultation services. In addition, the center operates two satellite clinics in the area. The psychiatric staff of the center hold Georgetown faculty appointments. Many attending faculty also teach and supervise the residents and students assigned to the center. Georgetown residents are assigned to all components of the center, and a major portion of our residency training is centered within the area A program both in the community and the Georgetown University Hospital. Medical students are also assigned to most of these components. Psychiatric residents are also consulting with the police, a halfway house, and Regency House within the District of Columbia.

13. Hypertension program. This program takes medicine to the people in Washington's inner city. Patients were screened for high blood pressure without cost at block parties, in grocery stores, churches and community centers by physicians and students. In a recent program, more than 3,000 persons were screened. Followup treatment is being given on a private patient basis at the D.C. General Hospital's Hypertension Clinic, operated by Georgetown physicians. Six Eastern High School students were taught to take blood pressures and were sent to check patients waiting in various specialty clinics at D.C. General Hospital. Fifty-four percent were found to have high blood pressure. A similar check run at our own outpatient clinic yielded about 39 percent with high blood pressure.

14. Outpatient clinics. Forty-eight specialized clinics (allergy, eye, pediatrics, et cetera) provide health care for medically indigent persons in the Washington community. Over 100,000 patient care visits and services per year are recorded. Approximately 90 percent of the patients are black. While the clinics are partially reimbursed by those who receive medicare, medicaid or other health coverage programs, the University clinics run an annual deficit of approximately $393,070 for nonreimbursable indigent service.

15. Emergency room. The emergency room is open 24 hours a day, providing emergency medical care to all citizens seeking it. Around 21,822 patients are seen in the emergency room each year.

16. Inpatient service. The Georgetown Hospital provides approximately 400 beds for the care of patients. Services are rendered to about 14,775 persons annually, the majority of whom are from the Washington metropolitan area. While the majority are private patients, the hospital does provide inpatient care for indigents at a cost of more than $0.8 million in nonreimbursable funds annually.

17. School of dentistry clinics and services. The dental clinics, which are open to all citizens in the community, receive more than 150,000 patient visits annually. Fees charged are at a minimum of what private care would demand. 7,000 new patients are seen yearly. In the clinics, junior and senior students,

working under the immediate supervision of the faculty, provide the treatment and care in this program. Georgetown dental students and residents also provide dental care service to indigent patients in the outpatient department of Georgetown University Hospital and at the D.C. General Hospital Dental Clinic.

18. District of Columbia general hospital program. The school of medicine and the school of dentistry perform a vital service to the community in this program. The school of dentistry, for example, provides its services without cost to the indigent patients. All oral surgery service, as well as treatment of oral infections and extractions, is included. An oral surgery intern or resident is on duty in the hospital emergency room 24 hours a day, 365 days a year, to handle this service. The school of medicine is involved in the day-to-day functioning of the hospital. Its faculty, physicians and residents and students are participants. The university provides services in both medicine, ob-gyn, and surgery, and their subspecialties. The staff is also responsible for graduate training programs. Technicians man the laboratories and are paid for by grant moneys from Georgetown.

19. Program to eliminate major nutrition problems. This program is working with physicians in the two Georgetown University community health plan locations to determine the most critical nutrition problems in the communities and set in motion a broad scale attack against these problems. The project will focus on: (a) treatment of obesity and malnutrition on an individual basis through the doctor/patient relationship in the health maintenance organization. Emphasis will be placed on the critical role of nutrition in preventive medicine. This will be done through heightened physician sensitivity to a person's nutrition needs in addition to whatever other health problems may bring him to the health center. Approved procedures will also be developed for diet control relative to specific diseases; and (b) involvement of the community in the decision-making process and support of the project. All community institutions including civic organizations, government, schools, food industry, families, churches, supermarkets, and doctors, will be vital to changing nutrition habits. The man-in-the-street must decide how important nutrition is to him and have access to education concerning good eating habits.

20. Amateur radio station. WA3FXJ, Georgetown University's amateur radio station, provides a number of community services. Primary among these is coordinating the pickup of pledges made to the cystic fibrosis research foundation. This annual activity involves four or five of the larger amateur radio clubs in Montgomery County, Arlington County, Fairfax, Prince Georges County and the District of Columbia. Additionally, WA3FXJ handles nearly a hundred telephone patches (phone patches) from amateur radio operators in foreign countries and aboard ships at sea who wish to contact families in the greater Washington, D.C. area. Members of the State Department and members of the armed services have been provided this service. Frequently, faculty members who are studying in foreign countries are able to contact their fellow faculty members at the university. The station has also been instrumental in securing urgently needed, rare medical supplies for immediate shipment overseas.

21. Health science program for high school students. This spring a new series of Saturday morning programs introduce high school students to clinical and laboratory research activities. Student groups visit various areas at the medical center and attend complementary seminars. This program is coordinated by medical, dental and nursing students at the university. Georgetown plans to work with students from Howard and George Washington Universities in providing experiences in the health sciences that will interest local high school students in those fields.

22. Summer enrichment program. This 8-week preparatory program during the summer is offered to incoming minority medical students. They receive most major courses of the freshman year in a condensed form along with courses in reading comprehension and study techniques. Full-time faculty members teach the courses on a 5-day schedule. The medical school supports this program and provides the students with a weekly cost-of-living allowance.

23. Continuing education programs for physicians, dentists, and nurses. The schools of medicine, dentistry, and nursing conduct programs designed to provide continuing education for practicing health professionals. The school of

medicine, for example, conducts the Thursday night medical-surgical cardiovascular conference. It is attended by about 200 graduate physicians and students weekly. At these sessions heart specialists, using patients for demonstration purposes, instruct in the diagnosis and treatment of complicated cardiovascular problems. The school of dentistry offers 8–12 courses of 2–3 days duration for dentists and dental assistants. Participants come from a wide area, including the District of Columbia. In nursing, where continuing education is likely to become a requirement for annual licensure renewal, the school offers summer and evening courses for area practitioners and educators.

24. Affiliations of the schools of medicine and dentistry. The faculty and staff of the school of medicine and the school of dentistry conduct patient care, teaching and research programs in a number of affiliated hospitals in the Washington area, including D.C. General, the Veterans Administration, Arlington, Fairfax, Providence and Sibley Memorial Hospitals, the Hospital for Sick Children, Columbia Hospital for Women, Children's Hospital and the Walter Reed and National Naval Medical Centers. Complementing the faculty in these programs are approximately 300 interns, residents and fellows from Georgetown.

25. Service to community agencies. Many faculty of Georgetown University Schools of Medicine, Dentistry, and Nursing donate their time and services on a voluntary basis to various community agencies such as the Heart Association, Cancer Society, Department of Human Resources, Regional Medical Program, and so forth, which in turn provide community services.

Georgetown University Medical Center School of Medicine, estimated financial operating information, fiscal year 1975–76

	Thousands
Revenues:	
Tuition and student fees	$4,489
Endowment revenue	316
Gifts revenue	113
Capitation grant	1,500
Physician augmentation program (CCF)	850
Sponsored programs	8,277
Faculty medical services	2,498
Student aid revenue	73
Other revenue	67
Total revenue	18,183
Expenditures:	
Educational programs	10,474
Sponsored programs	7,290
Medical center library	290
Staff benefits	–0–
Student services	221
Student aid	233
Physical plant operation	1,650
General administration	1,725
General institutional	423
Special projects	77
Total expenditures	22,383
Summary:	
Revenue	18,183
Expenditure	22,383
Need (from District of Columbia manpower bill)	[1] 4,200

[1] Need per student (enrollment 840) $5,000.

Georgetown University Medical Center School of Dentistry, estimated financial operating information, fiscal year 1975–76

	Thousands
Revenues:	
Tuition and student fees	$2,104
Endowment revenue	40
Gifts revenue	45
Capitation grant	775
Sponsored programs	654
Dental clinic	1,100
Student aid revenue	1
Other revenue	2
Total revenue	4,721
Expenditures:	
Educational programs	3,885
Sponsored programs	575
Medical center library	103
Student services	139
Student aid	67
Physical plant operation	1,014
General administration	359
General institutional	225
Special projects	154
Total expenditures	6,521
Summary:	
Revenue	4,721
Expenditure	6,521
Need (from District of Columbia manpower bill)	[1] 1,800

[1] Need per student (enrollment 600) $3,000.

STATEMENT OF CABLER J. BERGSCHNEIDER

Congressman Flood, Congressman Michel, and committee members, I am Cabler J. Bergschneider, a junior student at Georgetown University School of Dentistry and a resident of Peoria, Ill.

It is a pleasure to appear before this subcommittee today as representative of the students at Georgetown University School of Dentistry, to ask your favorable consideration for an appropriation of $9,050,000 for the D.C. Medical and Dental Manpower Act as amended (Public Law 93–389).

Tuition at Georgetown University School of Dentistry has just been raised from $2,900 per year to $4,400 per year. This combined with additional fees for books and instruments of approximately $1,600 per year brings the total student expenditure to $6,000 per year. Very few students can afford this type of expenditure.

The appropriation requested for fiscal year 1976 provides up to $3,000 per dental student enrolled in the school. If this is not approved, the school will be compelled to raise tuition by $3,000, thus bringing the total expenditure per year to about $9,000 per student. If tuition is increased to this amount many students will have no choice but to leave school and seek alternative careers.

On behalf of the students of Georgetown University School of Dentistry, I ask your favorable consideration of the appropriation for Public Law 93–389.

MONDAY, MAY 19, 1975.

FAMILY PLANNING SERVICES AND POPULATION RESEARCH

WITNESSES

GEN. ANDREW O'MEARA
MRS. JENNIE RASOFF, PLANNED PARENTHOOD, WORLD POPULATION
REV. BYRON COLLINS, GEORGETOWN UNIVERSITY
DR. MARGARET LIVENGOOD, WILKES-BARRE, PA.
DR. ROBERT C. STEPTO, DIRECTOR, OBSTETRICS AND GYNECOLOGY, COOK COUNTY HOSPITAL, CHICAGO, ILL.

General O'MEARA. Mr. Chairman, Mrs. Jennie Rasoff of Planned Parenthood, World Population and Father Byron Collins of Georgetown, and I thank you for the opportunity to appear again on the needs for fertility services and fertility research.

With your permission, I would like to introduce a short and dispassionate article on the state of the art of contraception today. It comes from Barron's Financial Weekly which has no interest except in whether the producing companies are going to make money. "A big constraint to usage has been the recurring reports on the pill's side effects which range from depression and acne to blindness and stroke."

Its assessment of the IUD is considerably longer but it is no more encouraging or shall we say no less devastating. It winds up with an assessment that during the past 10 years the amount of money and effort going into this vital area of research has declined.

Now our first witness today, Mr. Chairman, is Dr. Livengood of Wilkes-Barre, Pa.

Dr. LIVENGOOD. Mr. Flood and Mr. Michel, my name is Dr. Margaret Livengood of Wilkes-Barre, Pa. I am the medical director of maternal health services of northeastern Pennsylvania. As a pediatrician with a master of public health degree in maternal and child health, I have spent most of my professional life working to improve family planning and health care services for women and families. Last year our program in northeastern Pennsylvania provided family planning care to more than 7,000 patients. In addition to contraceptive services, this included cervical and breast cancer screening, VD tests, and various procedures to detect anemia, diabetes, urinary tract infections, and high blood pressure. In caring for my patients, I am continually reminded of the need for new and more effective contraceptives. Current methods simply do not meet the needs of all women. For medical and humane reasons, it's essential that more reliable, more convenient, and more completely safe methods of birth control be produced.

Pending the development of better contraceptives, however, I think Congress can share my pride in the accomplishments of our program in northeast Pennsylvania. It's been gratifying and frankly somewhat surprising to find that we are filling substantial, long-term needs of so many people. We are meeting a growing, previously unattended demand, so I'm deeply troubled by problems which could jeopardize our ability to provide care to the Pennsylvania families relying on us.

First, the Nation's current economic condition has created an unexpected, urgent demand for help from women who are more anxious

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than ever to avoid unplanned pregnancies. Second, the pressure on our limited resources may be substantially increased because of the Department of Health, Education, and Welfare's efforts to reduce Federal funding of family planning grant programs.

The impact of unemployment and the poor economy is one I had not anticipated and one that Congress probably did not expect when the present funding level was established.

Between July 1974 and March 1975, 6,000 new cases were added to the AFDC rolls in Pennsylvania. Almost 7,000 families were added to the general assistance rolls. Most of these cases include at least one woman of childbearing age. Another indication of the economic situation is the unemployment rate which was 11.2 percent for the Wilkes-Barre/Hazleton area of Pennsylvania in March. These circumstances may be somewhat more severe than for the Nation as a whole. But they are not unique. A number of other metropolitan areas face economic problems even worse than those in northeastern Pennsylvania. And I know from talking with colleagues throughout the country that they are seeing the same reflection of the economic recession that we have observed in Pennsylvania. An unexpectedly large number of unemployed women, patients previously served by private physicians and public assistance recipients are turning to public clinics for family planning help. At a time when the ability to pay for private medical care is reduced, these women recognize more clearly than ever the hardship that an unplanned pregnancy would impose.

This increase in patient load is occurring at the very time inflation and increased operating costs have already put severe stresses on our budget. I think you will be interested to know that our experiences in Pennsylvania have been duplicated in other family planning projects throughout the country. A nationwide survey of organized programs revealed an increased demand for services, higher operating costs, and limited funding. A complete text of the study is attached to the text of my testimony, but I would like to draw your attention, especially, to the fact that in a cross section of family planning projects, the number of new patients seen during January and February of this year is 13 percent higher than during the same months in 1974. The average waiting time for a clinic appointment has risen to 9.9 days. And the number of patients served in the average clinic session has increased significantly. This has occurred at a time when some clinics have been forced to reduce staff, cut salaries, and take other economy measures. Some steps can be taken to ease financial pressures, of course, without impairing the quality of medical care. But as a physician, these cost-cutting actions worry me. How thinly can medical personnel and resources be stretched before we provide bad care and inferior services?

At this point I would like to interject a piece of information that the State of Pennsylvania has asked us to discontinue screening for venereal diseases in our clinic, doing only selective screening because we have no more funds for it.

Mr. MICHEL. Is that formerly funded by the State.

Dr. LIVENGOOD. Right. We have been sending the tests with State funds. Mr. Whittington has asked me to get selective screening only.

Mr. MICHEL. Do they consider that a decline of priority in Pennsylvania?

Dr. LIVENGOOD. Apparently they are going to screen in the big cities—Pittsburgh and Philadelphia. We are up in the country and they feel the yield is low. You miss a few and then you have an epidemic. This is my concern as a physician.

Mr. MICHEL. It is ours, too.

Dr. LIVENGOOD. In order to serve former patients and the increasing load of new patients, our program in Pennsylvania is entirely dependent on Federal funds available under title X of the Public Health Service Act. In order to avoid turning patients away, we will need a budget increase of at least 25 percent during fiscal year 1976. You can understand why I was disappointed and unsettled to learn that the Department of Health, Education, and Welfare has requested that funds for the title X family planning program be cut by 21 percent.

DHEW's position on family planning funding is the second major problem area that troubles me. The Department has said that medicaid reimbursements and social services funds available under title IV–A of the Social Security Act will offset the reduction in title X funds and meet the need for services to new patients. Unfortunately, our program has repeatedly been frustrated in efforts to medicaid of title IV–A funding. We have been trying since December 1973 to persuade State officials to repay us the cost of services to medicaid patients. We have a voluminous file of correspondence, meeting notes, and documentation, but we still do not have a vendor number that would qualify us for medicaid payment. Even if we eventually become certified, our reimbursement for serving a medicaid patient will be limited to $6. When you consider the range of counseling, diagnostic, and screening procedures we provide, you can see how woefully inadequate a $6 reimbursement is in comparison to our expenses.

Our efforts to receive social services funds for providing family planning care have also been long and extremely difficult. I'm happy to tell you we have been informed that our social services funding is finally being approved. But in comparing notes with physicians and administrators of other programs, I've found that many of them have repeatedly run into the blank walls we've encountered.

At the very best, reliance on medicaid funding means that the services are available, for practical purposes, only to welfare recipients, not to the working poor. Furthermore, funding is available under a variety of disparate qualifications and standards established by the States. At the worst, reliance on the State programs means that the funding is not available at all when a program is not approved for reimbursement as ours has not been.

In a report submitted to Congress April 15, the General Accounting Office confirmed my doubts and documented four major limitations of these third-party reimbursement programs. First, many clinics provide nonmedical services such as outreach, counseling, referral, and education. I have found these to be essential components of a good family planning program, but, as GAO pointed out, they are not reimbursable under medicaid. Second, many clinics cannot meet various technical and bureaucratic requirements of the third-party reimbursement structure. Third, some States do not pay the full cost of the services provided. Since the $6 paid in Pennsylvania would

cover only a fraction of actual expenses, I wasn't surprised to find that GAO said the "gap could be quite large." Finally, many clinics are not recognized as eligible for reimbursement. Again, our own problem is included here.

As you can see, medicaid and social services funding are no help for many of the Nation's family planning programs. In order to maintain our present level of services, adequate funding for projects authorized in title X of the Public Health Services Act is essential. Without a budget of at least $135 million for title X, it will be virtually impossible to meet the urgent needs of new patients and the ongoing demand from present patients.

In regard to the budget figure, here, I ask you to look very carefully at the DHEW budget which claims to allocate $240 million for family planning services. If these funds were actually available for family planning, our needs would be adequately filled. But the budget should not be taken at face value. DHEW has recommended only $79 million for project grants under title X—a reduction of 21 percent from last year's budget. As you can see from the experiences in Pennsylvania, the Nation's family planning program really rests on title X funding. The rest of the money DHEW claims is being allocated to family planning is for use in the medicaid and the title IV–A social services program. Much of this money simply is not and never will be spent for comprehensive family planning services. DHEW has never documented family planning expenditures under medicaid and title IV–A and, for practical purposes, the funding for project grants and auxiliary expenses is the only relevant part of the budget.

If this funding falls below $135 million, I foresee several specific results. Some patients would be turned away or required to wait long periods of time for services that are needed immediately. The quality of care would gradually be reduced as various cutbacks become unavoidable.

At this point I might also say, the young who are extraordinarily ignorant of what family planning could do for them, and we see this in our prenatal delivery program which recently opened a satellite clinic in Hazleton, half of our patients are under 20. Half are unwed. Half have never used contraception and of the remaining half, only 28 percent have used an effective method. It is catastrophic for a teenager to get pregnant.

Now, in Outreach and educational programs, and this is where we reach that group, these programs have enabled us to attract high risk patients, low-income women and other special groups into our clinics would be reduced or eliminated. These possibilities are clearly unacceptable to persons who believe in the goal which Congress established of making family planning services available to all Americans.

Mr. Chairman, I believe the Federal Government can make no wiser investment than to support family planning services. I've repeatedly seen the life and well-being of families improve when they have gained access to family planning services. In addition to the impact on individuals, I've found that family planning services affect the welfare of entire communities. The cost of a family planning program is offset many times over by savings and benefits. When pregnancies are planned and wanted, maternal and infant deaths decline;

there are fewer premature births; the incidence of mental retardation and birth defects declines; the need for abortion services drops.

At a time when our country faces economic difficulties and when our Federal budget is tight, it is more important than ever before to make an investment that will result in health and human benefits for American families.

SUMMARY OF TESTIMONY BY DRS. LIVENGOOD AND STEPTO

RECOMMENDATIONS FOR FISCAL YEAR 1976

Family planning services: $135 million.
Population research: $60 million.

SERVICES

1. Unemployment and economic problems have increased the demands on clinic resources, lengthened the waiting period for appointments, resulted in staff reductions and created the possibility that quality of care will be impaired.
2. Third-party reimbursement programs are an inadequate alternative for financing family planning services. Adequate funding for project grants is particularly essential at a time when a lapse in our national family planning efforts would have tragic consequences for millions of women and their families.

RESEARCH

1. Despite congressional and public concern regarding the safety of existing methods of family size limitation, the funding levels for our national research effort remain vastly inadequate.
2. Resources requested for the Center for Population Research will be so limited as to require a reduction in present commitments and an inability to support any new, approved research. The growing pressure of continued inadequate. funding threatens a near collapse of much valuable research.

Family planning services—project grants

Fiscal year:	*Millions*
1973—Actual	$100
1974—Actual (excluding released impounded funds)	100
1975—Projected	100
1976—President's proposed budget	79

Impact of Current Economic Conditions on Provision of Family Planning Services

In order to examine effects of the recession on the provision of family planning services, the Alan Guttmacher Institute conducted a mail survey in March 1975 of 119 agencies providing organized family planning services throughout the United States. The sample included a deliberately heavy representation of larger programs, but included a cross section of typical projects. Of 80 agencies which responded to the questionnaire and follow-up letters, three said they no longer provide family planning services. The final completion rate was 66 per cent.

Of the 77 respondents, 20 were health department programs, 43 were Planned Parenthood affiliates, 11 were other family planning agencies and three were hospitals. Of these agencies, 28 percent had budget expenditures of less than $200,000 in 1974; 25 percent had budgets between $200,000 and $500,000; 29 percent spent between $500,000 and $1 million; 18 percent had expenditures greater than $1 million.

Table 1.

Characteristics of Respondents

Type of Agency	No.	Percent
Hospitals	3	3.9
Health Departments	20	26.0
Planned Parenthood	43	55.8
Other	11	14.3
Total	77	100.0

Size of Expenditures, 1974

<$50,000	4	5.9
$50,000-99,999	7	10.3
$100,000-199,999	8	11.8
$200,000-299,999	5	7.4
$300,000-499,999	12	17.6
$500,000-699,999	12	17.6
$700,000-999,999	8	11.7
$1,000,000 +	12	17.6
Total	68	100.0

Number of New Patients, 1974

<1000	5
1000-1999	1
2000-2999	3
3000-4999	4
5000-6999	4
7000-9999	3
10,000-12,999	2
13,000-15,999	2
16,000-19,999	1
20,000 +	3
Total	28

New Patients, Jan. and Feb. 1974

	No.	Percent
<150	12	17.9
150-299	9	13.4
299-499	6	9.0
500-799	13	19.4
800-1199	12	17.9
1200-1499	2	3.0
1500-1999	5	7.5
2000-2499	4	6.0
2500-2999		
3000 +	4	6.0
	67	100.0

Impact of Recession and Changes in Number of Patients Served

In 1974, 52 agencies (about 67 percent) took one or more steps to ease the financial pressures of rising costs and limited funds. Of these clinics, 22 reduced their staffs; nine closed clinic sites, eight eliminated clinic sessions, and seven reduced session hours. Furthermore, 26 raised or initiated clinic fees and seven reduced salaries; five agencies cut back on ancilliary medical, lab, and/or social services and a similar number froze vacancies and added to the job responsibilities of existing staff. Fewer took other steps: four shelved plans for program expansion; two implemented stricter screening of patients.

Probably largely as a result of cutbacks in staff, closing down of clinic sites and fewer sessions, the number of patients served per session hour has increased from an average of 6.7 patients in 1973 to 8 patients in 1975. Concurrent with this increase, there has been an extension of the waiting period for an appointment to 9.9 days in 1975. The increase in patients served per session hour accompanied by the delay in patient appointments suggest that the programs are already under pressure to meet the current demand for their services.

There are early indications of a growing demand for subsidized family planning services in 1975. Among agencies surveyed, the number of new patients seen during January and February of this year was 13 percent higher than during the same months in 1974. To meet the demand for services without impairing the quality of care provided, it appears that organized programs, at the present level of finances, would have to further extend the waiting period for appointments.

Table 2

Impact of Recession by Changes in Number of New Patients

Impact Variables	Respondents Affected by Recession					
			Number of respondents with*			
	Total Responses	Percent of Total Responses	Increase in New Patients 1973-74	Increase in New Patients 1974-75	Decrease in New Patients 1973-74	Decrease in New Patients 1974-75
Cutback in staff	22	42.3	10	12	10	6
Close sites	9	17.3	4	4	5	3
Close sessions	8	15.4	2	4	5	3
Shorter hours	7	13.5	4	4	3	2
Reduce salaries	7	13.5	4	3	2	2
Raise or initiate fees	26	50.0	8	14	13	7
Cutback in ancilliary medical, lab and/or social services	5	9.6	3	3	2	2
Additional responsibilities for staff	5	9.6	4	5	1	
Freeze expansion plans	4	7.7	1		2	3
Stricter screening of patients	2	3.8	1	1		
(Base)	(52)		(20)	(29)	(22)	(12)

*Based only on number of respondents for whom patient statistics were available for specified periods.

Changes in Caseload, Number of Patients Per Clinic Session, Session Hours, and Waiting Time for Appointment, 1973-75

				Percent Changes								
				1973-74			1974-75			1973-75		
	1973	1974	1975	Jan.	Feb.	Total	Jan.	Feb.	Total	Jan.	Feb.	Total
New Patients				10.5	8.2	9.4	11.1	14.5	12.7	22.7	23.8	23.3
Visits				37.6	28.8	33.2	26.4	27.7	27.0	73.9	64.5	69.2
Ave. No. of patients per session	18.8	20.5	23.9			9.0			16.6			27.1
Ave. Length of session (hours)	2.8	2.9	3.0			3.6			3.4			7.1
Ave. No. of patients per session hour	6.7	7.1	8.0			6.0			12.7			19.4
Ave. Waiting time for appointment (days)	8.3	8.8	9.9			2.3			12.5			19.3

Characteristics of Patients Served and Changes in Medical Fees

The data indicate that the recession has produced a financial hardship for middle-income women. Those who might have sought birth control services from private physicians are now obtaining free or relatively inexpensive services at organized clinics. About 60 percent of the agencies surveyed were serving more unemployed women. Over half were caring for more patients previously served by private physicians.

By early 1975, 44 percent of the total sample had raised or initiated patient fees. Not surprisingly, agencies which raised or initiated fees tended to serve more higher-income patients.

The average fee for a medical examination is 17 percent higher than the average charge prior to the recent fee changes. The rise in clinic fees does not appear to have deterred patients from obtaining services at organized family planning programs, possibly because organized programs ordinarily utilize sliding fee scales to determine the amount a particular patient can afford to pay for services. A substantial proportion -- 40 percent of agencies who raised or initiated fees -- were seeing more no-charge patients than previously.

For a number of agencies, uncollected fees have mounted. For them, the uncollected fees rose by 29 percent between 1973 and 1974.

Table 3

Percent of Total Respondents

Patient Characteristics	All Respondents		Raised or Initiated Medical Exam Fees		No Change	
More higher-income patients	28.0	(21)	33.3	(10)	23.7	(9)
More lower-income patients	40.0	(30)	43.3	(13)	42.1	(16)
More Medicaid patients	45.3	(34)	50.0	(15)	47.4	(18)
More Welfare patients	42.7	(32)	30.0	(9)	57.9	(22)
More full-pay patients	12.0	(9)	10.0	(3)	15.8	(6)
More partial pay	26.7	(20)	36.7	(11)	23.7	(9)
More no-charge patients	36.0	(27)	40.0	(12)	39.5	(15)
More unemployed patients	60.0	(45)	66.7	(20)	63.2	(24)
More previously served by FMD	50.7	(38)	50.0	(15)	60.5	(23)
More patients from long distances	26.7	(20)	23.3	(7)	34.2	(13)
More college students	36.0	(27)	40.0	(12)	39.5	(15)
More high school students	58.7	(44)	66.7	(20)	63.2	(24)
(Base)		(75)		(30)		(38)

Table 4.

Distribution of Respondents by Changes in Medical Exam Fees:

	Responses	
	No.	%
Raised fees	25	36.8
Initiated fees	5	7.4
Did not charge fees	19	27.9
Do not charge fees	19	27.9
Total	68	100.0

Average Maximum Medical Exam Fees:

Current $19.29 (based on data for 41 respondents currently charging fees)

Previous $16.45 (based on data for 36 respondents previously charging fees)

Percent difference in average fees 17.3%

Distribution of Respondents by Changes in Uncollected Fees:

	Responses	Aggregate Amount of Uncollected Fees		
	No.	1973	1974	% Change
With billing systems	18	$141,835	$182,662	28.8[a]
Newly installed billing systems	3	—	9,358	—
Charge fees but no billings	7			
Charge no fees	19			
Total	47			

[a]Based on 13 for whom data were available

Deficits in 1975

A substantial proportion of the agencies surveyed were under no illusion that their financial position would improve in 1975. Thirty-two (42 percent) anticipated deficits. Programs of varying sizes are broadly represented in this group. They expect to receive 43 percent of their funds for 1975 from federal grants, five percent from Medicaid-Title XIX, and 20 percent from Title IV-A and state money. About 32 percent of funding was expected to come from private contributions, fees, interest and sale of contraceptives.

The table below summarizes changes in budgets, salaries, number of employees, fixed costs, number of new patients and visits that occurred between 1974 and 1975 for the group of programs which said they anticipate deficits in 1975 and for the group which does not.

		Anticipate Deficit	
	Total Responses	Yes	No
Budget	14.9	10.2	17.1
Salaries	11.7	13.0	11.0
Full-time Employees	5.0	1.8	6.8
Part-time Employees	-0.8	-8.1	6.5
MD Salary/Hour	2.1	2.3	2.0
Nurse Salary/Hour	6.4	8.3	5.7
Clerk Salary/Hour	8.0	11.1	6.5
Rent & Utilities	13.2	25.4	7.8
Telephone	9.9	11.2	9.2
Supplies	20.4	18.4	21.3
Insurance	65.3	89.4	47.3
New Patients	12.7	27.2	6.9
Visits	27.0	30.9	25.5

The table reveals that programs hard-hit by the recession are those in which the number of patients has increased greatly at the same time when staff has

Table 5

Anticipate Deficit by Size of Budget:

Budget, 1975	Total Responses		Anticipate Deficit: Yes		Anticipate Deficit: No	
	No.	%	No.	%	No.	%
Below $100,000	10	14.3	5	17.2	5	12.2
$100,000-199,999	7	10.0	2	6.9	5	12.2
$200,000-299,999	4	5.7	1	3.4	3	7.3
$300,000-499,999	17	24.3	10	34.5	7	17.1
$500,000-699,999	8	11.4	5	17.2	3	7.3
$700,000-999,999	11	15.7	3	10.3	8	19.5
$1,000,000 +	13	18.6	3	10.3	10	24.4
Total	70	100.0	29	100.0	41	100.0

Anticipate Deficit by Sources of Funds:

	Percent of Total Responses	Anticipate Deficit Percent of Responses: Yes	Anticipate Deficit Percent of Responses: No
Number of Respondents	66	26	40
Sources of Funds:			
Total	100.0	100.0	100.0
Federal Grants	50.0	42.6	52.6
Medicaid-Title XIX	5.1	4.5	5.2
Title IV-A	13.0	14.2	12.7
State Funds	2.9	6.2	1.8
County or City (Local)	0.6	0	0.7
Private Contributions	14.3	12.7	14.9
Fees	11.7	14.9	10.6
Interests, Sales of Contraceptives	2.3	4.8	1.5

Percents do not add up to 100.0 due to rounding

been reduced in effort to cope with increased operating costs. Budgets have risen but the increases apparently just cover regular increases in salaries. Expenditures for rent and utilities have gone up by 25 percent, supplies costs have risen 18 percent and insurance expenses have increased as much as 89 percent. It is evident that plans for expanding programs are precluded in most organized programs.

The greater demand for subsidized services, accompanied by high operating costs and limited funds, will probably result in further major efforts to curtail services. Of the 32 agencies who anticipate deficits in 1975, 21 will reduce staff, 15 will close sites, five will shorten clinic, three will reduce salaries, 19 will raise or initiate fees, and four will either cut back ancilliary medical services, reduce patient intake, and/or eliminate all educational, training and outreach services.

Table 6

Impact of 1975 Deficits on the Provision of Family Planning Services in 1976

Impact Variables	R Respondents Anticipating Deficits in 1975	
	No.	Percent of Total Responses
Cutback in staff	21	65.6
Close sites	15	46.9
Shorter clinic hours	5	15.6
Reduce salaries	3	9.4
Raise or initiate fees	19	59.4
Cutback in ancilliary medical services	1	3.1
Reduce patient intake	1	3.1
Eliminate all educational/ training and/or outreach services	2	6.2
(Base)	(32)	

[From Barron's, Feb. 24, 1975]

DRUG ON THE MARKET

Oral contraceptives are selling ex-glamour. Side effects of pills, IUD's, spate of FDA recalls discourage users. Scientific breakthrough not in sight.

SATURATION POINT?

Try as the drug houses may to come up with new pills, the U.S. market seems to have reached the point of saturation, well below its numerical potential. A big constraint to usage have been recurring reports on the pill's side effects, which range from depression and acne to blindness and stroke. Latest example: an article published last week in the Journal of the American Medical Association. Based on a study completed in 1971, it warns that contraceptive pills increase the user's risk of suffering a stroke. The findings got considerable play in the press. Yet a spokesman for J. & L.'s Ortho Pharmaceutical Corp. pointed out that its package inserts and patient information "have contained references and precautions regarding this possible association since 1968."

Even overseas, where the overpopulated and undernourished Third World seemed to hold limitless potential, sales have been disappointing. Women who can barely count, it developed, can hardly be expected to figure 21 days and do addition and subtraction besides. Meanwhile, alternate forms of birth control have come along, including a greater acceptance of sterilization. And, in the United States with the abrogation of State antiabortion laws in 1972, the number of terminated pregnancies has risen sharply.

Nor have there been significant product innovations. Johnson & Johnson's new Modicon tablet, for instance, is the same estrogen-progestogen steroid combination first marketed by Searle 15 years ago. Its lower dosage may result in fewer side effects, but the difficulties never have been completely eliminated.

One thing, however, is clear: 15 years after the introduction of oral contraceptives and IUD's, half the women users in the United States still prefer some other—and less effective—type of birth control. As indicated, the primary reason is that both the pills and IUD's have been plagued by well-publicized side effects which producers have been unable to eliminate.

In the case of the pill, the main difficulty has been the estrogen component, which has been associated primarily with various blood-clotting diseases, ranging from varicose veins to fatal strokes. The IUD has been found in some cases to cause perforation of the uterus, infection and sometimes death.

As a result, since the mid-sixties pill manufacturers have turned increasingly to products with lower dosages of estrogen. Currently, between 80 percent and 90 percent of U.S. oral contraceptive users take low-dosage estrogen-progestogen combination pills. But producers have been able to do little else than lower the dosage. And, as the sales figures show, they have not overcome consumer fear of the drugs.

The history of the IUD is similar, only the time frame is different. As enthusiasm for steroidal contraception waned in the late 1960's and early 1970's with the awareness that there were problems not likely to be soon overcome, interest grew in the IUD. With a pregnancy rate of about 3 percent, the IUD was not as effective as the pill (0.8 percent), but it was second best. Since it is only a piece of plastic inserted in the uterus for any length of time (nobody knows how it actually works), the IUD does not enjoy the replacement business of oral contraceptives.

POTENTIAL APPEARED BIGGER

However, when consumer resistance to the pill developed, the potential IUD market appeared substantially bigger, particularly since the devices were judged safe. To be sure, there was the hazard of perforating the uterus wall and perhaps causing infection. But that was not comparable to the possibility of massive blood clots in the lung or a sudden cerebral stroke risked by users of the pill.

With high hopes, small concerns like Anka Research Ltd. of Queens, N.Y., were incorporated for the sole purpose of manufacturing IUD's. But their hopes were soon dashed. In May 1973, FDA agents swooped down on Anka and seized some 9,000 of its Majzlin Spring devices. The FDA claimed that they caused cramps, bleeding, perforation and possible need for surgical removal. Anka, a privately owned concern, quickly shut up shop.

The FDA pointedly said that it deemed no other IUD then on the market to be harmful. It was disclosed, however, that the agency had considered the Majzlin

Spring a problem since 1970. At the same time, the FDA admitted that it had found that IUD's, in general, were not as effective in preventing pregnancy as most people believed.

STARTLING DISCLOSURE

None of this, however, touched what was considered the safest and most effective IUD on the market: A. H. Robins' Dalkon Shield. But last year, the other shoe dropped—on the Dalkon Shield and the rest of the IUD business. In May, Robins made the startling disclosure that 32 women, who became pregnant while wearing its Dalkon Shield, had subsequently suffered septic abortion and that four had died as a result. Robins halted its IUD sales (which accounted for about 3 percent of its revenues).

Then, last August the FDA implicated Ortho's Lippes Loop, which the agency said had caused five deaths, and Schmid's Saf-T-Coil, related to one mortality. This covered the bulk of the IUD market and, while both the Lippes Loop and Saf-T-Coil are still sold, the effect on the business has been depressing, to say the least. Dr. Jack Freund of A. H. Robins figures that even though his company is the only one with a moratorium on its product, other companies have been so hurt by the publicity that they are hardly selling IUD's at all.

STIFF FDA REQUIREMENTS

Nor are revolutionary new products apt to suddenly spur sales of birth-control devices. Former president of Syntex Research, Dr. Carl Djerassi, who pioneered steroidal research in the 1950's, believes that birth control in the 1980's will not differ significantly from what it is today. His prognosis is confirmed by other drug-company executives.

Although pharmaceutical houses and government-funded university scientists continue their research into the many facets of human reproduction, the amount of money being funneled into specific new product development may have actually declined in the last decade. One reason is that FDA requirements on testing and clinical studies of new drugs have reached such a magnitude that drug producers feel the return on the investment of time and money is simply not worth the effort.

General O'MEARA. Our last witness is Dr. Stepto of Cook County Hospital.

Mr. FLOOD. I'm sorry, but you have no more time.

General O'MEARA. I think he can speak very briefly.

Mr. FLOOD. I know, but you have more than 15 minutes.

Dr. STEPTO. Mr. Chairman, may I file for the record the report?

General O'MEARA. Could he identify himself?

Dr. STEPTO. I am Dr. Robert C. Stepto, M.D., director, obstetrics and gynecology, Cook County Hospital, Chicago, Ill.

I would like to file my statement for the record.

TESTIMONY OF ROBERT C. STEPTO, M.D., DIRECTOR, OBSTETRICS AND GYNECOLOGY, COOK COUNTY HOSPITAL, CHICAGO, ILL.

Mr. Chairman, I am Robert C. Stepto, M.D., of Chicago, Ill. I am the director of obstetrics and gynecology of Cook County Hospital, which has the highest number of deliveries per annum of any hospital in the United States and one of the largest gynecological care facilities with over 26,000 patient visits per year. I am pleased to have the opportunity to be here today to present my views with regard to the fiscal year 1976 appropriations for the field of population sciences research.

As you know, Mr. Chairman, this category of biomedical and social science research encompasses our national effort toward the development of a range of safe and effective methods of fertility regulation. This is necessary in order to meet the needs of all individuals in our diverse society. This endeavor is conducted by the Center for Population Research, a subunit within the National Institute of Child Health and Human Development.

Mr. Chairman, I wish to state without hesitation or exaggeration of any kind that today work in this vital field is in serious jeopardy. Despite the Congress best intentions, and in the face of great public concern regarding the safety of our present birth planning methods, and regardless of the concerned recommen-

dations of the professional community, this program has reached a point where it cannot deliver on its commitments. Without a budget of at least $60 million in fiscal year 1976, it will be virtually impossible to attain any progress in this field.

Year after year, the Center for Population Research has operated under a budget ceiling which has made growth impossible. First-rate scientific work, approved for funding by the program's administrators, has remained backlogged due to lack of dollars. New knowledge, derived as the result of congressional emphasis in 1970, is not being applied today in clinical work because of major cutbacks. Talented researchers, who several years ago were willing and able to undertake careers in this developing area, are looking elsewhere rather than risk a shortfall of funds and concomitant lack of status.

Again this year, given the meager administration budget request for NICHD, the Center for Population Research will be unable to fund any new programs. Even more alarming is the fact that existing research programs face severe reductions in funds which have already been committed to them and which have programs underway. This means that much valuable work will have to be discontinued at a point where breakthroughs in some areas are imminent. The energy and effort required to sustain the field are on the brink of being lost for the future. Where last year budget restraints were causing chaos for some programs, this year they may bring collapse.

In the State of Pennsylvania, Mr. Chairman, over a dozen universities, hospitals, and scientists are research grantees of the Center for Population Research. The University of Pennsylvania School of Medicine, for example, where Dr. Luigi Mastroianni is the director of the CPR-supported program project in reproductive biology, currently operates 16 individual research grants in reproductive biology and socioeconomic research. These programs are at a level of nearly $1.5 million. Since its inception in January 1972, it has placed particular emphasis on the processes of fertilization and early embryonic development. Both the individual research projects and the overall institutional support face sharp cutbacks over those already experienced last year.

In Illinois, over 37 individual research programs are underway at virtually every research institution in the State. These include Southern Illinois University, the University of Illinois, DePaul University, and Illinois State University. In 1972, the University of Chicago received a 5-year grant award for the support of its Biomedical Center in Population Research. The center involves scientists with appointments in eight departments of the College of Biological Sciences. Projects and collaborative programs now in progress cover a broad spectrum of important areas, including investigations in the control of fertility and infertility. Northwestern University's program project focuses on basic research in hormone action involved in reproduction, utilizing investigators in physiology, chemistry, and pathology to lead to new approaches to the problems of fertility regulation.

At both Rutgers and Princeton Universities in New Jersey, important research is underway in the population sciences. The National Fertility Study, conducted at Princeton, is the single-most important index to fertility and birth-planning practices and attitudes in the United States. Data from that study, and from Princeton's graduate program in demography, is widely utilized as the authoritative "last-word" by demographic analysts around the world. Both the study and the graduate program are supported by the Center for Population Research. In fact, it is this work which disclosed the fact that between 1965 and 1970 nearly 45 percent of all births to married women were unplanned at the time of conception and that 15 percent were reported by the parents as having never been wanted. This data stands as considerable evidence of our still far-from-perfect birth planning methods.

The Center for Population Research also supports seven research programs at the University of Massachusetts in Amherst. These are in the fields of physiology and social science research. Case Western Reserve University in Cleveland has an important program project in reproductive biology. At the University of Wisconsin, over a dozen individual research grants, including core support for its population research center, total over $1 million.

All of these projects are vital, Mr. Chairman. And right now, every one of them is in jeopardy. I have mentioned these particular institutions because they may be of interest to you and members of the subcommittee. But let me hasten to add that there are hundreds of extremely valuable research projects throughout the country now facing budget slashes that will threaten their viability.

Mr. Chairman, as you know, the birth rate in the United States is currently at the lowest point since the Government began gathering reliable statistics

early in this century. It is apparent that at least for the time being American couples are choosing to have smaller families. To accomplish this aim, they are making the widest possible use of all available family planning methods. This is despite the fact that all of our present methods have serious limitations—both in their availability, effectiveness, acceptability and in the health side effects which may accompany them. In fact, it has become all too obvious that our basic knowledge of human physiology and our ability to promote or control fertility is abysmally deficient. If we knew more about such basic matters as the structure of hormones that trigger ovulation, the processes by which a human egg is fertilized, knowledge of the nature of the spermatogenic process, and the means to precisely detect the time of ovulation, fertility regulation could more closely complement the body's natural processes. In fact, with additional scientific knowledge, it should be entirely possible to develop a more reliable natural method of birth planning. This research is also essential to assist millions of couples who wish to bear children but who experience problems of infertility. However, until more adequate means are available, 42 million American women of chilbearing age must continue to depend upon present inadequate technology, with their attendant health risks, unwanted, accidental, and often dangerous pregnancies, or abortion.

Mr. Chairman, it is painfully obvious that research which is so vital to the health and well-being of all American families cannot hope to achieve any strides in the future unless its budget is increased. In every fiscal year since 1970, the Congress has sought to expand this program. I ask that you continue your strong support for the program and not allow an already deteriorating situation to be further compounded by OMB's reductions again this year. This field simply cannot afford another year of restrictive budgeting. If increased Federal support is not forthcoming, we shall be establishing blocks to progress that may not be overcome for many years. An additional $5 million is needed in fiscal year 1976 in order to merely maintain the present effort. However, an additional $13.6 million is required for the support of new research and training in fiscal year 1976. This would bring the program to a more realistic level of $60 million, surely as minimum an amount our society can afford for this vital work.

CENTER FOR POPULATION RESEARCH

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, FISCAL YEARS 1973-76

[In millions of dollars]

	Fiscal year—			
	1973	1974	1975	1976
President's budget request to Congress	[1] 44.1	39.2	45.4	41.9
House/Senate Conference allowance	[2] 51.3	47.7	51.0	----------
Available for obligation	39.9	[3] 39.4	50.7	----------

[1] Original fiscal year 1973 budget.
[2] Conference on original fiscal year 1974 budget.
[3] Excludes restored fiscal year 1973 impounded funds ($11.9).

MONDAY, MAY 19, 1975.

NEIGHBORHOOD HEALTH CENTER AND RELATED PROGRAMS

WITNESS

GERALD BLANK, ASSOCIATE DIRECTOR, THE GREATER NEW YORK HOSPITAL ASSOCIATION

Mr. FLOOD. Mr. Gerald Blank of the Greater New York Hospital Association.

Mr. BLANK. I am Gerald Blank, associate director, the Greater New York Hospital Association.

The Greater New York Hospital Association is a coordinating agency for the programs of all the major voluntary nonprofit hospitals, long-term care facilities including intermediate care and skilled nursing facilities, and all the municipal hospitals in the metropolitan area. Our member voluntary hospitals include such institutions as St. Vincent's Hospital and Medical Center of New York, the Mount Sinai Hospital, New York Hospital, Lenox Hill Hospital, St. Luke's Hospital Center, New York University Medical Center, and others.

Dedicated to serving the health and welfare needs of the community, the association seeks to advance the interests of its member institutions by building cooperation among them, by assisting them in achieving ever-increasing levels of effective performance, by encouraging essential education and research endeavors, and by interpreting all these functions to the general public and to allied professional, governmental, and other organizations. The association also maintains active liaison with groups in related fields interested in improving community health and raising standards of patient care.

Unless the cuts proposed by President Ford in Federal funding for neighborhood health centers, maternal and child health, mental health, and migrant health programs can somehow be prevented, I have to tell you that the consequences to voluntary hospitals and to the patients we serve will be disastrous. A tabulation of the actual figures on the proposed cuts is appended to the text of this statement.

The nature of the disaster will become all too obvious when, in the New York City area alone, some 75,000 men, women, and children, part of a total patient load of 300,000, are deprived of the ambulatory care services which the neighborhood health centers now provide. These 75,000 will have no choice but to turn to the ambulatory care departments of the voluntary and municipal hospitals of our city for the care they need.

Yet the simple truth is that our voluntary hospitals in New York City sustained a $50 million deficit in 1974 in providing ambulatory care services. One consequence so far is that 1 hospital has had to close down competely, 2 are in receivership, and 15 others are technically insolvent because their liabilities exceed their assets.

Obviously, our hospitals are simply not going to be able to cope with this avalanche of additional people in need of ambulatory care. We shall have no alternative but to curtail some services and eliminate others altogether. Even without the impact of the proposed cut in neighborhood health center and related programs, we face the prospect of cuts in our ambulatory care services program. This program, previously called the ghetto medicine program, depends upon matched New York City-New York State funding. Early indications, however, are that we shall for the coming year not even be able to count on the same funding level as last year, despite a 12-percent inflationary increase and the effect of a labor wage settlement which is likely to add 11 percent to that figure.

Perhaps those who are calling for this 25-percent cut in Federal funding of the neighborhood health center and related programs are under the illusion that they will somehow be saving taxpayers 25 cents on every dollar now being spent on ambulatory care services. If so, the illusion should be rapidly dispelled. It is axiomatic among

knowledgeable health care professionals that early diagnosis and prompt treatment are not only essential to good health care, such services are also highly economical. The illness caught in an early stage can be treated and cured while the patient is still ambulatory, at relatively low cost to the patient and the community. But the illness which is untreated during the early stages usually develops to the point where the patient must be hospitalized, at rates now running well over $100 a day.

That is not the total cost, however, of this short-sighted policy. The individual whose illness is neglected to the point where he must be hospitalized, is often the head of a family, a worker, and a taxpayer. But while hospitalized, he ceases to contribute to the economy and becomes a drain upon it. Obviously, those who call for cutbacks in the funding of the neighborhood health center and related programs, which make it possible for so many workers to continue to function effectively, are being penny wise and pound foolish.

The neighborhood health center program throughout the country provides more than comprehensive, family-oriented ambulatory care to indigent populations in medically underserved areas. The centers also train community residents in daily living skills in a variety of constructive ways. They help people better cope with the impact of inadequate housing, bad diet, and other conditions which otherwise take a heavy toll in disease and early mortality.

All these programs are doing a vital, necessary job of meeting the health care needs of largely economically deprived patient populations. Located in communities where the need is greatest, they have made tremendous progress in the fields of health education, in preventive services, in training for childbirth and child care, in meeting medical needs in areas where the family doctor has virtually disappeared. It would be tragic and short-sighted indeed, now when these programs are providing these services so effectively and in so doing are making expensive impatient care unnecessary in so many cases, if their funding were to be slashed the brutal 25 percent which this administration is demanding.

I hope your greatly respected body will do what you can to prevent this kind of vast human tragedy from taking place. I urge you to oppose the administration cutback and to insist on a continuation of at least the current funding level for the neighborhood health center and related programs.

Thank you.

PROPOSED CUTBACKS IN FEDERAL PROGRAM FUNDING, 1975-76

Program	1975	1976	Reduction
Neighborhood health centers:			
Patients	1,600,000	1,300,000	300,000
Funding	$205,000,000	$155,000,000	$50,000,000
Centers	177	109	68
Maternal and child health funding	$254,000,000	$193,000,000	$60,000,000
Mental health funding	199,000,000	160,000,000	39,000,000
Migrant health funding	24,000,000	19,000,000	5,000,000

Mr. FLOOD. Thank you.

MONDAY, MAY 19, 1975.

ALCOHOLISM

WITNESSES

LEVONN BENALLY, MEMBER, NATIONAL INDIAN BOARD ON ALCOHOLISM AND DRUG ABUSE
ERNIE TURNER
GEORGE HAWKINS

Mr. FLOOD. Mr. Levonn Benally, member of the Indian Commission on Alcoholism and Drug Abuse and Mr. Ernie Turner.

What is your tribe?

Mr. BENALLY. Navaho.

Mr. FLOOD. And you?

Mr. HAWKINS. Cheyenne.

Mr. BENALLY. My name is Levonn Benally, member of the National Board on Alcoholism and Drug Abuse and assistant director for the Navaho alcohol and drug abuse program in Window Rock, Ariz. I would like to address myself to the appropriations of NIAAA. I believe the information I received at the time I was out in Arizona was that I would be addressing myself to the Jacksonville Center but at this time I would like to go ahead and change that so I would be addressing the NIAAA appropriations.

According to the budget submitted by NIAAA in formula grants and project grants where our Indian programs originate there is a rescission of about $24 million this year.

The original amount for this year was $64,908,000. I believe the request for this fiscal year is $45,451,000.

As it affects the Indian programs throughout the country this, according to the proposed budget, will cut programs from 168 to 70 programs which is almost by 70 percent. This would cut a lot of existing programs which have been implemented and are doing a very good job in working with the alcoholism problems throughout the country.

One statement I would like to strongly emphasize is this: Alcoholism is the No. 1 problem for Indians for social, economic, and many other reasons. I think it is very urgent that we ask for additional funds from NIAAA and also I think there is a possibility of channeling the moneys through State programs.

We have been getting direct funding from NIAAA. This is one of the things that I would strongly recommend, that direct funding from NIAAA continue instead of getting it through State formula grants.

I think the Indian programs I have been affiliated with and I have gone through various programs like Ernie Turner's and George Hawkins' programs, they have done a tremendous job in helping the alcoholics and their families also. I think about 3 years ago if someone told me I would be here testifying before the House Subcommittee for Appropriations I would probably have laughed in their face, because I was one of those people there. The program that I am affiliated

with has helped me tremendously. I think I would continue to support Indian programs in their endeavor to fight alcoholism.

One of the things I would like to bring out also is: I would say alcoholism is a slow cancer eating away at various tribes. If nothing is really done eventually it will be the downfall of the tribes. With this statement I would like to turn this back over to Ernie Turner.

Mr. TURNER. Mr. Chairman, I have a prepared written statement here for the record. I would like to go over it.

Mr. FLOOD. We will place your statement in the record.

Mr. TURNER. In order that we may find answers or solutions to a problem of alcoholism among native Americans, we must first be convinced that a problem exists, and to what extent it exists.

We cannot begin to estimate the scope of the problem in terms of human suffering. Alcohol contributes to family disruption, health-related problems, accidents, malnutrition, homicide, suicide, child neglect, et cetera, not to mention the emotional suffering and loss of lives. Many words have been written and many people have spoken about the plight of the native American, however, none adequately describe the devastating killer we face today in alcoholism.

Alcohol has taken more native American lives than any other illness or any battle fought by our people, yet it receives little or no attention. We are told that it is our No. 1 health problem, however, it does not receive the No. 1 attention. We have lived with little hope of a future, just an existence without a purpose for being.

The spirits of our dead, who loved this country with its great forests, mountains, and winding rivers, cannot possible rest peacefully while we sit and listen to the sad wind moan while we await our doom.

Many years have passed with no bright star on the horizon to lead us from a meaningless existence. We are told now, that we can plan our own destiny and set up programs to solve our own problems. Our greatest problem has to be an illness that most of us have no resistance to, alcoholism. We began to think in terms of what can I do to help, we have become powerless over alcohol, however, many of us are recovering. We were allowed to help plan, implement, and operate programs in treatment and prevention.

It is a tremendous undertaking and sometimes very frustrating, however, it offers great rewards in terms of accomplishment and self-satisfaction. We can begin to hold our heads up and take pride in our determined effort to make good as the soil under our feet responds with more feeling, because it is rich with the ashes of our ancestors who can rest easier as there is now hope in our future.

Yet, even as I write, there exists the threat of failure. Failure to continue adequate support of our programs, or failure to provide direct support. If our fears are true and future support is directed through State government, then many of our programs will fail. Most of the States do not have time to be concerned with the problems of the native American, and many Indian reservations do not recognize State government.

There is also the threat that by letting the States handle the funds, we will be faced with another bureaucracy and funds intended for Indian programs will be used to support this bureaucracy. Most of us working in Indian alcoholism programs have taken great pride in

the fact that most of the financial support has been used to provide direct services. If we are forced into decentralized funding our programs will be faced with a grave problem, and many will not survive.

In order to provide an effective system of service delivery, we have, through self determination, employed mostly recovering Indian alcoholics to work in our programs. We have learned in the streets, jails, and hospitals what no university could teach. The experience we gained and are sharing with our brothers and sisters cannot be taught; however, certain skills in using our experience can be learned in colleges or training centers. We must be allowed to develop our own training and standards for certification. Many of our people do not have enough formal education to pass standards set by non-Indians, yet we are very effective as alcoholism workers.

We will continue to pursue our objectives in ways that are effective. Many of our Indian communities do not have alcoholism programs and most are understaffed. We have just began to scratch the surface and if we are to succeed, much more support will be needed from our white brothers.

I am director of the Seattle alcoholism program. I am formerly from Alaska.

Here is a report put out by HEW on Indian Health Trends and Services. I would like to place in the record, pages 31 and 32, the leading causes of death. Accident is the leading cause and we know most of our accidents are caused by alcoholism. Cirrhosis of the liver from 1955 to 1971 has gone up 221 percent. It is the fourth leading cause of death.

[The report follows:]

MORTALITY

LEADING CAUSES OF DEATH

Accidents continue as the leading cause of death in the Indian and Alaska Native population. One out of every five deaths in this population group is the result of an accident. Less than 1 out of 16 deaths in the U.S. population is the result of an accident. Diseases of the heart and malignant neoplasms are the second and third leading causes of death among the Indians. These two classifications are ranked 1 and 2 in the U.S. population. Cirrhosis of the liver, 4th leading cause of death in the Indian population, is the 10th leading cause of death in the United States. The crude death rate for cirrhosis of the liver has increased 221 percent since 1955. Suicides, diabetes mellitus, and homicide have also experienced considerable increases in their crude death rate during this period. Major reductions have been noted for enteritis and other diarrheal diseases, tuberculosis, influenza, and pneumonia certain causes of mortality in early infancy, and congenital anamolies.

AGE-ADJUSTED DEATH RATES

The age-adjusted death rate for the Indian and Alaska Native is 28 percent above that for the "U.S. All Races." The Indian age-adjusted death rate is 35 percent greater than the white population but is 11 percent below the all other races rate.

The Indian age-adjusted rates are considerably above the U.S. rates for cirrhosis of the liver, tuberculosis, all forms, accidents, influenza, and pneumonia. The age-adjusted rates for the Indians for major cardiovascular diseases, malignant neoplasms, and bronchitis, emphysema, and asthma are below comparable rates for the United States.

AGE-SPECIFIC DEATH RATES

Age-specific death rates for the Indians and Alaska Natives in the 24 reservation States are above the age-specific death rates for all age groupings through

age group 55–59. For the age groupings 60–64 and beyond the age-specific death rates for the United States are higher than the rates for the Indian population.

The age-specific death rates for the Indian population are based on deaths for calendar year 1971 and the estimated population for July 1, 1971, distributed according to the 1970 census age distribution.

TABLE 4.1.—LEADING CAUSES OF DEATH AMONG INDIANS AND ALASKA NATIVES IN 24 RESERVATION STATES

	Crude death rates		Percent change
	1971	1955	
All causes	771.7	927.2	—17
Accidents	157.1	155 6	+1
Diseases of heart	142.0	133.8	+6
Malignant neoplasms	62.5	59.1	+6
Cirrhosis of liver	45.6	14.2	+221
Cerebrovascular disease	42.8	46.4	—8
Influenza and pneumonia	38.6	89.8	—57
Certain causes of mortality in early infancy	29.6	67.6	—56
Diabetes mellitus	23.0	13.9	+65
Homicide	20.6	15.9	+30
Suicide	18.7	8.7	+115
Congenital anomalies	10.9	19.0	—43
Tuberculosis	7.8	55.1	—86
Arteriosclerosis	6.5		
Nephritis and nephrosis	6.0		
Septicemia	5.3		
Bronchitis, emphysema, and asthma	5.1		
Enteritis and other diarrheal diseases	4.4	39.2	—89
Infection of kidney	3.7		

Note.—Data not available.

Mr. FLOOD. In view of what you have told us down through the years about the economic condition of the Indians on the reservation, how in the world can they afford the cost of drugs or alcohol, either or both, on the reservation? It is bad enough in the inner cities where crime produces those things, but on the reservation you have pretty good control of your people. How do they get the money to take these drugs?

I understand reservations have pretty strong governments.

Mr. TURNER. I think that is a very good point. If I may address this subject, there are a lot of programs on and off reservations that deal with symptoms of alcoholism. They provide support and information for poor health, unemployment, welfare grants.

Mr. FLOOD. How does the addict get the money for the alcohol and drugs? How do they get the money?

Mr. TURNER. From these programs that are making it easier for the alcoholic to drink, the welfare system.

Mr. MICHEL. You would not advocate doing away with welfare to reduce the drinking problem?

Mr. TURNER. No, but there should be some kind of control.

Mr. FLOOD. They tell me the control on the reservation is usually pretty good, the ones I know about. The only ones I know of are the Seminoles, in particular.

Mr. BENALLY. On the Navajo Reservation liquor is illegal but there are bootleggers out there. I know it is getting worse and worse with the drug problem on the reservation. The thing we are looking at on the reservation is preventive programs.

I think we have been involved in this rehabilitation and treatment process for 6 or 7 years and really not getting anywhere. We have to go into prevention on a long-term basis. I think one of the areas where

you go back to why some of the Indians drink, I think one of the reasons why is because of the boarding school setup and being separated from the home and parents. I think there has to be something done with that particular setup there. So I personally, regardless of whether they have the money or not, or if they have the liquor or not, that is not the real problem. We have to get back to the real problem and that is in prevention.

Mr. FLOOD. Thank you gentlemen, very much.

[The statement of Mr. Hawkins follows:]

STATEMENT OF MR. GEORGE HAWKINS, EXECUTIVE DIRECTOR, UNITED INDIAN RECOVERY ASSOCIATION, INC.

Mr. Chairman, I most sincerely appreciate the opportunity to attend this meeting, my name is George Hawkins, and I am the executive director of an organization titled United Indian Recovery Association, Inc. This organization is composed of Indian alcoholism programs located in Texas, Oklahoma, and Kansas and also we have a correlation with an organization titled National Indian Board on Alcoholic and Drug Abuse.

We feel the extreme need for an organization of this type to function in four critical areas:

1. Research; 2. facilitator; 3. advocacy; and 4. communication.

I will take up only the first item, "research", because I feel that it graphically illustrates the effects on all areas of the entire Indian bit. In the paper I have attached, the figures were gleaned from the Oklahoma State Crime Commission. This is indicative to the area in which the disease of alcoholism rests with the State of Oklahoma.

This survey was taken from 22 counties and cities in which there are significant Indian population and also from the 2 most populous and largest metropolitan areas.

I want to apologize for the top group of figures, there seems to be an omission or typographical error.

This one area of research we are delving into may be more shocking but the Indian has been aware of and lived with this situation: In every county surveyed, the percentage of Indian arrests was higher than the percentage of Indian residents.

Either we are living up to the image of "all Indians are drunks" or perhaps there is discrimination. Whatever the cause we are attempting to discover the reasons behind these shocking results and then we will try to work toward the solution in order to preserve the dignity and integrity of the Nation's first citizens.

As it relates to Indians, we sincerely believe that this capsulized analysis, of one segment of the Nation is indicative of the entire United States of America.

This paragraph taken from the "Report to the Congress", dated March 11, 1973, also is very pertinent: "According to Indian Health Service alcoholism probably adversely affects more aspects of Indian life than any other health factor and has been an Indian health problem since the 17th century. IHS reports that alcoholism causes cirrhosis, nutritional deficiencies and neuropsychiatric disorders, disintegrates family relationships, and adversely affects the economic functioning of the whole Indian society."

Due to the great unpopularity of alcoholism and for the treatment, rehabilitation, education, and information on alcoholism, a greater effort toward solving this problem has not been evidenced by the States, Bureau of Indian Affairs, Indian Health Service, tribal governments and Indians organizations.

It is only thorugh the dedicated efforts of some individuals within the Office of Economic Opportunity which ended in July 1972, and thereafter by HEW's National Institute of Alcohol Abuse and Alcoholism, that we have only begun to scratch the surface in discovering the causes of this devastating Indian problem and it would be tragic to stop or curtail this vital effort.

It has only been through the efforts of the Federal Government, through the National Institute of Alcohol Abuse and Alcoholism, that the Indians have been given an opportunity for trying to solve this problem and we feel that it would be tragic that these efforts from the Federal level be curtailed.

I thank you for the opportunity for making this presentation.

A COMPARATIVE PROFILE

County	Total incarceration rate						Total incarceration rate for alcoholic offenses		
	Total arrests made	Number Indian arrests made	Percentage Indian arrests	Indian percent of total	Indian population in county	Percent of total population	Drunkeness total arrests	Drunkeness Indian arrests	Percent Indian arrests
Custer:									
Sheriff's Office	277	83	29.0	57.0	800	3.5	20	1	5.0
Clinton	1,724	1,057	61.3						
Total	2,001	1,140							
Roger Mills:									
Sheriff	65	17	26.1	75.2	294	6.6	155	138	89.0
Hammon	157	150	95.5						
Total	222	167							
Blaine:									
Sheriff	575	348	60.5	68.7	801	6.7	694	576	83.0
Watonga	480	377	78.5						
Total	1,055	725							
Dewey: Sheriff	206	94	46.6	45.6	253	4.4	77	45	58.4
Kingfisher:									
Sheriff	416	81	19.4	29.9	257	1.9	226	117	51.7
Kingfisher	221	110	49.7						
Total	637	191							
Caddo:									
Sheriff	744	386	51.8	35.2	4,080	14.0	1,686	1,416	84.0
Anadarko	1,802	511	28.3						
Total	2,546	897							
Kiowa: Sheriff	253	132	25.2	25.2	490	3.9	234	95	40.5
Stephens:									
Sheriff	44	0	0	1.9	476	1.3	417	10	2.3
Duncan	929	18	1.9						
Total	973	18							
Comanche:									
Sheriff	810	89	11	10.4	3,343	3.0	1,005	166	16.5
Lawton	4,849	453	8						
Total	5,659	542							
Johnston:									
Sheriff	197	43	21.8	24.3	615	7.8	177	52	29.3
Tishomingo	82	25	30.4						
Total	279	68							
McCurtain:									
Sheriff	529	86	16.2	32.5	2,493	8.7	1,760	709	40.2
Idabel	675	124	18.3						
BrokenBow	1,244	587	41.7						
Total	2,448	797							
Cherokee:									
Sheriff	349	132	37.8	55.2	4,416	19.0	1,317	822	2.4
Tahlequah	1,511	895	59.2						
Total	1,860	1,027							
McIntosh:									
Sheriff	470	58	12.3	11.7	1,550	12.5	273	44	16.1
Eufaula	23	0	0						
Total	493	58							
Okfuskee Sheriff	206	49	23.7	23.7	1,278	12.0	79	27	34.1

County	Total incarceration rate						Total incarceration rate for alcoholic offenses		
	Total arrests made	Number Indian arrests made	Percentage Indian arrests	Indian percent of total	Indian population in county	Percent of total population	Drunkeness total arrests	Drunkeness Indian arrests	Percent Indian arrests
Adair:									
Sheriff	360	210	58.3	68.2	4,150	27.4	734	523	71.2
Stilwell	532	399	75.0						
Total	892	609							
Mayes:									
Sheriff	685	158	23.6	24.4	2,496	10.7	577	206	35.7
Pryor	471	79	16.7						
Salina	148	82	55.4						
Total	1,304	319							
Osage:									
Sheriff	838	171	20.4	25.6	2,565	8.7	607	202	33.6
Pawhuska	369	138	37.3						
Total	1,207	309							
Wagoner:									
Sheriff	295	21	7.1	7.9	799	3.6	235	26	11.6
Wagoner	195	18	9.2						
Total	490	39							
Pawnee:									
Sheriff	489	135	27.6	35.9	783	6.9	313	149	47.6
Pawnee	140	91	65.0						
Total	629	226							
Kay:									
Sheriff	403	113	28.3	51.9	1,865	3.8	1,422	964	67.7
Ponca City	1,712	985	57.5						
Total	2,115	1,098							
Moble:									
Sheriff	168	40	23.8	24.9	783	4.7	104	42	40.3
Perry	149	39	26.1						
Total	317	79							
Creek:									
Sheriff	220	4	1.8	9.0	1,913	4.2	295	60	16.9
Sapulpa	737	83	11.26						
Total	957	87							

Tulsa County—1974

Tulsa Police Department:	
Total arrests for drunkenness	4,452
Indian arrests for drunkenness	842
Percent of Indian arrests to total	18.9
Total of all arrests by Tulsa Police Department	10,992
Total Indian arrests by Tulsa Police Department	1,150
Percent of Indian arrests to total	10.4
Percent of Indians in total population of Tulsa County	2.7

Oklahoma County—1974

Oklahoma City Police Department:	
Total arrests for drunkenness	10,351
Indian arrests for drunkenness	3,526
Percent of Indian arrests to total	34
Total of all arrests by Oklahoma City Police Department	27,446

Total Indian arrests by Oklahoma City Police Department	4,391
Percent of Indian arrests to total	15.9
Percent of Indians in total population of Oklahoma County	1.0
Total arrests in 22 countries surveyed	26,749
Total Indian arrests in 22 counties surveyed	12,673
Percentage of Indian arrests in 22 counties surveyed	47.3
Total arrests for alcoholic offenses in 22 counties surveyed	12,401
Total Indian arrests for alcoholic offenses in 22 counties surveyed	6,380
Percentage of Indian arrests for alcoholic offenses in 22 counties surveyed	51.4

MONDAY, MAY 19, 1975.

HEALTH SERVICES ADMINISTRATION—ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, HEALTH RESOURCES ADMINISTRATION, HUMAN DEVELOPMENT, AND COMMUNITY SERVICES ADMINISTRATION

WITNESS

HON. TENO RONCALIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WYOMING

Mr. FLOOD. Now we have the high honor and great privilege of having with us a distinguished colleague from the great State of Wyoming, Teno Roncalio.

Mr. RONCALIO. I am happy to be here today with my shoes on.

Thank you very much, Mr. Chairman, and Mr. Michel.

Because I am chairman of the Consent Calendar Committee and due on the floor in about 5 minutes, I will reluctantly boil down my statement.

I hope it can be put in the record in full.

[The full statement follows:]

Mr. Chairman, I appear before you today to respectfully request your consideration of several items of the fiscal year 1976 health and welfare budgets that are of direct importance to my State of Wyoming. My statement will be brief and includes the following areas: Health Services Administration, the Alcohol, Drug Abuse and Mental Health Administration, Health Resources Administration, Human Development, and finally, the Community Services Administration.

I am distressed to see several sizable cutbacks in funding for program activities of the Health Services Administration, especially in the areas of community health centers, family planning, and migrant health. I ask that the subcommittee consider these funding requests carefully, bearing in mind that the need for these programs has not diminished. I hope the funding requests of these services will be increased at least to their fiscal year 1975 funding levels.

In a more particular way, I direct the subcommittee's attention to the comprehensive health grants to States category, under the community health services. New authorizing legislation to amend the Public Health Services Act will come before the House for consideration sometime this week. The House version includes $100 million for title 314(d) funds for fiscal year 1976, the Senate version authorizes a spending level of $160 million.

It is probable that the conference version of the authorizing legislation will arrive at a figure for comprehensive health grants to States somewhere between $100 and $160 million. I urge the subcommittee to appropriate funds for this program at the full authorization level that will be recommended in final action on this legislation. Should authorization not be approved for the health grants to States, the State of Wyoming would lose about $350,000. Put in more realistic terms, a loss of title 314(d) funds to Wyoming health programs would mean a loss of 31 health service workers and discontinuation of several major health service programs. Failure to fund the comprehensive health grants to States

would spell disaster for many of the outstanding health programs that have developed on Federal aid to increase and improve quality health care.

A second area of concern to me under the Health Services Administration is an $83 million decrease in maternal and child health programs. We can talk about facts and figures, talk prices and the economy, and lose sight of the humanness involved in maternal and child care. If the subcommittee will bear with me for a moment, I wish to read a few lines taken from a letter I received from a constituent, whose words state the read meaning of what we are doing here today, "it seems like it is enough to penalize a child by being born into a family that does not have the economic or educational means to provide an adequate start in life, but then to add the penalty of poor health and poor stimulation, and, in some cases, outright abuse and neglect is too much of a handicap." I urge the subcommittee to increase the appropriations level for maternal and child health programs to the more realistic fiscal year 1975 level of $254.5 million.

In the Alcohol, Drug Abuse and Mental Health Administration's budget requests for fiscal year 1976, there are two areas of main concern to the State of Wyoming. The first is the proposed phaseout of the community mental health center program. The administration's justification to phase out this program is not a realistic or viable one. The belief that the mental health centers in this country will be able to support themselves depending solely on State and local revenues is unrealistic in view of the recent and sizable increase in the number of Americans seeking the services of the mental health centers. It has been termed a feasible assumption that this increase is due to the uncertain economic situation of today, and the very real fear of the unemployment line. I ask that the subcommittee increase the appropriations request for general mental health activities, at least to the fiscal year 1975 level of $395 million. Not to take such an action would leave our mental health centers with only $306 million to carry on services which are more and more in demand, and would place additional stress on the already overburdened staffs and financial situations of the mental health centers.

I cannot overemphasize the very real need of mental health activities in those energy resource impact areas in my State of Wyoming. People are living in the most austere living conditions, from trailers to tents. The overcrowded and transient conditions in these areas have an adverse effect on the mental outlooks of those experiencing this kind of situation.

A second consideration in this same area that is most discomforting to me is the fact that no funds have been requested for construction activities for community mental health facilities. Congress established 1980 as the target date for completion of some 1,000 mental health centers across the United States. To date, 591 centers have been completed. The need for mental health facilities will not go away because of a tight money situation resulting from this Nation's economic woes. I ask the subcommittee to reinstate funds for mental health facilities construction at an appropriation of at least $28 million, a slight increase over the funding level for fiscal year 1975. The State of Wyoming only has three mental health facilities to serve the growing population of the State. Plans are in the making for a community health complex to be constructed in Casper, at the center of the State. The community mental health center in Casper hopes to be a part of this complex, but State and local revenues will not be sufficient for construction of the community mental health facility to be included in it. Therefore, I urge the subcommittee to include an appropriation for construction for community mental health facilities.

I am pleased to see increases in appropriations for both alcohol and drug Abuse treatment and prevention in the fiscal year 1976 budget requests. It is my sincere hope that the subcommittee approves these increased appropriations for these activities.

Under the Health Resources Administration, I wish to direct my remarks to the recently approved authorization of $161 million for nurse training. Comparable legislation in the Senate included $218 million for nurse training activities. It is my sincere hope that this subcommittee approves an appropriation for this category at the full authorization level that will be set in conference action on this legislation.

A fourth area of concern comes under the human development category under special institutions. I ask the subcommittee to approve the $1.5 billion request for all of the program activities of human development. I am particularly interested in the $5 million requested for youth development, which provides for continued support of projects for runaway youth . . . for temporary shelter

care, as well as services essential to meeting the immediate emotional, psychological, physical, and social needs of runaway youth. It is my hope that the subcommittee increases the appropriation for this activity to its fiscal year 1975 level of $10 million.

Finally, I wish to speak on the newly organized Community Services Administration, established in 1974 by Public Law 93-644. Activities formerly assigned to the Office of Economic Opportunity will now be administered by the CSA. I ask that the subcommittee approve the $363 million appropriated for the CSA. I was very much impressed with the data sent to me by the director of the Cheyenne community action. The Cheyenne program has a caseload of over 7,000 people between January 1974 and January 1975.

Of that total, more than 3,000 cases were termed unmet needs, in other words, cases for which there is no referral source. It is obvious that without adequate funding, the problem cannot be solved, there must be sufficient moneys available to community services personnel to initiate new and necessary programs. Community action services provide people with everything from employment information, to juvenile aid, to transportation, and family counseling, right down to the basic and immediate needs of food, clothing, and shelter. I urge the subcommittee to approve the realistic request of $363 million.

I sincerely hope that the subcommittee will give these particular budget requests of health and welfare activities your full consideration, and eventually your favorable approval. Thank you for the opportunity to bring these projects and considerations before the subcommittee.

Mr. RONCALIO. The gentleman who just left reminded me of the Shoshones and the Araphoes. I wish to include them in my statement especially in regard to their terrible drinking problems. I don't know what the answer is.

In Wyoming we are mining a lot of strip-mine coals by the hundreds and hundreds of millions of tons and shipping it to 35 States and that is a reason why, in the austerity that comes from that economic burst, we need money for child and maternal health programs.

Even though there is great prosperity for those who own and lease the coal, it has resulted in increases in the number of people using our federally funded mental institutions at Lander, Cheyenne, and Sheridan. In the whole State we have less than three mental health facilities, within 98,000 square miles, where our people have to live. Now, we are few and far between in small towns but nevertheless having only three facilities gives you some indication of the problems they have to work with, the miles they have to drive and the real tragedies and real calling and dedication people have to do this work.

I would be happy to answer any questions you might have.

Mr. FLOOD. Thank you very much.

Mr. RONCALIO. Thank you, Mr. Chairman and Mr. Michel.

Mr. FLOOD. The committee is adjourned.

TUESDAY, MAY 20, 1975.

REHABILITATION WORK

Witnesses

HON. SAM GIBBONS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

MARCELINO HUERTA, EXECUTIVE VICE PRESIDENT, MACDONALD TRAINING CENTER FOUNDATION

Mr. FLOOD. We now have the high honor and great privilege of having with us this morning our distinguished colleague from the

great State of Florida. Having been raised in St. Augustine and gone to the Florida Military Academy, I know something about the area generally.

The Hon. Sam Gibbons, and with him is Mr. Huerta, executive vice president, MacDonald Training Center Foundation.

Mr. GIBBONS. Mr. Chairman, I have come to introduce Mr. Marcelino Huerta. He is a friend of long standing of mine. Mr. Huerta is one of our great football players from our community and State. He coached football after having played and made an outstanding name for himself there.

Mr. FLOOD. Where?

Mr. GIBBONS. He coached at the University of Tampa, Parsons, and Wichita State, and turned out great football teams.

Mr. FLOOD. What did you play?

Mr. HUERTA. I was a guard. I recruited many Pennsylvanians, though.

Mr. FLOOD. I was good, too. In those days there weren't any squads. You played the whole game. There were about 11 men and everybody played every hour, every game, every year; no substitutes.

Mr. GIBBONS. Because of his love of people and his ability to lead, Mr. Chairman, he has gone into the work of helping retarded children, and he has one of the largest and finest schools for the retarded in the country.

Mr. FLOOD. We know about this.

Mr. GIBBONS. He is very interested in getting you to put some special language in the appropriation bill that will make it possible to fund a jobs program for the retarded. I think it would be much better to let him tell you about it than for me to do so.

But it is great work, and it really works and needs just some special attention by you members of this subcommittee.

Mr. FLOOD. We will take a brief recess to answer the quorum call.

[Recess.]

[Mr. Huerta's full statement follows:]

STATEMENT OF MARCELINO HUERTA

Mr. Chairman and members of the Appropriation Committee for the Department of Labor and Health, Education and Welfare, I'd like to preface my remarks by stating that I am not what some people call a professional in the field of rehabilitation. I'm better described or known as a broken-down coach, having been a college football coach for over 18 years before entering this profession approximately 6 years ago.

As a college coach and in the last 6 years I've had the privilege of traveling all over this country, speaking before all types of organizations, visiting homes of different cultures and economic backgrounds. In conversation with all these folks we have discussed athletics, world problems, crime, our economic problems, and many other subjects. If I were asked which two topics have been the most discussed and are creating the most concern, I would have to say crime and our economic problems.

Our people are all concerned about crime. There is fear of bodily harm and being robbed all over this country. If there is an industry in the United States that is doing well, it has to be the industry that develops equipment against burglary. But I'm not here to discuss crime. I'm here to discuss the economic problems or rather, one phase of our economic problem that I, in rehabilitation work, feel we can help with.

As I travel and meet with people in industry, one of their biggest complaints

is that they cannot get the effort out of their labor force that they feel they should. Industry has a feeling that labor is out to get all they can and do as little as possible, that there is very little loyalty or pride in the labor force and, as a matter of fact, a gerat majority of these people steal if given half a chance. In visiting homes and talking with these laborers, I have come to the conclusion that the feeling of industry is justified—not only in the feeling that they are not getting their moneys worth, but I've found that a lot of laborers are somewhat ashamed of their jobs, even though honorable. As you visit with these people—you hear this comment: "I don't want my son or daughter to be a carpenter, plumber, or painter. I want him or her to be a teacher, C.P.A., doctor or lawyer." If this holds true, along with our advancements in technology, we'll be without a labor force soon. As I said earlier, I'm a broken-down football coach and not real smart but somehow I believe we'll always be in need of some type of labor force. That is why I'm here, to ask you all to help me and other people in rehabilitation work to develop a labor force that is proud, loyal, and grateful for the chance and opportunity to work.

At our training center—the MacDonald Training Center Foundation—we deal with the retarded. Our goals are to develop them as completely as possible—physically, in personal adjustment, vocational adjustment, independent living skills, and on-the-job training so that once we place them in jobs they'll have a better chance of staying and living out in the community.

Many years ago when I was a young boy I'd sit around and listen to my dad tell of his experiences when he came over from Spain. I recall how he'd tell us how hard he worked—the long hours, the hard labor, and the difficulty he had in understanding his supervisors because he didn't speak English. He only knew three words: "Ham and eggs." I also remember how proud he was that he worked hard and always produced for his bosses. He was always proud of his ability to work and satisfy his supervisors and of the awards he received by being honored by having the yearbook dedicated to him several times while he worked as a janitor in a high school. He always bragged that he never missed a day of work. He used to tell me as I grew: "Son, get an education, get as much education as possible—but never be ashamed of work, regardless of what it is, as long as it is honorable," My dad is 82 years old now and still proud of the years he worked on the State road department, cigarworker, and as a janitor.

As I think of my dad's experiences and problems of the retardates as we place them, I can see a resemblance between the retardates that are proud, loyal, hard workers, and so willing to learn and please, and the immigrants, such as my dad, who came over around the turn of the century and worked, wanted to work, were dependable, proud, and loyal to their employers. The difficulty that these immigrants had with the language and the rough, tough foremen is comparable to the problems our retardates have. If you have a little patience and understanding they'll do their job to perfection.

Gentlemen, we're doing that job. We are preparing retardates and other handicapped to work, live independently, or in halfway houses—they are producing work with pride, loyalty, and satisfaction.

In the 6 years that I've been at MacDonald Training Center I have seen many young people accepted in our center from State institutions that most people would never dream of hiring, much less feel they would be capable of work, but after a lot of time and hard work these same people are out working and paying taxes.

The last few years we have been doing a much better job—a better job because you all have helped by appropriating more money to enable us to do a better job.

We have, at our place, a program made possible through your generosity—the project with industry program that has been tremendous in helping us with our work. Even though MacDonald Training Center has been a leader through the years in rehabilitation of the retarded, this program has really been one of the biggest steps taken in the field since we developed the vocational capacity scale at MacDonald Training Center, and, gentlemen, if allowed to continue it will play an even bigger part.

To give you all an idea of what we have been able to do with the help of this program let me give you all a few facts and figures. From February 1, 1973, to January 1, 1974, our project with industry programs accepted 108 clients. We were able to place 81 in full-time employment. We replaced 36 other clients who had lost their jobs and had 13 on the job training. Gentlemen, 81 of 108 is 75 percent placement. The annual earnings of these 81 totaled $325,000, in a range of

$1.60 to $3.96 per hour. The cost per client served was $1,083.10. If these clients were wards of the State of Florida it would cost the State of Florida approximately $800,000. Instead, today they are hard workers in our area, some living independently, others in halfway houses, but all are hard-working, happy, grateful employees. They are taxpayers and most of them giving to the United Fund—helping others.

Just a few more figures: $10,000 per retardee in Florida times 81 equals $810,000, savings to Florida instead, $325,000 earned by retardees equals $1,135,000 plus side; $372,600 [81 times $4,600] cost to State and Federal Government to train these 81; $762,400 plus side in our PWI program alone in 1 year.

If the other 10 PWI projects have the same type of success, it would be approximately $7,624,000 to the plus side.

Like our program in retardation there are other projects with industry programs working with other types of handicaps. Like ours, their placement success is high because (1) of the overall concept of proect with industry working closely with industry.

In Tampa, I'm chairman of the committee on employment of the handicapped for the chamber of commerce. Industry in our area is aware of our labor force. Our on-the-ob training allows industry to see these handicapped at work. The experience is good training for the clients and it sells itself to the employer. (2) Because Congress passed the affirmative action, Rehabilitation Act, industry is coming to us looking for guidance and leadership in ways to develop a good labor force of handicapped people. We in Tampa are now serving as a resource center. One of my staff members just returned from speaking before the American Society for Development & Training. He spoke on training and placement of handicapped with emphasis on affirmative action. (3) Because the handicapped only want a chance, they are handicapped, know it, and work like hell to satisfy. They know they have to work twice as hard because of their handicap and for this reason alone, they work like that immigrant I mentioned earlier. They will do everything possible to please. In visiting with the manager of Sizzling Steak Rest the other day he mentioned to me that the most dependable employee he's had is a retarded girl we placed at his restaurant 5 years ago. She is never late and has never missed without a legitimate excuse. Like her, you'll find most handicapped want only a chance to compete. We owe every American this.

I just read where the Senate passed and sent to the President a $5.3 billion emergency appropriations bill to produce 900,000 jobs.

Some of the major allotments are $1.6 billion for public service jobs, $485 million for summer jobs.

Gentlemen, this is all fine—needed. I'd like to mention that the largest labor force in America that has the biggest percentage of unemployment is the handicapped. All they want is a chance—not for temporary or summer jobs but permanent jobs.

Gentlemen, I'd like to ask that as you approve the moneys needed to do the job you put extra emphasis and more money, at least $8 million, in section 304(d) of the Rehabilitation Act—project with industry—so that (1) it will not get lost in the jungle of programs, (2) enable us to continue to expand this new idea. The project-with-industry concept has rough spots but we are improving it and now with the affirmative action I see the two together being the answer to developing that labor force I've been speaking of—the people that will produce work permanently on a job with a smile.

Even though I've only been in this field 6 years I see the results emerging. I've traveled all over our country visiting rehabilitation centers to learn, we've hosted a national meeting of project with industry, I've even been asked to lecture abroad at an international meeting to tell our story. It is working. We are improving the quality of life of every handicapped individual that enters our center. Our goals are being fulfilled. Give a handicap a job and you'll never have to look for a replacement.

Help us continue to do the job that is needed to be done.

Thank you.

Mr. HUERTA. Let me first say, Mr. Chairman, that I am a little hurt. I have made over 2,000 speeches in the 20 years that I have coached, and the audience never left before I got started the way you did today. So I am a little nervous.

Mr. FLOOD. That is par for the course here.

Mr. HUERTA. This is what the gentleman from the media just told me.

Let me very briefly tell you what we are doing, how I feel, and what I have observed.

The young lady here has the complete message.

In the years that I coached, Mr. Chairman, I traveled all over this country. I have spoken in your State from Philadelphia, to Pittsburgh, Williamsburg, Cambra, all the small towns where they have good football players. I have been in practically every community in this country as a coach and in the field of rehabilitation. In visiting with the families of all the different cultural backgrounds, one of the biggest problems, the No. 1 topic I have heard in the discussions are, one, crime; two, the economic problem. They are concerned about these two. I am not here to discuss crime.

I am talking about our economics, our labor. I read in the paper this morning where we have all kinds of problems with our economics, placing people in jobs, looking for jobs for people.

I have been at the MacDonald Training Center for 6 years. I am not a professional in the field of rehabilitation, as far as professionals are concerned, but I have witnessed the tremendous job that we do with the handicapped.

To give you an idea of what we do: MacDonald Training Center brings in the retarded beginning with 1-year-olds and all the way up. We try to work with them physically, to help them make social adjustments, and personal adjustments, and to give them all types of training that will make them complete persons.

When they get older, we work on vocational training for them and try to find a place for them in the community. The MacDonald Training Center has placed an average of 60 to 70 retarded in industry in the last 7 to 8 years.

The project with industry is something that has enabled us to do an even better job than before in working with the handicapped. I have hosted national conventions in Tampa for the project with industry, and I have seen projects such as ours with other handicapped work, placing the handicapped in industry through the project with industry. I know it works.

I would like to refer to my notes. I would like to make one point here.

When I was a young man, I would sit around my house and listen to my dad. My dad came from Spain. He used to tell me how hard he worked, the long hours that he worked, the difficulty he had in understanding his supervisors because he didn't speak English. He only knew three words, "ham and eggs." I remember how proud he was that he worked hard and always produced for his bosses. He was proud of his ability to work and satisfying his supervisors and of the rewards he received by being honored by having the yearbook dedicated to him several times while he worked as a janitor in a high school. He always bragged that he never missed a day of work. He used to tell me as I grew, "Son, get an education, as much education as possible, but never be ashamed of the work you do regardless of what it is as long as it is honorable." My dad is 82 years old now, and he is still proud of the work that he did working in the State road department, as a cigarmaker and janitor.

As I think of my dad's experiences and the problems of the retarded as we place them, I can see a resemblance between the retards that are proud, loyal, hardworkers and willing to learn and please, and the immigrants such as my dad that came over at the turn of the century and worked. They wanted to work and were dependable and proud and loyal to the employers. The difficulty the immigrant had with the language and the rough, tough foreman is comparable to the problems of our retarded.

Gentlemen, we are doing a great job. We are preparing retarded and other handicapped to work and live independently or in halfway houses. They are producing with pride and satisfaction.

In the 6 years that I have been in MacDonald Center I have seen many young people accepted into our center from State institutions that most people would never dream of hiring much less feel they would be capable of work. But after a lot of time, hard work, and love, these young people are out working and paying taxes.

In the last few years we have been doing a better job, a better job because you all have helped by appropriating more money to enable us to do the job.

We have at our place, as I mentioned earlier, a program made possible through your generosity, the project with industry program that has been tremendous in helping us with our work. Even though MacDonald Training Center has been a leader through the years in the rehabilitation of the retarded, this program has been one of the biggest steps taken in the field since we developed the vocational capacity scale.

I might mention the vocational capacity scale is the only one validated in the world in working with the retarded. We are going to continue to improve, gentlemen, if we are allowed to continue with this project with industry.

To give you an idea what we have been able to do with the help of this program, let me give you just a few facts. From February 1, 1973, to January 1, 1974, our project with industry program accepted 108 clients. We were able to place 82 of these clients in full-time employment. We replaced 36 other clients that had lost their jobs and had 13 on-the-job training.

That is about a 75-percent placement. The annual earning of these 81 retarded totaled $325,000 in a range of $1.60 to $3.96 per hour. The cost per client served in the project with industry to the Federal Government was $1,083.

Gentlemen, if these clients were wards of the State in Florida, it would cost the State of Florida over $800,000 to keep them. Instead, today they are hard workers in our area, some living independently, others in halfway houses, but they are all hard-working, happy, and grateful employees. They are taxpayers and most of them giving to the United Fund, helping others.

Let me give you a couple of more figures. It costs $10,000 per client to keep a kid in a State institution. If these 81 were still in a State institution like I mentioned earlier, it would cost the State $810,000 to keep them.

Instead, we have them working in the community, which is a savings of $810,000. They earn over $325,000, which on the plus side is $1,135,000. It costs the State and the Federal Government, project

with industry, and the grants we get from the State, $372,000. Subtract that cost from the plus factor and you have over $700,000 on the plus side through the project with industry.

There are 10 other projects such as ours in the country. If all of them have as much success as we have had, that would be a savings or a plus factor of $7,624,000.

Like our program, there are many all over the country. Like ours, their placement success is high because of the concept of the project with industry. We work closely with the industry itself. Our kids go into the factories to work. They get to go side-by-side by other employees. It gives them a chance to be competitive. The experience is good for its client and also it sells itself to the employer.

One of the main reasons we are working and having success is because of the Congress. You all passed the affirmative action bill, whatever it was; I think it was Public Law 92–122. Industry is coming to the MacDonald Training Center today, looking for guidance and leadership in ways to develop a good labor force of handicapped people. We in Tampa are now serving as a resource center. One of my staff members just spoke in Las Vegas for the American Society for the Development of Training. He spoke on training and placement of the handicapped.

The handicapped want a chance. They will work twice as hard as the average man because they know they have to work twice as hard to please. They will do everything possible to please. Right before I came up here, I visited with the manager of the Sizzling Steak restaurants. He mentioned to me the most dependable employee he had was a retarded girl we placed there 5 years ago. She has never been late or missed without a legitimate excuse. Like her, you will find many others that are willing to do the job.

I just read this past weekend where the Senate passed and sent to the President $5.3 billion in an emergency appropriation bill to produce 900,000 jobs. Some of the major allotments are $1.6 billion for public service jobs; the other was $485 million for summer jobs.

Gentlemen, we need this. This is all fine, but I would like to mention that the largest labor force in America that has the biggest percentage of unemployment are the handicapped. All they want is a chance, not a temporary or summer job, but permanent jobs.

Mr. GIBBONS. They need some language in your appropriation bill to set out this program, or it will get lost over at HEW. That is the problem they face. If you can help them in that, you will help a lot of fine people.

Mr. HUERTA. It is 304(d), Rehabilitation Act, project with industry.

Mr. FLOOD. Thank you very much, gentlemen.

COMMUNITY SERVICES ADMINISTRATION

HON. JAMES ABDNOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

DR. GEORGE J. MAUER, SENIOR POLICY ANALYST WITH THE STATE ECONOMIC OPPORTUNITY OFFICE, OFFICE OF THE GOVERNOR, STATE OF SOUTH DAKOTA

Mr. FLOOD. We have next Congressman James Abdnor, of South Dakota, and he has with him, Dr. George Mauer, senior policy analyst

of the State Office of Economic Opportunity of the great State of South Dakota. Congressman?

Mr. ABDNOR. Thank you, Chairman Flood. As you already know who the witness is, it is a pleasure for me to introduce Dr. Mauer to you to represent the Governor of South Dakota and, as you say, the great State. So I won't take any more of his time but call on him.

Mr. FLOOD. All right.

Dr. MAUER. Thank you very much. In view of the introduction by Congressman Abdnor, I will bypass the reading of the cover letter which accompanies my testimony and also the preliminary remarks, both of which I have submitted in writing, which I trust will be made a part of the permanent record.

Mr. FLOOD. Yes; that will be done.

[Dr. Mauer's letter to Congressman Flood follows:]

SOUTH DAKOTA OFFICE OF EXECUTIVE MANAGEMENT,
STATE ECONOMIC OPPORTUNITY OFFICE
Pierre, S. Dak., May 20, 1975.

HON. DANIEL J. FLOOD,
Chairman, and Members of the House Appropriations Subcommittee on Labor, Health, Education, and Welfare, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman and members of the subcommittee; attached herewith is the testimony which I will be privileged to present before your subcommittee this date. It pertains to the fiscal year 1976 appropriations for the Community Services Administration, and more specifically it addresses a number of the programs recommended for zero funding by President Ford.

Given the recent nature of our difficulties in international relations and the interrelated economic complications at home, one might excuse those responsible for a budget that places austerity above humanity. However, I must admit that my testimony does not reflect that sympathy, for it is abundantly clear to those of us who work in antipoverty programs that the President has been ill advised.

Aside from the argument of inflationary expenditures, which can be more effectively curtailed in many hardware programs, there is no reasonable justification for the discontinuation of key elements of C.S.A. programs. In fact, given the current State of the Union, especially as regards unemployment and rising prices of goods and services, it is evident that the need to serve the poor of this Nation is greater than at any time since the Great Depression.

As a result I am compelled to respectfully urge your refunding in full all of the programs—SOS, energy, community partnership, SEOO's and EFMS/community food and nutrition program—that the President's advisers singled out for demise. The Director of C.S.A. has already attested to their worthiness, and in my allotted time I will seek to illustrate the impact of those programs operational in South Dakota.

Your indulgence and consideration of my testimony will be greatly appreciated, for its impact on the lives of at least 120,000 South Dakotans is great. Thank you for your attention to this matter, and for the opportunity to appear before the subcommittee to make these observations a part of the permanent record.

Sincerely yours,

DR. GEORGE J. MAUER,
Senior Policy Analyst.

Mr. MAUER. Mr. Chairman and Members of the House Appropriations Subcommittee on Labor, Health, Education, and Welfare.

I am George Mauer, senior policy analyst with the State economic opportunity office, office of the Governor, State of South Dakota. I appear for the purpose of rendering testimony relative to selected programs and appropriations concerning the Community Services Administration. Because you are well versed in the multiple issues that warrant these hearings, and have had the benefit of expert opinion on

all matters that affect the form and function of C.S.A., I will dispense with generalizations and proceed to the heart of antipoverty strategy about which those at the grassroots level have the greatest concern.

It is gratifying to note that both the President and Congress recognize the general merit of working toward the elimination of the paradox of poverty in the United States. That differences exist between the two branches on approaches and levels of support in the pursuit of agreed upon goals is not uncommon nor undesirable. In this instance, as regards appropriations for selected authorized programs of C.S.A., the President has reached a decision, namely to recommend zero funding in fiscal year 1976 for a number of projects basic to the war on poverty. As you know, these include SOS, energy, community partnership, SEOO's and EFMS. It is specifically to speak to the appropriateness of these judgments that I welcome the opportunity to address this body.

It is common knowledge that the fundamental reason for the search for economies in Government is the President's concern about the course of our current inflation coupled with recession. Thus cutting the budget becomes virtuous, especially where advisers allege duplicative effort. That, I submit, is all well and good, but not where assumptions are fallacious or where austerity is arbitrarily placed above humanitarian needs. Such is, in my opinion, the basis of the case against the President's recommendations, which I beseech you to consider.

Because of time limitations, I cannot possibly illustrate the extent to which zero funding of selected C.S.A. programs will diminish the work of State and local agencies in coping with the problems of millions of Americans caught in the bonds of poverty. What I can do is to testify to the efficacy of those programs in my State and show cause why they should be retained and fully refunded.

Three of the ongoing programs jeopardized by the President's funding requests are particularly crucial to South Dakota and I am sure to the elderly and poor across the Nation. The first of these, emergency food and medical services, now known as the community food and nutrition program, has proven to be especially beneficial. We have utilized appropriations thereto to provide a meaningful variety of services to those in dire need. Such efforts have included food, medical, and transportation aid to the indigent victims of natural disasters not served by traditional programs, funding of garden and cannery projects to demonstrate the value of self-help, providing support to families unable to maintain an ample diet under existing food stamp and nutritional programs, and facilitating the development of livestock and grocery cooperatives as well as guaranteed loans among low-income farmers. Thus EFMS addresses substantive needs, is highly effective, and permits prompt and lasting reseponse to many of the problems of poverty-stricken persons.

The second of these programs, senior opportunities and services, is no less deserving. Because it is the only Federal program which specifically addresses the needs of the elderly poor, it is an essential component of antipoverty work. SOS in South Dakota has been used to establish senior centers, all of which have become viable and increasingly self-sufficient. In addition the program has allowed effective outreach, whereby those in need are linked with appropriate

health, education and part-time employment opportunities. Such outreach also extends to technical assistance for elderly small business enterprises, as well as the generation of supplementary private and public funding support. Thus SOS bridges gaps in existing aging legislation and complements as well as supplements related programs.

Equally if not more effective among these ongoing programs are State economic opportunity offices. Fifty-four of them nationwide and among the territories serve as a vital link in Federal-State-local and community action agency relations, and symbolize the essence of federalism. All, in one form or another, assist and advise the Governor, CSA and other concerned Federal agencies in antipoverty matters, as well as coordinate pertinent programs in their State, provide technical assistance to CSA grantees, and facilitate resource mobilization. Morever, in South Dakota, the SEOO has been responsible for the development of a public service careers program, which has made headway in the recruitment and upgrading of unemployed and underemployed citizens, especially among the traditionally poor. In addition, the State Housing Development Authority, designed to meet the housing needs of many low-income families, was conceived, developed and initially funded by our office. More recently, the South Dakota SEOO has sponsored a statewide information and referral system which will become operational in the next few months. Thus SEEO's advocate and effect creative policies and programs that impact directly upon the poor and the fixed-income elderly.

At this point a few additional observations are in order relative to heretofore authorized yet unfunded programs. One of these concerns energy conservation assistance. As you know, CSA legislation includes provision for a comprehensive energy-saving program, specifically applicable to the poor and low-income elderly, whose homes tend to be most vulnerable to the heat of the summer as well as the cold of the winter. Not only are greater costs incurred for their utilities, but valuable fuel and electrical resources are wasted owing to inadequate winterization.

Although the President is fully aware of this, I find it ironic that he has evidently elected to meet this part of the crisis through the Federal Energy Administration. For aside from relocating the national level of responsibility, there is no doubt that the delivery systems of such services will be the 900-plus community action agencies across the Nation. I submit that CSA is far better versed in relating to the CAP's than is FEA, and if the funding of the Winterization Assistance Act of 1975 is not yet resolved in favor of CSA it clearly should be.

The second of the heretofore unfunded programs that merits the attention of the Congress is community partnership. As you are aware, it would provide for matching grants to State and local agencies for the purpose of carrying out new or expanded antipoverty programs. Because virtually all other funding is earmarked for specific services, and therefore allows little flexibility, community partnership would give incentive to more creative approaches in meeting the needs of the poor as well as in supplementing programs in the respective States where each finds the greatest need. Moreover, it would serve to better interrelate State, local and private activities by way of

evolving human service agreements in keeping with the literal intent of the title, community partnership.

In summary, I respectfully submit that these programs cited for extinction by the President are serving vital purposes. The foundation has been laid by these and related programs whereby many of our less fortunate citizens can extricate themselves from the paradox of poverty. To dismantle this effort now would clearly dilute the impact of the Community Services Administration and its affiliated State and local agencies. More importantly, a wide array of significant services to needy individuals and families from coast to coast would be curtailed. Surely this is not conducive to further unshackling their chains of dependency nor in helping them to achieve independence through self-sufficiency.

Therefore, on behalf of concerned citizens in South Dakota, and those similarly affected across the Nation, I respectfully request your consideration of refunding in full those programs presently operative. In addition, I ask your support of an appropriation to those other programs that have been legislatively authorized but unfunded to date. I sincerely believe that such an investment in human development will help to meet the needs of impoverished persons, thereby allowing more of them to lead productive lives.

Sir, I need not tell you of the suffering of large segments of the populace due to the present condition of the economy. Stagflation is here, it is real, and it primarily affects the disadvantaged American. To withdraw now, even piecemeal, from confronting the problems of the poor, is to invite the reappearance of human catastrophe tantamount to the Great Depression. Such signs are on the horizon and make patently clear that our work in the war on poverty is far from done.

Thank you for your attention, Mr. Chairman.

Mr. FLOOD. You did that right on the nose. Thank you very much.

Mr. ABDNOR. Thank you, Mr. Chairman. I want to say Dr. Mauer has great expertise in this field and is doing a fine job for South Dakota.

INVESTIGATIVE POWERS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

WITNESS

HON. EDWARD I. KOCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. FLOOD. We now have with us from the great State of New York, Congressman Koch, who is an old pal of ours for many, many years and well known to us for his concern on social welfare matters.

[Mr. Koch's complete statement follows:]

STATEMENT OF REPRESENTATIVE EDWARD I. KOCH

Mr. Chairman, I am testifying today on a subject which is of great concern to me—the investigative powers of the Department of Health, Education, and Welfare. My own findings on this subject are shocking, and I am here today to ask that this Committee completely revamp and expand the oversight and enforcement powers of the DHEW.

The total estimated HEW outlays for fiscal year 1976 are $118.4 billion. This constitutes more than one-third of the Federal budget, and involves 320 separate programs. Unfortunately even a cursory look at these programs reveals instances of mismanagement and corruption. While HEW's scope is so extensive that cases of deception are to be anticipated, the enforcement and investigative bodies employed by the Department are themselves so lax as to be rendered ineffective.

DIVISION OF INVESTIGATIONS

Why, Mr. Chairman, are there only 10 persons in HEW's Division of Investigations? This Division is supposed to "investigate allegations of fraud, malfeasance, embezzlement, misappropriation and other forms of illegal activity" throughout the entire country in all of HEW's 320 programs. Does anyone suggest for a minute that this task can possibly be performed effectively by a team of 10 persons? The very thought is laughable.

To expand on this farce, let me give the Committee a breakdown of how the 10 investigators are placed throuhgout the Nation. Two agents are located in New York City, two in Atlanta, one in Chicago, one in Seattle, one in San Francisco, and three in Washington, D.C. When a high priority case recently broke in Dallas, the two investigators from the Atlanta region had to fly to Dallas to deal with that problem, leaving their own cases unattended. In New York a medicaid scandal of major proportions involving 164 physicians and 9 clinics needed a thorough investigation by HEW. Assigning one full-time investigator to that case cut the investigative forces of the entire New England region by 50 percent. Obviously, that one man couldn't possibly handle a case of such magnitude by himself. Mr. Chairman, these are just two illustrations of the impossible task faced by the Division of Investigations, an agency which has consistently encountered difficulties with respect to support from the Congress as well as within its own department. In February of 1975 the Division of Investigations requested the reprograming within HEW of 10 positions for their Division for fiscal year 1975. The Senate Appropriations Committee 2 weeks ago decided to postpone consideration of the request. The reaction of Mr. Nathan Dick, Director of the Division of Investigations, was very pessimistic and he said that he saw no hope that the positions will be approved for this fiscal year.

In 1973 when the Division of Investigations and Security began to expand into the field of investigating fraud and abuses of HEW programs it was placed under the Office of the Assistant Secretary for Administration and Management. As a result, all of the Division's requests for funding must be incorporated with the request of that Office, which also has several other divisions within its jurisdiction. For fiscal year 1976 the Division of Investigations officially requested 26 new investigators. Although the request certainly seems minimal in view of the enormity of its responsibilities, it was pared down within the Department of Health, Education, and Welfare, and the request that Congress received was for 12 new inspectors. Speaking before a House Government Operations subcommittee, Dr. John Ottina, Assistant Secretary for Administration and Management, said, "I have felt that adding 10 [the reprogramed positions now being held up by the State Appropriations Committee] plus 12 [what he pared the Division's request to] to a staff of 10 is a lot of growth within a 12-month period." Dr. Ottina seems to feel that the reprograming request will ultimately be approved, and with that in mind he cut the amount of positions from the original 26 requested to 12. Mr. Chairman, if the 10 reprogramed positions are not approved and even if Congress does approve the Assistant Secretary's request for 12 staff positions, the total investigative force at HEW will be 22 people. This would hardly alleviate the 40-man-year backlog the Division now has to deal with. After all, in late 1973 and early 1974 the Division had 17 staff persons, but unfortunately that number was cut by Senate committee action last year. In addition, Secretary Weinberger supports the Division's request for increased funding and has signed the requests for reprograming.

Mr. Chairman, something must be done to end this outrageous situation. I would like to propose that the Division of Investigations be removed from the Office of the Assistant Secretary of Administration and Management and established as a separate entity within HEW. If the Division were listed as an independent line item on HEW's budget requests directly under the Office of the Secretary, it would have a much better opportunity to justify to the Congress its ac-

complishments and needs. Such a transferral would make it immune from departmental budget cuts by officials who might not want their programs investigated. Mr. Dick, the Director of the Division supports such a transfer. The power of this Division must be expanded so that it can adequately oversee and investigate abuses to its attention.

FRAUD ABUSE AND SURVEILLANCE BRANCH

I would also like to address the grossly inadequate situation governing the monitoring and investigation of medicaid abuses. In this case the HEW's "watchdog" is the fraud and abuse surveillance branch of the Medical Services Administration. Until April 20 of this year, one man named Harry Schneider, a GS–9 earning $14,000 annually, was employed to monitor all fraud and abuse perpetrated on the medicaid program. On April 27, the day before Dr. John Ottina testified before a House Government Operations subcommittee, another administrator was added to this area. Eleven new positions for this branch have been approved and the additional personnel will assume their duties as soon as they are hired. However, according to one HEW official, the department of personnel has been "dragging its feet" in approving two upper level administrators for this branch, and I should add that of the 11 positions, only 9 will be professional people.

For fiscal year 1976 the branch has requested 108 new positions. There is an urgent immediate need for these poistions to be approved. The Federal monitoring of the medicaid program is done entirely by this office. If there is any way that this Committee can expedite the appropriation of funds for this branch I urge that it be done. Every day untold thousands of dollars are being stolen from our medicaid program and hardly anything is being done to stop it. A GAO report to the Senate Finance Committee Subcommittee on Health states that "As of March 1, 1975 the Secretary of HEW had not used his authority to withhold all medicaid funds from a State and HEW had not imposed other monetary penalties against any State "that did not comply with Federal medicaid regulations. The GAO also found that the Social and Rehabilitation Service had not:

Withheld Federal funds from States that were not in compliance with Federal requirements.

Given sufficient attention to reviewing and evaluating States' medicaid operations;

Obtained or analyzed data needed to detect potential problem areas in State medicaid programs; or

Adequately considered recommendations made by consultants and the HEW Audit Agency for correcting program deficiencies;

It is urgent that the requested staff positions be approved, and that competent investigators be hired to put a stop to the rampant fraud in the medicaid program.

Mr. Chairman, as you can see, steps must be taken to improve the inspection system of our HEW social programs to avert the continued squandering of millions of our taxpayer dollars. In a May 19, 1975 article which appeared in the New York Times it was reported that the medicare program was overcharged $27 million by doctors, hospitals and nursing homes over the last 5 years. "About half that amount was recovered by the end of 1974 and the balance remained outstanding." We must pay to increase the enforcement capacities of these programs immediately, or we will pay with the money which is stolen from them.

Mr. KOCH. Mr. Chairman, if I may, I would like to file the full text and make some comments on what I consider to be the highlights of it.

I am here, Mr. Chairman, in support of the various requests to fund additional personnel for the Division of Investigations in HEW. As you know, Mr. Chairman, there are 320 HEW programs. They are not audited very well, and there is an enormous amount of corruption. You can understand that when you are dealing with $118.4 billion in HEW programs, and the Division of Investigations, which is supposed to investigate all of the 320 programs, to ascertain whether there has been fraud or malfeasance, misappropriation, et cetera, is made up of 10 persons, the job cannot be effectively performed.

Now, initially there had been a request to add 26 staff persons to the

Division. The Administration then came in and simply reduced that to 12. If you gave the Division the total 12, the investigative staff at HEW would be 22 people to investigate 320 programs.

In the State if New York, we now have a scandal of major proportions involving 164 physicians and 9 clinics in a medicaid fraud. There are only two people in all of New York and New England who are allocated by HEW for the purposes of investigation. Having one of these men work full-time on that scandal means that there is only one person in the entire New York-New England area looking at the 320 HEW programs.

It is a farce of a kind. The Administration's position is that if they double the 10 people now in the Division of Investigations to approximately 20 or 22, that this is an enormous step forward; it is a minuscule step forward. For every person we put on with the ability to investigate corruption, that salary will be paid many times over when they locate, as they will, the corruption in various programs.

I would like to point to another area where there is simply a lack of understanding of how important it is that we audit programs. In the HEW program relating to medicaid, where they spent last year something over $8.7 billion on medicaid, there has been only one person up until April 20 of this year, one person—named Harry Schnider, a GS–9, who earns $14,000 annually—employed to monitor all fraud and abuse perpetrated on the medicaid program, and he is only allowed to do that half a day. He has other jobs assigned to him.

On April 27, an additional person was placed in that program.

Now, the medicaid program is so replete with fraud and corruption and incompetence that it boggles one's mind and to think there should only be one person—now there are two—auditing such a program is to me indicative of the fact that when the Administration says it is interested in economy, that that comment is not borne out by their actions, because these programs should be firmed up.

From the press just the other day there was an article in the *New York Times* which stated that the medicare program was overcharged—this is an Administration release—was overcharged $27 million by doctors, hospitals and nursing homes over the last 5 years. I suspect it is more than that, but that is the figure they gave. "About half that amount was recovered by the end of 1974 and the balance remains outstanding."

Of course, you will find that much of the recovery is going to be barred by the statute of limitations because if they don't bring the action within 6 years, normally it can't be recovered.

What I am saying, Mr. Chairman, is this: That one of the areas that requires the concern of this committee, and I know that it is concerned about it, is that of stopping fraud, abuse, mismanagement, overcharging, and making certain that people who do that and defraud the taxpayers and the beneficiaries of these various HEW programs are caught, the money returned to the Government, and the perpetrators punished.

At the present time, because of lack of investigatory manpower, this is not being done the way it should, and I urge consideration for an increase in the investigative forces of the Department of Health, Education, and Welfare.

Mr. FLOOD. Thank you very much.
We will take a brief recess for a vote.
[Recess.]

HEALTH PLANNING AND DEVELOPMENT ACTIVITIES

WITNESSES

DR. JAMES R. KIMMEY, ADMINISTRATOR OF THE WISCONSIN DIVISION OF HEALTH POLICY AND PLANNING
RICHARD P. ADAMS, TEACHER AND MAGISTRATE, VICE PRESIDENT OF THE HEALTH AND HOSPITAL PLANNING COUNCIL, NORTHEASTERN PENNSYLVANIA
ROBERT C. MacGREGOR, EXECUTIVE DIRECTOR, HEALTH AND HOSPITAL PLANNING COUNCIL, NORTHEASTERN PENNSYLVANIA

Mr. FLOOD. Mr. Robert MacGregor, Dr. James Kimmey, the American Association for Comprehensive Health Planning.

Dr. KIMMEY. I am Dr. James Kimmey, administrator of the Wisconsin Division of Health Policy and Planning. I am accompanied today by Mr. Richard P. Adams, vice president of the Health and Hospital Planning Council of Northeastern Pennsyvania; and Mr. Robert C. MacGregor, executive director of the Health and Hospital Planning Council of Northeastern Pennsylvania.

We are representing the American Association for Comprehensive Health Planning, which is a national membership organization of agencies originally funded under sections 314(a) and 314(b) of the Health Service Act. The organization over time has developed more than 50 State planning agencies and more than 200 areawide planning agencies under the provision of that act and these agencies, I think, have made some real contributions in the past 8 years since the enactment of that legislation in terms of kind of introducing something new on the American health care scene which is goal-oriented forward planning for the health services and distribution and development of health resources.

Under the old law, Public Law 89–749, there were limits on the ability of health planning agencies to promote implementation of their plans. We have learned from the experience of the past 8 years that a consensus planning model in which you hire a hall and bring together providers and consumers and come up with rationale plans doesn't work very well in many areas.

Too often the plans that are put together in this way aren't followed by the people who really have authority to distribute resources in the community. We have learned from the experience of the past 8 years it is not enough to require that one kind of federally funded activity be consistent with plans while another one is exempt from plans.

When this happens too often the program is turned down because it is not needed and ends up being funded through some other mechanism and it is not included in the consistency requirements.

Experience has given ample evidence that planning then without

links to the decisionmakers and regulators can't have the effect that is required if we are really to be able to do what planning in the health field should be able to do and that is help rationalize our health services delivery system, institute containment of health care costs which is a major problem, and also pave the way for national health insurance when it comes.

The National Health Planning and Resources Development Act, Public Law 93–641, took cognizance of this. It put together within one structure of local/State agency planning, resource allocation, and regulation.

We think this is a very important concept. Our organization supports the changes that Congress put into Public Law 93–641 and we feel they accurately deal with the problems we identified over the past 8 years and that they do provide an opportunity to build a health care delivery system for the future and that can accommodate effectively to the stimulus of national health insurance, that can institute cost containment measures in this country.

In passing this landmark bill the Congress took note of the deficiencies in funding which has plagued the health planning agencies in the past. In the House report the Committee on Interstate and Foreign Commerce noted that one of the great deficiencies in the comprehensive health planning program for the 8 years that it has been in effect has been inadequate funding of both State and local agencies, and this inadequate funding has led to inability to collect the kind of data that is needed, to conduct the kind of planning that is required, and the agencies have had to spend an inordinate amount of their time raising other funds in order to operate.

The Federal funding has not been sufficient. The Interstate and Foreign Commerce Committee also very clearly stated its general intent that this kind of "fiscal anemia" that has affected these agencies not again stand in the way of carrying out the entire intent of Congress, and it set forth in the clearest terms its conception of the levels of funding which will be necessary to do the job that is intended.

Since these expressions of congressional concern and intent were set forth in the legislation and in the reports, they created expectations both at the community level and at the State level concerning the kind of things that health planning would do in the future and the way it would be funded and the level of funding.

In developing authorizations to support these amounts, our association and others worked closely with Mr. Rogers' committee and we think that the committee took into consideration the fact that you can't start this program out 100 percent right off the mark and therefore the authorizations are somewhat lower than the figures that are expressed in the legislation as representing the need for basic funding of health planning and development.

We think that they took the cut for the startup period in the authorization. Having set the amounts of authorization in the initial years at amounts less than would be required to carry out the full scope of activities in the act, we understand that and that is a rational thing to do.

What we do not understand is HEW's fiscal 1976 request which starts from the authorizations, not the need, and institutes severe reductions, using the same logic Congress had already applied.

Therefore, we think the health planning development program, which is a very critical one at this juncture, is placed in fiscal "double jeopardy" on the part of the administration.

We, therefore, respectfully request this committee appropriate funds for fiscal 1976 that are adequate to allow this program to start off as soon as possible and move forward quickly.

The possibility of national health insurance, makes this a particularly critical program. Without a program like this, without planning ahead of the fact and the development of the resources, the infusion of large amounts of money and services can lead to some great difficulties in the system itself.

Therefore, on page 5 of the prepared testimony we have a series of recommendations for appropriations levels for fiscal 1976.

Mr. McGregor and Mr. Adams would like to speak to some of the agency problems and the funding of agencies at the community level which are very important in this. We were concerned about the HEW figures because they seem to have been developed on the basis of dividing population and so forth.

These gentlemen can talk to those figures.

[Dr. Kimmey's statement and attachments follow:]

STATEMENT OF DR. JAMES R. KIMMEY

Mr. Chairman and members of the committee, I am James R. Kimmey, M.D., administrator of the Wisconsin Division of Health Policy and Planning. I am accompanied today by Richard P. Adams, a teacher and magistrate, and the vice president of the Health and Hospital Planning Council of Northeastern Pennsylvania, and Robert C. MacGregor, executive director of the Health and Hospital Planning Council of Northeastern Pennsylvania.

We are here today as representatives of the American Association for Comprehensive Health Planning, a national membership organization of agencies and individuals involved in health planning activities at the State and local levels throughout the United States. The majority of our members are agencies funded as 314(a) and 314(b) health planning bodies under provisions of Public Law 89–749. In the 8 years since that law went into effect, 56 State or territorial health planning bodies, and more than 200 areawide health planning bodies, have been created. Despite organizational and operational problems in the early years, despite shifting concepts concerning the role of health planning agencies, and despite less than adequate financial support, these agencies have provided something new and effective on the American health care scene—consumer-directed forward planning for the development and distribution of health care resources. The activities started by these agencies are of vital importance in attaining control over the rate of inflation of health care costs and in developing the infrastructure for national health insurance.

Under the old law, there were limits on the ability of health planning agencies to promote implementation of their plans. We have learned from the experience of the last 8 years that it is not enough to hire a hall, bring together providers and consumers, and develop rational plans. Too often, the plans and agreements reached under such a consensus model have little real effect on the resource allocation decisions of the action agencies in a community or State. We have learned from the experience of the past 8 years that it is not enough to require consistency with health plans from some components of the system, while exempting others from such requirements. Too often, that which was denied as inconsistent with goal planning has been done anyway through another mechanism.

Experience has given emple evidence that planning without links to decision-makers and regulators could make only limited contributions to a more rational health system. In late 1973, Congress began a review of the health planning, resource allocation, and regulatory activities required to support an increasingly federally financed health care delivery system. The result was the development and passage of Public Law 93–641, the National Health Planning and Resources Development Act of 1974, which was signed into law by President Ford on January 4, 1975. This legislation—which merges four preexisting programs—extensively revises both the philosophy and the structure of federally supported health planning and development activities in the United States. It establishes a clear relationship among planning, resource allocation, and regulation functions in the health care field. It assures broad-based consumer participation in these processes. It provides a vertically integrated structure for such activities based on community agencies. It clearly expresses Congress' intent that the health field move in an organized fashion to pave the way for enactment of national health insurance.

Our organization supports the changes incorporated by the Congress in Public Law 93–641; we feel that they accurately reflect the experience of the past 8 years and build upon strengths while remedying weaknesses. We applaud Congress' intent that a strong, well-financed health planning and development system be established as rapidly as possible.

In passing this landmark bill, the Congress took note of the deficiencies in funding which prevented the development of the full potential of the predecessor health planning agencies. In it is report accompanying H.R. 16204, the Committee on Interstate and Foreign Commerce noted that "one of the great deficiencies of the existing CHP programs at both the State and areawide levels has been a lack of adequate financing for their planning efforts. This meant that agencies are unable to hire adequate staff, or to pay the staff which they do hire reasonable and competitive salaries, that they often fail to do proper data gathering and analysis with which to make planning decisions, and that an inordinate amount of their time and energy has been devoted to the raising of additional funds." The Congress clearly stated its general intent that "fiscal anemia" would not again thwart the intent of the law. And it set forth in the clearest terms its conception of the levels of funding which would be necessary to do the job it intends be done.

Since these expressions of congressional concern and intent were clearly set forth in the legislation, and in the reports accompanying the legislation from both Houses, they created expectations concerning both the functions and financing of health planning and development in the future. In developing authorizations to support the amounts that they felt were needed to perform the functions envisioned under this act, Congress recognized there would be a "start-up period." They therefore set the authorizations for the initial years of the program at less than the amounts that would be required to carry out the full scope of activities envisioned in the substance of Public Law 93–641. This philosophy we understand. What we cannot understand is the Department's fiscal 1976 budget request, which starts from the authorizations, not the need, and institutes severe reductions, using the same logic that was already applied by the Congress in setting authorization levels in the first instance. Thus health planning and development, a critical program for the future, and one which must develop as quickly as possible, is placed in fiscal "double jeopardy" by the administration's fiscal year 1976 budget.

We respectfully request that this committee appropriate funds for fiscal year 1976 that are adequate to allow this new and important activity to move forward as quickly as possible. Based on our understanding of the real costs of carrying out the activities envisioned by Congress; of the funding sources now available to state and areawide health planning which would be subsumed under the general appropriations for Public Law 93–641; and of the intent of the limited authorization figures in the bill to compensate for start up, we recommend the figures in the table that follows for your consideration as adequate appropriations for health planning and resources development for fiscal year 1976.

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING RECOMMENDED APPROPRIATIONS, FISCAL YEAR 1976, HEALTH PLANNING AND RESOURCES DEVELOPMENT

[In thousands of dollars]

	Required to achieve intent	Fiscal year— 1976 authorized	1976 administration request	1976 AACHP recommendation
	(1)	(2)	(3)	(4)
Health systems agencies:				
Planning [S. 1516]	159,750	[1] 90,000	[1] 45,000	[1] 90,000
Basic [S. 1516(b)(1)]	106,500			
Matching [S. 1516(b)(2)]	53,150			
Development [S. 1640]	213,000	75,000	0	25,000
State health planning and development agencies [S. 1525]	35,000	30,000	[2] 9,500	20,500
Medical facilities assistance [S. 1613; S. 1625]	130,000	130,000	100,000	130,000
Planning methods development [S. 1533]	[3]	[3]	[4] 5,000	5,000
Centers for health planning [S. 1534]	5,000	8,000	[4] 2,000	5,000
Application development assistance [S. 1514]	[3]	[3]	500	1,000
S. 1122 transfer from trust fund	8,000	[3]	[5] 4,000	8,000
Program management	14,000	[3]	9,000	14,000
Total	[6] 564,750	[6] 333,000	175,000	298,500

[1] Since amounts in cols 2–4 are inadequate to assure even basic funding for all HSA's, no differentiation is made between basic and matching funds. (see analysis 1.00).
[2] HEW intends to fund 28 State agencies from this $9,500,000 and a like number from a like amount in the 1975 supplemental, giving an effective total request of $19,000,000. (see analysis 2.00).
[3] No set authorization for this purpose in 93-641.
[4] No information is available on the proposed distribution of the $7,000,000 earmarked for methods development between grants and contracts and centers. The split used is assumed. (see analyses 4.00 and 5.00).
[5] HEW intends that no trust fund moneys be used after Dec. 31, 1975. (see analysis 6.00).
[6] This total excludes amounts under sum ufficient authorizations, and is thus low.

Attached to this statement are a number of more detailed discussions of the specific effects of the Administration's fiscal year 1976 budget request on the maintenance of existing activities which are incorporated into Pub. L. 93–641 and on the development of new activities mandated for States and areas under this legislation.

American Association for Comprehensive Health Planning Recommended Appropriations, Fiscal Year 1976

Health Planning and Resources Development

1a. Health Systems Agencies: Planning Funds

1. Required to achieve intent	$159,750,000
2. Fiscal year 1976 authorized	90,000,000
3. Fiscal year 1976, administration request	45,000,000
4. Fiscal year 1976, AACHP recommendation	90,000,000

Notes

(1) *Required to achieve intent.*—This figure was calculated from the language of S. 1516(b) of Pub. L. 93–641 in which Congress set forth its intent that a basic grant of 50¢ per capita be made to each HSA, and that a supplemental grant would be available to match qualifying local funds up to 25¢ per capita. In its report the House Committee stated that agencies "should be assured of a minimum level of Federal support without having to raise matching funds; therefore, the Committee has given this assurance." Applying the basic capitation to an estimated population of 213 million would yield $106.5 million, and assurance of availability of Federal funds to match local contributions would require an additional $53.25 million.

(2) *Fiscal year 1976 authorized.*—Recognizing that, despite the existence of many operating agencies which can be expected to become HSA's, there will be a

delay in transition to the new mechanism, the congressional committees carefully considered an authorization figure for fiscal year 1976. Thus the $90 million authorized represents a conscious reduction from the amount needed to achieve full operation.

(3) *Fiscal year 1976 administration request.*—The administration request for $45 million is extremely difficult to understand. Background papers for this budget prepared by administration sources suggested a need for $75 million based on a series of assumptions concerning the number of HSA's, the average population served, the minimum staff, and the other costs of operation expressed as a cost per position. This approach is unrealistic in that it has no basis in experience with an operating agency nor does it relate to the functions being mandated under 93–641. (See AACHP recommendation below.) We can only assume the $45 million represents an arbitrary reduction to meet some administratively determined fiscal ceiling. HEW's announced intent to conditionally designate all HSA's and further restrict funding on that basis would also help explain the low figure. We agree with the House Committee that where an existing eligible agency applies "it is not intended that a period of conditional designation would be required."

(4) *Fiscal year 1976 AACHP recommendation.*—AACHP recommends $90 million be appropriated for health system agencies in fiscal year 1976. This is the amount authorized. It should be remembered that the authorization falls short of the amount that Congress felt represented a basic minimum guarantee to carry out health systems planning at the substate level. In considering the $90 million request, two sets of factors should be borne in mind. First, there are a number of new complex labor-intensive activities which health systems agencies are expected to carry out which have not been a part of the activities of the 314(b) agency, the RMP, or the EHSDS responsibilities in the past. Second, the existing agencies have received moneys from the trust fund for section 1122 activities, and are now expected to perform those activities from their core grant. Attached to this analysis is a table with an estimated budget required to fully implement the Congress' intent for a health systems agency. This budget is based on actual experience of a highly-rated operating 314(b) agency which should have no difficulty making the transition to HSA status.

PROJECTION OF COSTS TO CARRY OUT HSA FUNCTIONS *

In order to estimate costs of carrying out the HSA functions prescribed in Public Law 93–641, relationship is made between the nine HSA functions and the eight areawide CHP agency functions used in the national assessment program of 1973–74 around which HPC's work program is organized.

In some cases, the CHP functions relate directly to the HSA functions; in other cases, specific work program activities under certain CHP functions have to be assigned individually to HSA functions.

One essential function of every agency which is included in CHP functions, but not included in the HSA functions, is agency management. This function has been added to the list of HSA functions.

Estimated staff days and salary costs for each 1975 work program category is shown. Other cost items are shown including fringe benefits, travel, occupancy, supplies, equipment, etc.

The final column shows the estimated cost in 1976 of present work program categories (when appropriate) and/or CHP functions aggregated according to HSA functions. Costs are also estimated for HSA functions not previously mandated as part of CHP functions.

*These estimates were prepared by the Health Planning Council, Inc., of Madison, Wisconsin, a 314(b) agency serving an area of 11 counties with a population of 782,000. The HPC area has been recommended as a health service area for purposes of P.L. 93–641.

STAFF DAYS AND COSTS FOR CARRYING OUT 1976 HEALTH PLANNING COUNCIL WORK PROGRAM AND PROJECTED STAFF DAYS AND COSTS FOR CARRYING OUT HSA FUNCTIONS IN 1976

[By HSA function and CHP function]

HSA function/CHP function	1975 actual			1976 projected		
	Staff days	Number of staff	Cost	Staff days	Number of staff	Cost
1. Assemble and analyze data on the status of health in the area and of health resources in the area (sec. 1513(b)(1)):						
CHP function—Data management (1 activity):						
Data coordinator	30	.....	$1,650	60	.....	$3,630
Research analyst	180	.....	6,120	360	.....	13,464
Statistical clerk	100	.....	2,500	103	.....	2,606
Total	310	.....	10,270	523	.....	19,700
2. Develop, annually review, and amend as necessary a health system plan (HSP), a statement of goals for the area (sec. 1513(b)(2)):						
CHP function—Health plan development and implementation (7 activities):						
Planning associates	594	.....	39,396	710	.....	41,393
Secretaries	353	.....	8,825	435	.....	11,006
Total	947	.....	48,221	1,145	.....	52,399
3. Establish, annually review, and amend as necessary an annual implementation plan (AIP) describing objectives and methodologies for achieving the HSP goals (sec. 1513(b)(3)):						
CHP function—Agency program development and evaluation (1 activity):						
Planning associate	50	.....	3,550	90	.....	5,940
Secretary	15	.....	375	15	.....	380
Total	65	.....	3,925	105	.....	6,320
4. Develop and publish specific plans and projects for achieving the objectives established in the AIP (sec. 1513(b)(4)):						
CHP function—Studies (11 activities):						
Planning associates	380	.....	22,903	540	.....	35,640
Secretary	50	.....	1,250	160	.....	4,048
Total	430	.....	24,153	700	.....	39,688
5. Provide technical assistance to entities in the area toward implementation of the above plans (sec. 1513(c)(2)):						
CHP function—Community relations and mobilization (4 activities):						
Planning associate	252	.....	16,336	360	.....	19,800
Secretary	95	.....	2,375	103	.....	2,606
Total	347	.....	18,711	463	.....	22,406
6. Provide financial grants-in-aid or contracts for projects consistent with plans (sec. 1513(c)(3)):						
CHP function—none.						
Planning associate				180	.....	11,880
Secretary				60	.....	1,518
Total				240	.....	13,398
7. Coordinate activities with PSRO'S, regional planning commissions, and other planning bodies (sec. 1513(d):						
CHP function—Planning coordination (1 activity):						
Planning associates	165	.....	10,680	165	.....	11,798
Secretary				30	.....	825
Total				195	.....	12,623

STAFF DAYS AND COSTS FOR CARRYING OUT 1975 HEALTH PLANNING COUNCIL WORK PROGRAM AND PROJECTED STAFF DAYS AND COSTS FOR CARRYING OUT HSA FUNCTIONS IN 1976—Continued

HSA function/CHP function	1975 actual			1976 projected		
	Staff days	Number of staff	Cost	Staff days	Number of staff	Cost
8. Review and approve or disapprove each proposed use in area of Federal funds appropriated under Federal health legislation, or made available to the State under a Federal formula grant (sec. 1513(a)):						
CHP function—Project review (1 activity):						
Planning associate	25		$1,615	180		$11,880
Secretary	25		625	25		633
Total	50		2,240	205		12,513
9. Review and comment to State agency on all capital expenditures and new service projects in area institutions (sec. 1513(f), and recommend appropriateness of institutional services (sec. 1513(g)):						
CHP function—Project review (1 activity):						
Planning associate	240		15,185	360		25,740
Secretary	155		3,875	195		6,435
Total	395		19,060	555		32,175
10. Recommend to the State facilities projects under Title XVI and establish priorities among such projects (sec. 1513 (h)):						
CHP function—Project review (1 activity):						
Planning associate	15		940	20		1,210
Secretary	15		375			
Total	30		1,315			
11. Maintains agency organization and administration:						
CHP function—Agency management (9 activities):						
Management team	378		23,928	358		29,216
Planning associate	314		19,741	430		25,256
Bookkeeper	100		2,500	150		4,620
Secretary	105		2,635	120		3,300
Public information and technical writer				230		6,930
Total	897		48,804	1,288		69,322
Grand total	3,636	16	187,839	5,439	24	281,754

Note: Number of personnel is based on 230 days, per person, per year available for input into work program activities. (This excludes vacation, holidays, and sick leave.)

	1975 actual	1976 (projected)
Staff complement:		
Planning associates	8	13
Research analyst	1	2
Secretaries/clerical	5	7
Management	2	2
Total	16	24

HEALTH PLANNING COUNCIL, INC., COMPARISON OF COSTS FOR CARRYING OUT 1975 HPC WORK PROGRAM AND PROJECTED COSTS FOR CARRYING OUT HSA FUNCTIONS IN 1976

	1975 actual	1976 (projected)
Salaries:		
HSA function:		
1	$10,270	$19,700
2	48,221	52,399
3	3,925	6,320
4	24,613	39,688
5	18,711	22,406
6		13,398
7	10,680	12,623
8	2,240	12,513
9	19,060	32,175
10	1,315	1,210
11	48,804	69,322
Total	187,839	281,754
Vacation, sick pay, holidays	22,528	33,810
Total salaries	210,367	315,564
Employee benefits	23,711	37,867
Payroll taxes	15,200	23,667
Total personnel costs	249,278	377,098
Occupancy	21,145	27,000
Travel, conferences, meetings	18,300	27,450
Printing, publications, subscriptions, dues	10,700	16,050
Epuipment purchase		7,800
Equipment rental, maintenance	11,700	15,210
Office operations	23,290	34,785
Consultants	6,500	9,750
Total budget	340,913	515,143

HEALTH PLANNING COUNCIL, INC., 1975 ACTUAL INCOME COMPARED TO 1976 PROJECTED INCOME

Source	1975 actual	1976 projected
Federal funds	$189,385	$328,440
314(b) grant	155,000	[1]
1122 contract	34,385	[1]
HSA capitation	[1]	[2] 328,440
Other funds	130,748	56,000
WRMP	34,311	[1]
EMS grant	13,117	[1]
Local support	83,320	[3] 56,000
Total	320,133	384,440

[1] Not available.
[2] Calculated in accord with formula required under S. 1516(c)(2) as follows, assuming $90,000,000 appropriation: amount appropriated ($90,000,000) over amount needed ($106,500,000) times 50¢ times population (782,000) equals $328,440.
[3] Reflects loss of $27,000 in 1975 income which is "nonqualifying" under Public Law 93-641.

AMERICAN ASSOCIATION FOR COMPREHENSIVE HEALTH PLANNING RECOMMENDED APPROPRIATION FISCAL YEAR 1976

HEALTH PLANNING AND RESOURCES DEVELOPMENT

1b. Health Systems Agencies: Developmental Funds

1. Required to achieve intent	$213,000,000
2. Fiscal year 1976 authorized	75,000,000
3. Fiscal year 1976 administration request	----------
4. Fiscal year 1976 AACHP recommendation	25,000,000

(1) *Required to achieve intent.*—This figure was calculated from the language of S. 1640(b)(2) which establishes a limit of $1 per capita for developmental funds to a health systems agency. In authorizing this type of grant, Congress recognized the need for flexible funding at the health service area level to develop and test new and improved health delivery concepts. The full capitation level of $213 million is not inconsistent with amounts spent for similar developmental activities under the predecessor Regional Medical Programs Act.

(2) *Fiscal year 1976 authorized.*—Congress authorized $75 million for fiscal year 1976 as a realistic figure for the second year of operation of the program.

(3) *Fiscal year 1976 administration request.*—The administration does not appear to have requested any developmental moneys for fiscal year 1976. The underlying assumption seems to be that no HSA will be ready to proceed to promote and fund developmental activities during this fiscal year. There are two reasons for the assumption, first, that few agencies will have developed to the level of being able to utilize such funds and second, that all agencies will be conditionally designated, and such agencies are not eligible to administer developmental funds.

(4) *Fiscal year 1976 AACHP recommendation.*—We recommend the appropriation of $25 million for establishment of area health development funds during fiscal year 1976. This figure is based on AACHP's sure knowledge that a significant number of existing 314(b), RMP, and EHSDS agencies are capable of immediate transition to HSA status without intervening conditional designation, and our knowledge that many such agencies have in existence carefully constructed community endorsed plans on the basis of which effective developmental grants could be made during a year funded from fiscal year 1976 appropriations. The zero appropriation requested by the Administration appears to be merely an extension of their desire to eliminate developmental activities as expressed in their efforts in previous fiscal years to defund the regional medical programs. Appropriation of this $25 million would promote continuity of developmental efforts that would otherwise be lost, as well as providing experience with the administration of such programs in the "best" new agencies which will be valuable in future years as the entire country is organized for health systems planning and development.

2. State Health Planning and Development Agencies

1. Required to achieve intent	$35, 000, 000
2. Fiscal year 1976 authorized	30, 000, 006
3. Fiscal year 1976 administration request	9, 500, 000
4. Fiscal year 1976 AACHP recommendation	20, 500, 000

(1) *Required to achieve intent.*—The calculation of an amount required to achieve congressional intent for State level activities is more difficult than for health systems agencies since the legislation suggests only that grants will pay up to 75 percent of operating costs of such agencies. There is no capitation figure within Public Law 93-641 for guidance. Using actual experience in Wisconsin, which has had a highly rated 314(a) agency with broad State statutory authority similar to that now mandated under Public Law 93-641, estimates can be developed of the cost of carrying out the mandated functions for all States. Table 2.01—attached to this analysis—extrapolates Wisconsin's experience and estimates of the costs of administering new mandated functions to arrive at a figure required to achieve intent. The $35 million represents 75 percent of the total estimated costs of carrying out a high quality State health planning and development activity at the national level. Clearly, it was Congress' intent that this be done.

(2) *Fiscal year 1976 authorized.*—Again, as was the case with health systems agency authorizations, the congressional committees structured an authorization level lower than might be required to achieve full intent. This recognized that there also will be a start up lag at the State level, as the various States must come into compliance with the requirements of the law before launching a full scale program.

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(3) *Fiscal year 1976 administration request.*—The administration requests $9.5 million for fiscal year 1976. This figure must be viewed in the context of a similar amount requested for a similar purpose in the fiscal year 1976 supplemental appropriations bill. Thus the effective request for State health planning and development purposes is $19 million. As was the case with the request figure

derived from HSA's, it does not appear to us that this was based on actual experience with the administrative costs of mandated activities which must now be undertaken by State health planning and development agencies. Such activities have been underfunded in the past, contributing to the spotty performance of State health planning agencies cited in the House and Senate report. In setting an appropriations level, it should be remembered that mandatory certificate of need, periodic review of institutional health services, and review of all new institutional health services are labor-incentive regulatory functions which require continuous monitoring in order to achieve maximal effectiveness in controlling costs and improving distribution of health resources.

(4) *Fiscal year 1976 AACHP recommendation.*—AACHP recommends appropriation of $20.5 million for State health planning and development agencies in fiscal year 1976. This figure, considered with the $9.5 million in the 1975 supplemental, brings the total available for such agencies to $30 million, the authorized level. Again, in requesting funding of the authorization, we wish to stress that the authorization was already reduced from the amount required to achieve intent to accommodate startup costs. Not only are the States expected to undertake a number of new programs, to support a more formally structured advisory council and committee network, and to expand existing planning activities, but also to assume within this appropriation activities previously supported from the Social Security Trust Fund and the separate Hill-Burton appropriation. Table 2.01 attached details these costs for Wisconsin.

TABLE 2.01.—A. FINANCIAL REQUIREMENTS FOR CONDUCTING MANDATED STATE FUNCTIONS UNDER PUBLIC LAW 93-641 (WISCONSIN, FISCAL YEAR 1976)

Function	Fiscal year 1975			Fiscal year 1976			
	Federal	GPR	Total	Cost to continue	Additional load [1]	Total required [1]	Per capita (cents)
Planning component	[2] 180	192	372	410	41	451	10.0
Conduct planning activities; prepare plans; support council; implement plans	180	192	372	410	41	451	10.0
Development component	100	53	153	168	−18	150	3.3
Medical facilities assistance administration	100	53	153	168	−18	150	3.3
Regulatory component	90	30	120	132	244	376	8.5
Capital expenditure review	90	30	120	132	15	147	3.4
Administer c/n [3]					62	62	1.4
Review of new institutional health services [3]					95	95	2.2
Periodic review of existing institutional health services [3]					72	72	1.6
Totals	370	275	654	710	267	977	21.9

[1] Estimates for 1976 based on new mandated activities.
[2] 314(a) only.
[3] New mandated activity.

Note: B. calculation of amounts required for such functions, all States: Federal share—Per capita amount (21.9¢)×0.75=Federal share (16.4¢)×213,000,000=$34,900,000.

3. Medical Facilities Assistance

1. Required to achieve intent	$30, 000, 000
2. Fiscal year 1976 authorized	130, 000, 000
3. Fiscal year 1976 administration request	100, 000, 000
4. Fiscal year 1976 AACHIP recommendation	130, 000, 000

(1) *Required to achieve intent.*—This is probably the most difficult area to calculate a figure required to achieve the program goals set forth by Congress in Public Law 93-641. The reports accompanying the bills from both Houses contain a great deal of detail about the need for development of outpatient facilities and for modernization of existing hospitals. Financial assistance for eliminating deficiencies in meeting structural and safety standards is essential. The job will not be accomplished in a single fiscal year and will require substantial Federal investment as well as investments by government at other levels and private sector institutions and organizations. For purposes of this analysis, we have set the level

required at the level authorized on the assumption that the committees recognized the extent of the problem and structured the authorization at their best estimate of a startup cost.

(2) *Fiscal year 1976 authorized.*—See discussion under (1) above.

(3) *Fiscal year 1976 administration request.*—As in other appropriation requests in the administration's fiscal year 1976 budget for health planning and resources development, the rationale for selecting the $100 million level is not clear. Since the need is at some level much higher than any realistic appropriation, one can only assume that this amount represents the limit the administration is willing to consider in the context of its 1976 budget strategy.

(4) *Fiscal year 1976 AACHP recommendation.*—AACHP recommends an appropriation of $130 million for medical facilities assistance in fiscal year 1976. Given the great need for modenization of existing medical facilities—for example, 25 percent of the beds in short-term, nonprofit, general hospitals do not meet structural and safety standards—and the need for construction of new outpatient medical facilities, particularly in urban and rural poverty areas, this amount seems fully justified as a first step. Without such funding, development of alternatives to inpatient hospitalization, with consequent cost savings, will be delayed even more.

4. Planning Methods Development

1. Required to achieve intent	(1)
2. Fiscal year 1976 authorized	(1)
3. Fiscal year 1976 administration request	$5, 000, 000
4. Fiscal year 1976 AACHIP recommendation	5, 000, 000

[1] No set authorization for this purpose in Public Law 93–641.

(1) *Required to achieve intent.*—There is no clear indication of the amounts Congress thought appropriate for planning methods development and technical assistance to HSA's and SHPDA's in the law or the record.

(2) *Fiscal year 1976 authorization.*—There is no specific authorization for this purpose.

(3) *Fiscal year 1976 administration request.*—Funds for this purpose are included under a general heading of "Planning methods development" with a total request of $7 million. Our estimate of the distribution to this category is $5 million.

(4) *Fiscal year 1976 AACHP recommendaiton.*—We recommend that $5 million be made available for grants and contracts for this purpose in fiscal year 1976. This would provide for 30–40 contracts for development of methods to meet the new types of responsibilities assigned HSA's and SHPDA's under Public Law 93–641.

5. Centers for Health Planning

1. Required to achieve intent	$5, 000, 000
2. Fiscal year 1976 authorized	8, 000, 000
3. Fiscal year 1976 administration request	2, 000, 000
4. Fiscal year 1976 AACHP recommendation	5, 000, 000

(1) *Required to achieve intent.*—The Congress envisioned establishment of "Centers for health planning" to provide a variety of types of assistance to HSA's and State agencies. The conference report states unequivocally that five such centers are to be in operation by June 30, 1976. This timetable seems essential if the centers are to have maximum effect on development of the new structure for health resources planning. In our view, such centers would require an initial grant or contract of $1 million, with reduced support in subsequent years as HSA's and State agencies purchase certain services. This approach would permit funding of 10 centers over 2 years, hopefully regionally distributed. (See table 5.01.)

(2) *Fiscal year 1976 authorized.*—Like most portions of this bill, it was intended that fiscal year 1975 be the initial year of funding at the $5 million level, and that fiscal year 1976 would be the second year, during which the initial centers would be supported and additional centers established.

(3) *Fiscal year 1976 administration request.*—Funds for this purpose are included under a general heading of "Planning methods development" with a total request of $7 million. Our estimate of the distribution to this category is $2 million.

(4) *Fiscal year 1976 AACHP recommendation.*—We recommend that $5 million be made available in fiscal year 1976 to permit rapid development of five centers to the point of full operational status by June 30, 1976.

TABLE 5.01.—CENTERS FOR HEALTH PLANNING

SUGGESTED SCHEDULE FOR ACTIVATION OF CENTERS FOR HEALTH PLANNING (TARGET: 10 REGIONAL CENTERS

	New centers		Continuing centers		
	Number	Cost	Number	Cost	Total costs
Fiscal year 1976	5	$5,000,000	0	0	$5,000,000
Fiscal year 1977	5	5,000,000	5	4,000,000	9,000,000

6. Application Development Assistance

1. Required to achieve intent	(1)
2. Fiscal year 1976 authorized	(1)
3. Fiscal year 1976 administration request	$500,000
4. Fiscal year 1976 AACHP recommendation	1,000,000

[1] No set authorization for this purpose in 93–641.

(1) *Required to achieve intent.*—Section 1514 of the act provides the Secretary can provide nonfinancial assistance to organizations desiring to be designated as health systems agencies. There are no guidelines in the law or the accompanying reports for establishing the amount of money that might be required. Conventional wisdom suggests that in health service areas where agency mergers are required or where completely new agencies must be created, that there will be a need for the type of assistance envisioned.

(2) *Fiscal year 1976 authorized.*—There is no specific authorization for this activity.

(3) *Fiscal year 1976 administration request.*—The administration seeks $500,000 for such assistance. This represents an average of $2,500 per agency if the administration's assumption of 200 HSA's turns out to be accurate.

(4) *Fiscal year 1976 AACHP recommendation.*—AACHP recommends an appropriation of $1 million for application development assistance. The assumption underlying this suggested figure is that approximately one quarter of the HSA's to be designated will require technical assistance from consultants or HEW staff, but that the agencies which do require such assistance will require an average of $20,000 in technical and other nonfinancial assistance to become organized. In an area which must merge agencies, or in which no agency currently exists, the organizational effort required is substantial, and the resources to undertake the organizational efforts are limited. Adequate Federal financing should be available so that such areas need not turn to special interest groups to support the costs of organization, either directly or in-kind. The suggested level would provide that assurance.

7. Section 1122 Transfer from Trust Fund

1. Required to achieve intent	$8,000,000
2. Fiscal year 1976 authorized	(1)
3. Fiscal year 1976 administration request	4,000,000
4. Fiscal year 1976 AACHP recommendation	8,000,000

[1] No set authorization for this purpose in 93–641.

(1) *Required to achieve intent.*—Although Public Law 93–641 includes the 1122 function as a mandated function of the State agency, neither the law nor the record reveals a clear intent that this function be funded under Public Law 93–641 appropriations. Indeed, the source of 1122 authority and funding is in the purview of another committee in each House. In the absence of any expression to the contrary, it is assumed that Congress intended that transfer of funds from the social security trust fund continue as long as section 1122 is in effect.

(2) *Fiscal year 1976 authorized.*—There is no fixed authorization for appropriation or transfer.

(3) *Fiscal year 1976 administration request.*—The administration requests

transfer of $4 million from the trust fund for the first half of 1976, and assumes that these costs will be picked up from planning grants to HSA's and State agencies under Public Law 93-641 in the second half. This pickup, if implemented, represents an effective reduction in funds available for expanded and new functions of the HSA's and SPDA's.

(4) *Fiscal year 1976 AACHP recommendation.*—If the Congress appropriates less than is needed to effectively launch the HSA and State agency activities (see analyses 1.00 and 2.00), then transfer of the full amount of support from the trust fund for this contractual activity should be permitted. Thus we recommend transfer of $8 million for the funding of 1122 contracts during fiscal year 1976, recognizing this could be reduced if sufficient basic operating funds were made available to HSA's and SPDA's.

8. Program Management

1. Required to achieve intent	$14,000,000
2. Fiscal year 1976 authorized	[1]
3. Fiscal year 1976 administration request	9,000,000
4. Fiscal year 1976 AACHP recommendation	14,000,000

[1] No set authorization for this purpose in 93-641.

(1) *Required to achieve intent.*—As in other areas where there is no specific capitation figure or other guide to intent, a level can only be inferred. In merging CHP, RMP, and Hill-Burton responsibilities, Congress expected some economies of scale in staffing and supportive costs at the Federal level. A reduction of 20 percent might be a reasonable target. Based on Federal staffing levels when predecessor programs were fully operative, such a reduction would suggest a staff complement of some 470 positions. In addition, Congress requires a number of new activities not previously undertaken at the Federal level, including an information center, and extensive standards development activities. Taken together these activities would require approximately $15 million.

(2) *Fiscal year 1976 authorized.*—There is no specific authorization level.

(3) *Fiscal year 1976 Administration request.*—The administration requests $9 million for program direction.

(4) *Fiscal year 1976 AACHIP recommendation.*—We recommend $14 million for these purposes for fiscal year 1976. This reflects our concern that inadequate staffing at the Federal and regional levels will retard development of the full program of activities set out in Public Law 93-641. The numbers of reviews and checks incorporated in this law provides an opportunity for delays in reviews, approvals, appeals, and other HEW functions if the administrative structure is inadequately staffed and financed. With a congressionally mandated set of target dates for various steps in implementation, HEW will have to forego quality of effort if program management appropriations are inadequate. It is in the interest of our members, and that of the success of this program, for adequate resources to be made available to HEW to administer this program.

Mr. FLOOD. Off the record.

[Discussion off the record.]

[Brief recess.]

STATEMENT OF RICHARD P. ADAMS

Mr. ADAMS. What I would like to do is take some of the things Dr. Kimmey has said and apply them to our agency, which is of course in your district, and talk about what it would do to the present health planning and resources in our district.

We have prepared my testimony and rather than take the 2 minutes I have to go through it to read it we would like to place it in the record.

Mr. FLOOD. Without objection, that will be done.

[The statement and attachments of Richard Adams and Robert C. MacGregor follow:]

TESTIMONY PRESENTED BY RICHARD P. ADAMS, VICE PRESIDENT OF THE HEALTH & HOSPITAL PLANNING COUNCIL OF NORTHEASTERN PENNSYLVANIA, AND ROBERT C. MACGREGOR, EXECUTIVE DIRECTOR OF THE HEALTH & HOSPITAL PLANNING COUNCIL OF NORTHEASTERN PENNSYLVANIA

Mr. Chairman, I am Richard Adams, of Kingston, Pa., a consumer from your home county of Luzerne and vice president of the Health & Hospital Planning Council of Northeastern Pennsylvania. With me is Robert C. MacGregor, executive director of the Health & Hospital Planning Council of Northeastern Pennsylvania. We are here today to give you our observations on the necessity for adequate funding for fiscal year 1976 of Public Law 93-641 in order to assist in the establishment of an effective health systems agency in northeastern Pennsylvania.

We hope, Mr. Chairman, that our views will assist you and the committee in making a determination that will result in funding for fiscal year 1976 of at least $107.5 million nationally for this significant piece of legislation. Anything short of that, Mr. Chairman, will act to undercut the spirit of the law.

The health and hospital planning council supported Public Law 93-641, the National Health Planning and Resources Development Act, during the legislative process because we believed, as a typical "b" agency, it would improve health planning and development not only in the country, but in the area which you represent and for which we are responsible. One of the assumptions we made in endorsing the legislation was that it would be adequately funded. This assumption was based upon the congressional recognition that adequate funding was essential to new health planning legislation. In taking this position we also reflected on our own experiences in northeastern Pennsylvania with the financial limitation of Public Law 89-741, under which we operate.

To be specific, Mr. Chairman, and in support of our request for increased appropriations, I would like to review with you the current situation as it pertains to funding of planning, review, and development activities in northeastern Pennsylvania, and to compare this to possible funding alternatives under Public Law 93-641 which have been suggested to your committee.

ANALYSIS OF CURRENT AND PROJECTED FUNDING FOR HSA IN NORTHEASTERN PENNSYLVANIA

Health budgets of health planning and research programs now operating in HHPC Region:

314 b—Public Law 89-749	$190,000
1122—Public Law 92-603	[1] 26,200
EMS—DOT highway safety	67,000
RMP—Admin. (est.) title IX, PHS Act	29,294
EHSDS—12 months, estimated	273,600
Total Federal funds, all programs	586,094

[1] $283,200 (total 314 b).

Amount of dollars needed for HSA's in county: $213 million×.5=$107.5 million

Factor: Authorized appropriation need in country=$90 million/$107.5 million=.837 [1]

Public Law 93-641 funding, S. 1516	Current population × grant	Total × factor (A)	Adjusted total (B)
I—0.50 Federal grant (basic)	658,178×0.50	329,089×0.837	275,448
II—0.25 Federal grant (supplemental)	658,178×0.25	164,545×0.837	137,724
III—0.25 local matching	658,178×0.25	164,545×0.837	137,724
Total		658,179	550,896

[1] Based upon analysis prepared by State of Wisconsin.

	Health budgets	Optimistic [1]	Probable [2]
HHPC—Current health budget	283, 200	586, 094	586, 094
RMP—Proposed funding	29, 294	658, 179	275, 448
EMS—Need	273, 600	[3] 72, 085	[4] 310, 046
Total	586, 094		

[1] Basic grant 50; Federal match 25; local 25.
[2] $0.419 per capita basic grant.
[3] Surplus.
[4] Deficit.

Mr. Chairman, our analysis shows that even if Congress does fund at the $90 million level nationally, the HSA budget for northeastern Pennsylvania will decrease in excess of 50 percent from the current level.

While HSA may achieve some economies through consolidation of functions, there is no conceivable way to overcome this large a deficit and perform the task intended by Congress in Public Law 93-641. In fact, it appears to us that activities will be curtailed rather than expanded under the current proposed funding.

Mr. Chairman, we came here today in the hope that by presenting to you the impact of proposed funding for our particular area with which you are familiar, that it might provide you with additional insight to make decisions for the entire Nation.

We would like very much to work with you and the committee members and staff in the ensuing period in order to insure that adequate appropriation would be made. We have discussed this issue with our board and have their support for our position here today. In view of the situation, it is our considered opinion that no less than full funding, which means $107.5 million for fiscal year 1976, is needed in order to guarantee the successful transition to HSA both nationally and in our own region.

Mr. Chairman, we are most willing to respond to any questions you or members of the committee might have at this time.

Mr. ADAMS. The probable thing that would happen under the present appropriations is we would have a large deficit, in the neighborhood of $310,000 and I feel personally that this would really go against the intent of the legislation and would make it rather difficult to obtain the type of people and do the type of planning that the intent of the original legislation has.

When you go right down to our present six-county area in northeastern Pennsylvania and look at what the funding would do at the present levels, the authorized funding is $90 million, and we feel strongly it should have been $107 million.

Mr. FLOOD. Six counties?

Mr. ADAMS. I am talking about nationally now.

Mr. FLOOD. What six counties?

Mr. ADAMS. The six counties are Lackawanna, Luzerne, Wayne, Pike, Sullivan, and Wyoming.

Mr. FLOOD. Who picked the district?

Mr. ADAMS. That was picked prior to my time. Maybe Bob could speak to that.

Mr. MACGREGOR. That was a State decision, Mr. Chairman, Commonwealth of Pennsylvania.

Mr. ADAMS. And using that particular area under the present level of funding, taking Jim Kimmey's figures and applying them to our district, we have come up with an awful large deficit, $310,000 deficit, to do what is presently being done in health planning in our region.

I think you could expand that to the entire country and so even at

full funding, which is the $90 million, our share of the pie for our region as it presently is constituted would be far below what is actually needed to do what the legislation intends us to do or the new health systems agency to do.

With that, and very briefly, we would ask for full funding, which even at full funding is below what we consider a dire need. We are persisting in what we feel is the error of the original legislation on the level of funding for the startup moneys.

Mr. MACGREGOR. Those budget figures, Mr. Chairman, contemplate the current budget of the CHP agency plus the budget experimental program.

Mr. FLOOD. Thank you very much.

Mr. OBEY. Dr. Kimmey, I do have about four or five questions I would like to ask you but for the purpose of saving time I will just submit them for the record and you can answer them later.

Dr. KIMMEY. Very good; be glad to do that.

[The information follows:]

Question. Why is the administration request for health systems agency funding so much lower than the amounts you feel are needed for this purpose?

Answer. The administration has made a number of assumptions in setting their requests which are not supported in the experience of operating agencies:

1. They assume a start-up period with new State and area agencies, and reduce the request to accommodate that period. Congress has already taken note of the start-up matter in setting authorization less than need.

2. They assume all new agencies will be conditionally designated, and therefore funded at less than the optimum for a time. Congress was very clear that those agencies which are ready should be fully funded immediately.

3. Since the law provided that conditionally designated agencies cannot administer developmental funds, the administration assumes such funds will not be needed in fiscal year 1976.

The effect of these effective assumptions, along with other factors stressed in the prepared testimony, is to artificially depress appropriation request levels.

Question. Why do you feel it is necessary to continue funding section 1122 activities at the State and and health systems agency levels from the social security trust fund?

Answer. The States contract with HEW to administer the section 1122 program, and in turn, contract witth area agencies for review and comment. Although Public Law 93–641 only requires that the State Health Planning and Development Agency be designated as the section 1122 agency, the administration is assuming that this means the costs of the program must be met under the title XV appropriations, and proposes a phasing out of trust fund moneys. If the administration view prevails, it will represent an effective reduction in the amount of money available to the States to implement all other parts of Public Law 93–641, since we must carry out section 1122 activities. Table 2.01 in the prepared testimony shows that Wisconsin requires a Federal grant of $407,000 to simply continue the activities carried out in fiscal year 1975. Since our historic share of most Federal programs is 2 percent, and since 2 percent of $19 million requested in total for the States is $380,000 the administration request will cause cutbacks under a bill in which Congress has mandated several new functions in addition to the current activities.

Question. Can States realistically proceed to develop these activities at the rate you suggest by the appropriations level you request?

Answer. We are convinced that they can. Wisconsin has one of the larger and better developed of State comprehensive health planning agencies at present. Our total budget for activities that could legitimately be supported under Public Law 93–641 is projected at $977,000 for fiscal year 1976, or 21c per capita. projecting this figure to the national scene would seem to indicate that $35 million would be required for all States. The authorization for fiscal year 1976 is only $30 million, again demonstrating that the Congress had already considered the

problem of start-up in setting the authorization levels. We are concerned that the inadequate funding which has been a major factor in retarding the growth and effectiveness of State CHP agencies in the past is going to continue under this new law. If this new program begins in the same inadequate way, the desirable benefits in terms of cost containment and more effective health systems will be further delayed, and indeed, perhaps permanently so.

Mr. FLOOD. Yes. I would like to see those.

Dr. KIMMEY. Thank you very much.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

WITNESSES

CAESAR A. GIOLITO, AMERICAN PSYCHIATRIC ASSOCIATION
DR. DANIEL X. FREEDMAN, VICE PRESIDENT, AMERICAN PSYCHIATRIC ASSOCIATION; CHAIRMAN, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF CHICAGO SCHOOL OF MEDICINE
DR. DAVID HAWKINS, PROFESSOR AND CHAIRMAN, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF VIRGINIA MEDICAL CENTER; PRESIDENT, AMERICAN ASSOCIATION OF CHAIRMEN OF DEPARTMENTS OF PSYCHIATRY

Mr. FLOOD. Mr. Caesar A. Giolito, the American Psychiatric Association.

Mr. GIOLITO. Mr. Chairman, it is my pleasure to introduce our witnesses for the American Psychiatric Association, Dr. Daniel Freedman and Dr. David Hawkins.

[Dr. Freedman's longer written statement follows:]

BIOGRAPHICAL SKETCH OF DR. DANIEL FREEDMAN

ABBREVIATED CURRICULUM VITAE—DANIEL X. FREEDMAN, M.D., CHAIRMAN, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF CHICAGO

Born: Lafayette, Indiana, August 17, 1921.

Education: 1947—B.A. cum laude, Social Relations, Harvard ('43); 1951—M.D., Yale University School of Medicine (Keese Prize for Research); 1966—Western New England Institute for Psychoanalysis, Graduate.

Previous positions: 1955–66—Instructor to Professor of Psychiatry, Yale University School of Medicine; 1957–66—Career Investigator, National Institute of Mental Health.

Memberships: Vice President, American Psychiatric Association (1975–77); Institute of Medicine, National Academy of Sciences (1974–79); President, American Association of Chairmen of Departments of Psychiatry (1972–73); President, Illinois Psychiatric Society (1971–72); President, American College of Neuropsychopharmacology (1969–70); American Society for Pharmacology and Experimental Therapeutics; Psychiatric Research Society; American Psychosomatic Society (Councilor, 1970–73).

Consultantships and committees—

Past: Psychopharmacology Study Section, NIMH (1960–65); Clinical Psychopharmacology Research Review Committee, NIMH (1965–67; Chairman, 1967–69); Panel on Psychiatric Drugs, National Academy of Sciences-National Research Council, Drug Efficacy Study (Chairman, 1966–68); Psychotomimetic Advisory Committee, NIMH/FDA (1967–69); Social Science Research Council, Director (1968–74); Foundations Fund for Research in Psychiatry, Director (1969–72); NIMH Research Scientist Committee (1969–74); National Research Council Committee on Brain Sciences (1971–74).

Current: National Research Council Committee on Problems of Drug Dependence, 1971– ; Drug Abuse Council, Inc., Director, 1972– ; NIMH Preclinical Psychopharmacology Research Review Committee, Chairman, 1974–79.

Editorial Advisory Boards: Chief Editor, AMA Archives of General Psychiatry, 1970– ; Biochemical Pharmacology, 1966– ; Journal of Nervous and Mental Disease, 1967– ; Communications in Behavioral Biology, 1967– ; Journal of Abnormal Psychology, 1973–

Author: The Theory and Practice of Psychiatry, with F. C. Redlich, Basic Books, Inc., 1966; Modern Psychiatry and Clinical Research: Essays in honor of Roy R. Grinker, Sr.; Offer, D. and Freedman, D. X., Eds., New York: Basic Books, 1972; American Handbook of Psychiatry, Freedman, D. X. and Dyrud, J. E., Eds., Vol. V., New York: Basic Books, 1975; Plus author of over 100 scientific articles.

Honors: 1973 Distinguished Achievement Award from Modern Medicine; 1973 Citation, City of Hope, 16th Annual Salute to Medical Research; 1974 Honorary Degree: Doctor of Science, Wabash College, Crawfordsville, Ind., 1975 The William C. Menninger Award, The American College of Physicians.

Dr. FREEDMAN. Mr. Chairman, the American Psychiatric Association, which represents 22,000 U.S. psychiatrists, is honored to appear before this committee and present its views on appropriations for the Alcohol, Drug Abuse, and Mental Health Administration for fiscal 1976.

I am Daniel X. Freedman, vice president of the association, and chairman of psychiatiry at the University of Chicago. With me to discuss health manpower is Dr. David Hawkins.

Mr. Chairman, we respectfully request that the text of our longer written statement be included in the record.

The administration has testified that its proposed decrease for fiscal 1976 of $163,305,000 below fiscal 1975 was based on congresional acceptance of the President's proposed rescissions for fiscal 1975. Since your committee has unequivocally rejected these rescissions, it is amply clear that the astonishingly low budget proposed for ADAMHA is now neither defensible nor feasible. These drastically decreased funding levels, in any event, cannot be responsibly implemented to meet ongoing obligations. Cutting the funding abruptly would precipitate irreparable damage to health programs, manpower, and services.

We are here to support the Congress and to advocate Federal responsibility. Aware of our national economic problems, we support prudence and fiscal restraint without endangering our existing public health capabilities.

Estimates so conservative that they are unchallenged by OMB's fiscal surgeons indicate that over 4 million Americans were treated for serious mental health problems last year. Three-quarters of a million Americans are currently in treatment for serious episodes of schizophrenia; 2 million of those born in the decade 1960–70 will develop this disease after the age of 15; severe depressive disorder affects well over a million annually; one-half million enter our State hospitals annually, and 1.2 million are annually treated in beds of general hospitals and community mental health centers. Mental illness is indeed a major public health problem. Yet, per patient under current care for heart disease and cancer we spend $250 for research, and for mental illness $20 per patient under care. The funds for fiscal 1975 for research—these are NIMH funds—in mental health are $1 million less than in 1971; 300 less projects could be undertaken and projects costing $10 million for pressing disease research simply could not be initiated. Mr. Chairman, I request the chart of this decline in mental illness and mental health research of NIMH be incorporated in the

record. The point, Mr. Chairman, is that there has been a starkly clear shrinkage even if inflation is not calculated over 5 years in our national capacity to generate knowledge, transmit skills and provide services for the mentally ill. This inexorable squeeze and ultimate phaseout of funds means not just that excesses are trimmed—they have been for 4 years—but the floor will disappear. This is not a discarding of the baby or bath water—but the bathtub!

Yet research in mental illnesses has produced remarkable breakthroughs on behalf of the treatment of depression and psychoses. With these, and developments in epidemiology, genetics, brain sciences and biochemistry, we could move toward more specific treatments, permanent cures and preventive measures. The Federal Government has a responsibility to continue this important work and we therefore recommend the amount of $105 million for this purpose, an increase of $12 million over last year's appropriations.

We strongly support the continuation of Federal responsibility for support of community mental health centers and will advocate the level of funding supported by the National Coalition for Health Funding when authorizing legislation makes this possible. A strong component for children's mental health services also represents one of the association's highest priorities.

The Federal effort in alcoholism has also suffered serious recent setbacks through restrictive funding. We support raising these levels to provide $85 million for project grants and contracts and $65 million for State formula grants.

The only increase the administration has proposed is one of $15,962,000 to maintain treatment capacity for 95,000 drug abusers. We will support that recommendation. But the administration's congressional testimony that this increase is to "offset" the other decreases is, if not incomprehensible, surely, totally irrelevent to serious mental health and mental illness problems.

Finally, we wish to oppose the decimation of the ADAMHA institute staffs, especially that of NIMH by 97 people. NIMH has already lost manpower in recent reorganizations. These personnel provide the core capability to administer vital programs for the mentally ill. We therefore strongly recommend funding to maintain the staff of NIMH at 490 positions, and for the National Institute of Alcohol Abuse and Alcoholism at 114 positions.

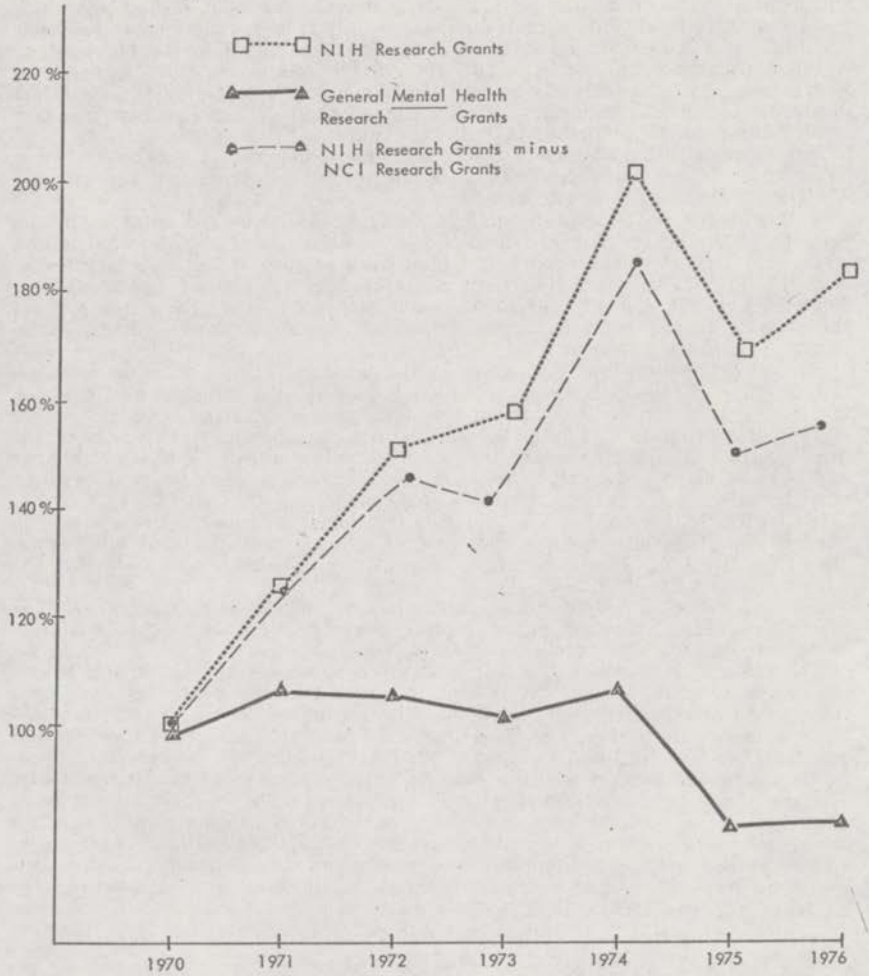
In testimony this year, the administration accurately stated that "the scope and magnitude of alcohol, drug abuse, and mental health problems in the Nation are enormous." We agree, but we recommend Federal action consistent with the present realities, rather than a massive abdication of responsibility.

Mr. Chairman, Dr. Hawkins will present the manpower training issues.

[The attachment follows:]

RESEARCH FUNDING

1970 - 1976
(EXPRESSED AS PERCENT OF 1970 FUNDING)



The American Psychiatric Association, which represents 22,000 psychiatrists in the United States, presents this statement on its recommendations regarding the fiscal 1976 budget appropriations for the Alcohol, Drug Abuse, and Mental Health Administration.

In doing so, we will allude to the inconsistencies in the Administrations testimony before the Congress vis-a-vis mental illness and the Federal role.

In its testimony before the Congress, the Administration stated that "The major mental illnesses continue to strike heavily throughout the population. In any given year, 15 percent of adults aged 18 to 74 may suffer significant symptoms of depression. And, more than 2 million Americans alive today will experience some degree of disruption in their lives as a result of schizophrenia. Based on a study of the cost of mental illness in 1971, we estimate that this constellation of problems cost the Nation $37 billion last year. Of this amount, $15 billion—or 14 percent of all health care expenditures in the Nation—went for direct care,."

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This powerful and compelling statement illustrating the severity of the problem was followed with funding recommendations by the Administration of the following vein, "* * * The appropriation request for alcohol, drug abuse, and mental health in 1976 is $653,627,000, a decrease of $163,305,000 below the fiscal year 1975 level. This overall decrease results from a reduction in research programs of $17,070,000; a reduction of $59,921,000 related to the phaseout of training programs; a reduction of $66,778,000 related to the decrease in Federal support for community mental health centers; a reduction of $25,857,000 in alcohol community programs; a reduction of $2,110,000 in program management funds; and a reduction in buildings and facilities of $7,522,000."

The Administration statement continues, "These decreases ($163,305,000) are offset by an increase of $15,962,000 required to maintain treatment capacity for 95,000 drug abusers at any one time."

Is this litany of Federal reductions being proposed as the solution to the pressing constellation of mental health problems that cost the Nation $37 billion last year? Are the phasedowns and phaseouts of mental health programs in research and manpower, the very underpinnings of mental health service delivery, and the discontinuation of community mental health center support the answers to this problem, whose scope and magnitude are enormous, in the words of the Administration?

The rationales that have been given by the Administration for the discontinuation of some of these vital programs have hardly been convincing. Their reason for the termination of Federal support for community mental health centers is that the program has been so successful that communities now have the incentive to fund their own. This argument flies in the face of lack of existing resources in many communities to start up their own centers, or even continue what has already been started with Federal support.

We realize that there is no authorizing legislation at this time to extend the centers' act, but fully endorse the level of support recommended by the National Coalition for Health Funding to continue Federal support for this important program.

Funding for children's services in community mental health centers is one of the association's highest priorities, and conversion grants in the legislation to be enacted should provide generously for this purpose.

The reason proposed by the Administration to phase out the mental health manpower program is that "It is now felt that training programs have been developed to the point that Federal subsidies are no longer required." Nevertheless, suitable alternatives for the training of mental health personnel are not available. As the National Coailtion for Mental Health Manpower pointed out in its testimony, neither revenue sharing, third-party payments, student loans, nor local financing have been effective. Insufficient funding will have a devastating effect on the recruitment and training of mental health manpower, an effect which we would have to live with for years to come. This is the wrong moment in history to curtail our manpower resources, when we are faced with enormous needs in areas of clinical services, research, alcoholism, drug abuse, and the needs of children, along with the likely emergence of national health insurance.

The following statistics illustrate this dilemma for mental health manpower:

NATIONAL MENTAL HEALTH PROFESSIONAL MANPOWER FOR CLINICAL SERVICES—1975 SUPPLY PROFILE AND PROJECTED 1981 SUPPLY/DEMAND PROFILE

Discipline	1975, 2½ percent utilization rate [1]	1981, 3½ percent utilization rate [2]		
		Estimated demand	Estimated supply [3]	Difference (gap)
Psychiatrists	[4] 27,500	[5] 40,300	30,900	−9,400
Psychologists	21,000	30,800	22,300	−8,500
Psychiatric social workers	21,000	30,800	23,650	−7,150
Psychiatric nurses	38,000	55,700	43,500	−12,200

[1] The 2½ percent utilization rate based on current national population is conservative and includes only that portion of the population with serious mental illness requiring specialized professional care. This utilization rate is limited by numbers of mental health professionals available to provide care.

[2] The 3½ percent utilization rate reflects an extremely conservative estimate of impact of NHI and some expansion of numbers of CMHC's by 1981. It is applied against Census Bureau D estimates (assuming low growth) of national population in 1980.

[3] Assumes maintenance (no increase) of current production rates, adjusted for minimal rates of attrition from the existing pool.

[4] Includes residents in training.

[5] Does not include adjustment for increased demand expected to result from reduction in importation of FMG's.

PROJECTIONS OF ANNUAL BUDGET FOR CLINICAL TRAINING PROGRAMS, 1975–81, ASSUMING MAINTENANCE OF FISCAL YEAR 1975 LEVEL OF EFFORT, ADJUSTED FOR 9 PERCENT PER ANNUM INCREASE TO OFFEST INFLATION

[In thousands of dollars]

	Basic clinical manpower training support	Technical assistance support and experimental approaches	Total clinical training program
Fiscal year:			
1975 [1]	$57,511	$10,000	$67,511
1976	62,687	10,900	73,587
1977	68,339	11,871	80,210
1978	74,490	12,939	87,429
1979	81,188	14,102	95,290
1980	88,494	15,372	103,866
1981	96,458	16,755	113,213

[1] Based on actual fiscal year 1975 appropriation.

The return given in public service by physicians receiving these stipends has also been great. NIMH figures illustrate that 5 years after training, 32 percent of psychiatric stipendees are serving in government, 19 percent in nonprofit settings, 4 percent in private-for-profit settings, and 44 percent are self-employed.

The phaseout of this program would cut 35 percent of the psychiatric residency training positions, and seriously curtail the mental health services to the poor and underprivileged groups being served by psychiatric residents.

Although the Congress has not concurred with the policy of the administration to phase out this program, the net effect of this unabated policy has been steadily decreased appropriations since fiscal 1972.

In fiscal 1972, $120,050,000 was appropriated by the Congress, and only $94,600,000 was appropriated in fiscal 1975.

The American Psychiatric Association recommends the level of $125 million for fiscal 1976 in order to maintain the program at a reasonable level. To restore this program to the level it was operating on in fiscal 1972 would require upwards of $140 million because of the inflationary factor. Serious gaps in service will occur if funding is not at the level of our recommendation.

Mental health research is an area that has produced notable advances in knowledge relating to the basis of mental and emotional illness, with evidence indicating other breakthroughs in the very near future.

The extramural research programs of NIMH consist of a broad area of activities, including research in schizophrenia and depression, relationships between the brain and behavior, and child development, to mention a few.

The intramural research effort of NIMH has produced significant advances in neuropharmacology, in investigating the genetic basis for schizophrenia, in manic depression, mental illness incident to old age, and a host of other areas.

Dr. Bertram S. Brown, Director of NIMH, stated at the American Psychiatric Association's annual meeting this month that "Investigations of the biochemical and biological underpinnings of behavior, of the role of heredity in mental illness, and of psychological aspects of child development have had a direct effect on the clinical psychiatrist's ability to treat mentally ill patients."

The discovery of the psychotropic drugs created a revolutionary breakthrough in mental health delivery, enabling thousands to remain in the community while being treated, and dramatically shortening the length of hospital stays for thousands of others.

Yet, the administration has proposed a severe decrease for mental health research from $93,252,000 that was appropriated by Congress for fiscal 1975 to $81 million for fiscal 1976.

We recommend the appropriation of $105 million for mental health research for fiscal 1976. This would permit the continuation of ongoing research programs, as well as the mounting of some new ones, such as service delivery research to discover improved methods of health care for mental patients.

It is not difficult to deduce from this general trend the serious vulnerability of the entire Federal effort in mental health. Given even the slower attrition of these programs through smaller congressional cuts each year, influenced as a direct result of drastically lowered Presidential requests, the elimination of

NIMH will sooner or later become a fait accompli. Once this occurs, it would be a comparatively simple task to siphon off the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism into bureau or office slots within DHEW.

The magnitude of the problem of mental and emotional illness, the Nation's No. 1 health problem, must be accepted and not denied Federal responsibility. The Congress must see this destructive action for what it is, and discourage this trend once and for all.

Psychiatrists are trained to listen to words very carefully, and they often pick up meanings albeit obscure. The administration's description of NIMH in its congressional testimony as the elder statesman could be construed as innocuous since it is the oldest of the three ADAMHA institutes. Nevertheless, we all know that the longevity of elder statesmen is not great, nor their role very active.

Funds for formula grants to States and project grants for alcoholism are also being significantly reduced. As stated by the National Coalition for Health Funding, "The false economy implicit in the administration's neglect to direct adequate resources toward the treatment and prevention of alcoholism at the State and community levels has never been more blatantly obvious than at present. It is logical to assume that the economy of the country will worsen markedly as a result of the continued neglect of the Nation's alcohol afflicted."

The administration proposes $45,400,000 for alcoholism project grants and $45,600,000 for formula grants to the States. This would allow for no new projects, and would create a cutback of 20 percent in the present project grants. Formula grants would be decreased $6,400,000 under the figure appropriated by Congress in fiscal 1975.

We recommend that these levels be lifted to $85 million for alcoholism project grants and contracts, and to $65 million for formula grants to the States.

Drug abuse is still a serious problem in the United States. The public requires additional education on the ill effects of drugs, and cocaine has emerged as a potentially lethal substance that is gaining in public use among the other dangerous drugs.

Nevertheless, this is the one area in mental health in which the administration has proposed an increase in funding for fiscal 1976.

We support the administration's recommendation of an increase of $15,692,000 to maintain treatment capacity for 95,000 drug abusers at any one time.

The important function of management and information for the institutes must also be maintained at an adequate operational level if there is to be the administrative capacity to run, oversee, and evaluate the programs, to administer the grants and contracts, and to provide technical support. A diminished function of this vital component would be effected by the administration's proposed cutbacks of 97 positions in NIMH.

We recommend sufficient funding to restore these positions at NIMH, and to maintain personnel strength of the three ADAMHA institutes at a level that will permit them to function effectively.

We as a nation cannot turn our backs on the 20 million people handicapped by mental and emotional illness. This clearly represents a national problem, and, therefore, a national responsibility.

The States have borne a large part of the burden, but the commitment of the Federal Government has created tremendous advances in the amelioration of life for mental patients, and permitted to return to society as productive citizens in thousands of cases.

If we relinquish our national responsibility toward these citizens, we will have denied them the opportunities granted to most other sick persons in our society, and we will have rendered ourselves a tremendous disservice in the years to come.

BIOGRAPHICAL SKETCH OF DR. DAVID R. HAWKINS

ABBREVIATED CURRICULUM VITAE—DAVID R. HAWKINS, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF VIRGINIA MEDICAL CENTER

Born: Springfield, Mass., September 20, 1923.

Education: 1945—B.A., Amherst College, September 1940–February 1943; 1946—M.D., University of Rochester School of Medicine, 1943–46:

Training: Intern and assistant resident in pathology, Strong Memorial Hospital, University of Rochester, N.Y., March 1946–July 1947; intern in internal

medicine, Strong Memorial Hospital, July 1947–July 1958; commonwealth fund fellow in psychiatry and medicine, University of Rochester, July 1950–July 1952.

Honorary societies: Phi Beta Kappa, Alpha Omega Alpha, and Sigma Xi.

Academic appointments: Instructor in psychiatry, University of North Carolina School of Medicine, 1952–53; assistant professor of psychiatry, University of North Carolina School of Medicine, 1953–57; associate professor of psychiatry, University of North Carolina School of Medicine, 1957–62; professor of psychiatry, University of North Carolina School of Medicine, 1962–67; instructor, Duke-UNC Psychoanalytic Institute, 1965–67; chairman, Department of Psychiatry, University of Virginia School of Medicine, 1967 to present; instructor, Washington Psychoanalytic Institute, 1967–73; teaching analyst, Washington Psychoanalytic Institute, 1973 to present; associate dean, University of Virginia School of Medicine, 1969–70.

Clinical appointments: Associate attending physician, North Carolina Memorial Hospital, Chapel Hill, N.C., July 1952–62; consultant to Veterans' Administration Hospital, Fayetteville, N.C., October 1956–67; psychiatrist in chief, Department of Psychiatry, University of Virginia Hospital, Charlottesville, Va., September 1967 to present.

Fellowships: NIMH and commonwealth fund special research fellowship at the Institute of Psychiatry of the University of London, the Maudsley Hospital, September 1, 1963–August 31, 1964.

Offices: Director of curriculum review and revision, UNC School of Medicine (1965–67); chairman, committee on medical education, group for the advancement of psychiatry (1966–73); chairman, subcommittee on manpower and training, Virginia Governor's commission on mental, indigent, and geriatric patients (1969–72); chairman, Curriculum Committee, University of Virginia School of Medicine, 1969–71.

Committee memberships: American Psychiatric Association Committee To Develop Psychiatric Knowledge Self-Assessment Program, 1969; member, Health Manpower Committee, Association of American Medical Colleges, 1973 to present; member, task force on manpower training and development, department of mental health and mental retardation, 1974 to present.

Dr. HAWKINS. My name is Dr. David Hawkins. I am professor and chairman of the Department of Psychiatry of the University of Virginia Medical Center and president of the American Association of Chairmen of Departments of Psychiatry.

I represent the 114 medical school departments of psychiatry. We are responsible for teaching mental health care to 53,000 medical students, to 4,700 resident physicians specializing in psychiatry, to professional trainees and other mental health professionals, to house officers training to be primary and family physicians, and to thousands of practicing physicians linked to our medical centers.

The bulk of the medically trained manpower core for the mental health needs of our 220 million citizens must be educated in these schools and deployed to deliver the needed care.

To carry out these essential tasks it is crucial that the fiscal year 1976 appropriations for mental health manpower training under the National Institute of Mental Health be sufficient. The issue is not the needs of the schools, the teachers, or the trainees, but whether the mental health needs of our citizens are going to be adequately served.

The success of this country in developing highly qualified mental health manpower has been extraordinary until recently. It would have been impossible without the Federal support through the NIMH. Mental illness, in both numbers of affected and economic cost to the Nation represent a major portion of the Nation's general health program.

I respectfully request that the chart attached to my presentation illustrating the deterioration of the mental health manpower program since fiscal year 1972 be included for the record.

As this chart shows, $120,050,000 was appropriated in fiscal year 1972 for mental health manpower training. Last year, the appropriation was only 79 percent of the figure of 3 years ago and inflation has eroded the program significantly beyond the 21-percent dollar loss. This year the administration is requesting a phaseout amount of $45 million, predicated on the erroneous assumption that the Congress would accept rescissions for fiscal year 1975.

At the present time there are 27,500 psychiatrists. At the present rate of production maintained, there will be 30,900 by 1980 as compared with a projected need of 40,300, using the most conservative population and utilization rates, leaving an anticipated deficit of 9,400.

These projected figures are based on the most conservative estimates. If this program were phased out we would lose 35 percent of our resident pool and about the same percent of experienced teachers. Already many of these programs are in difficulty and have cut back their numbers.

Psychiatric residents are not merely trainees, but experienced physicians who provide a substantial portion of psychiatric service to the poor. Moreover, a significant number who receive these stipends enter public service following training. To illustrate this, we ask that the record include an attached list of outstanding institutions which have followed the careers of their graduates.

Not only is psychiatric manpower in serious jeopardy but also manpower in psychology, psychiatric social work, and psychiatric nursing, which form the professional manpower pool to treat mental and emotional illness in our country.

The American Psychiatric Association and the American Association of Chairmen of Departments of Psychiatry recommend the sum of $125 million for mental health manpower in the NIMH appropriations for fiscal year 1976. Although this level will not restore the Federal effort of fiscal 1972, it would provide sufficient resources to prevent from falling drastically behind in the training of mental health manpower.

Thank you, sir.

[The attachments follow:]

TRENDS IN MENTAL HEALTH MANPOWER APPROPRIATIONS—ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

	National Coalition for Mental Health Manpower recommendations	Presidential request	House appropriation	Senate appropriation	Final conference appropriation [1]
Fiscal year:					
1972	$145,200,000	$104,600,000	$114,000,000	$120,050,000	$120,050,000
1973	(2)	96,350,000	110,000,000	132,050,000	110,000,000
1974	(2)	72,376,000	100,000,000	110,000,000	104,500,000
1975	(2)	65,100,000	85,100,000	104,099,000	[3] 94,600,000
1976	125,000,000	45,000,000			
	110,000,000				

[1] This column illustrates the deterioration of this vital program. (2 digit inflation not reflected in trend.)
[2] No specific recommendation.
[3] Demonstrates reduction.

RESIDENCY TRAINING PROGRAM, DUKE UNIVERSITY, DURHAM, N.C., EWALD W. BUSSE, M.D., DIRECTOR

Fifty-three residents have completed training at Duke University within the past 5 years; of these, 49 were supported in whole or in part by NIMH training stipends. The 53 residents are now engaged in the following activities:

Full-time public service:	
Public mental hospitals (14.4%)	7
Military service (9.4%)	4
Government work (16.4%)	8
Community mental health (12.5%)	7
Education (29%)	14
Part-time public service (10%)	10
Solo private practice (7%)	4

RESIDENCY TRAINING PROGRAM, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA., ALBERT STUNKARD, M.D., DIRECTOR

Forty-eight residents have completed training at the University of Pennsylvania over the past 5 years; 43 of them supported in whole or in part by NIMH training stipends. Their activities at present are as follows:

Full-time public service:	
Teaching (31%)	15
Military service (15%)	7
Federal or State mental health services (14%)	6
Community mental health centers and clinics (8%)	4
Advanced training (8%)	4
Research (7%)	3
Part-time public service:	
Teaching and private practice (8%)	4
Solo private practice (10%)	5

RESIDENCY TRAINING PROGRAM, EMORY UNIVERSITY, ATLANTA, GA., BERNARD HOLLAND, M.D., DIRECTOR

Fifty-six residents have completed training in the past 5 years; all of whom received support in whole or in part from NIMH training stipends. Their present activities are as follows:

Full-time public service:	
Community mental health centers	8
Hospitals	2
Military service	15
Education	4
Total (52%)	29

Part-time public service [1]	*Average percentages*
3 graduates, 1967	50
5 graduates, 1968	50
10 graduates, 1969	40
3 graduates, 1970	70
6 graduates, 1971	65
Total 27 graduates (48%) 1967–71	55

[1] Public service here includes part-time work in education, community consultation and community mental health centers, clinics, all kinds of hospitals, and research.

RESIDENCY TRAINING PROGRAM, CENTRAL STATE GRIFFIN MEMORIAL HOSPITAL, NORMAN, OKLA., HAYDEN H. DONAHUE, M.D., DIRECTOR

Twenty six-residents have completed training in the last 5 years of whom 10 were supported in whole or in part by NIMH stipends. The activities of these 10 are summarized below.

Full-time public service:	
Community mental health centers	2
State hospital	3
Part-time public service:	
Consultants-State health department	2
Staff, State hospital	1
Solo private practice	2

Of the 16 other residents who were supported by Oklahoma state stipends, their work is distributed as follows:

Full-time public service:	
State hospital	11
Part-time public service:	
Consultant to State school	1
Solo private practice	4

RESIDENCY TRAINING PROGRAM, HARVARD MEDICAL SCHOOL, MASSACHUSETTS MENTAL HEALTH CENTER, BOSTON, MASS., JACK R. EWALT, M.D., DIRECTOR

One hundred thirty-five residents have completed the program in the past 5 years: 46 of these residents received support in whole or in part from NLMH training stipends.

Of these 135, all but 13 have spent some time as full-time employees in the following agencies and facilities: military service; public health service; Massachusetts Mental Health Center; Boston State Hospital; Tufts Mental Health Unit; Cambridge City Hospital.

All of the 135 have spent some time teaching at State and Federal institutions.

At present, only two graduates are known to be in full-time private practice.

133 are in full or part time academic or public work. A great many of the graduates now teach one-fourth to one-half time and serve as supervisors of hospitals or clinics.

RESIDENCY TRAINING PROGRAM, NEW YORK STATE PSYCHIATRIC INSTITUTE, COLUMBIA UNIVERSITY, NEW YORK, N.Y., LAWRENCE C. KOLB, M.D., DIRECTOR

Eighty-five residents have completed training here in the past 5 years. Of these, 65 were supported in whole or in part by NIMH training stipends. The activities of these 65 at present are as follows:

Full-time public service: public mental hospitals, military service, community mental health centers, education	27
Part-time public service:	
2 graduates	90[1]
3 graduates	80[1]
7 graduates	70[1]
1 graduate	60[1]
13 graduates	50[1]
3 graduates	40[1]
6 graduates	30[1]
3 graduates	20[1]
Total, 38 graduates average percent	55[1]
Solo private practice	None
Solo private practice over 50 percent of time	12

[1] Percent of time in public service work.

RESIDENCY TRAINING PROGRAM, MENNINGER SCHOOL OF PSYCHIATRY, TOPEKA, KANS., PHILIP WOLCOTT, M.D., DIRECTOR

One hundred sixty-six residents have completed training here in the past 5 years. Thirty-three received NIMH training stipend support. Their activities are distributed thusly:

Full-time public service:	
State mental hospital	5
State medical hospital	2
Community mental health centers	3
Hospitals	5
Part-time public service: (Precise information is not available, but it is our impression that most graduates are doing part-time community service work.)	
Solo private practice	18

RESIDENCY TRAINING PROGRAM, UNIVERSITY OF COLORADO, DENVER, COLO.,
DOUGLAS B. CARTER, M.D., DIRECTOR

Of the 102 graduates of the psychiatric residency training program in the past 5 years, 98 have received support from NIMH stipends. These 98 graduates are now involved in the following activities:

Full-time public service:	
Military or public health	30
Education	11
State hospitals	9
Community mental health centers	4
Alcoholism and drug programs	1
Children's programs	3
Part-time public service:	
Education	6
State hospitals	7
Community mental health centers	17
Alcoholism and drug programs	1
Other	3
Solo private practice	6

Mr. FLOOD. Thank you.
Dr. HAWKINS. Thank you.

SOCIAL WORK EDUCATION

WITNESS

SIMON SLAVIN, DEAN, TEMPLE UNIVERSITY GRADUATE SCHOOL OF SOCIAL ADMINISTRATION, ON BEHALF OF THE COUNCIL ON SOCIAL WORK EDUCATION

Mr. FLOOD. Council on Social Work Education.

Mr. SLAVIN. Mr. Chairman, I am Simon Slavin, dean of the Temple University School of Social Administration. I am testifying on behalf of the Council of Social Work Education, a national voluntary organization composed of 83 graduate schools of social work and over 200 undergraduate programs for social work training located in leading colleges and universities across the country. Over 40,000 students are enrolled in these programs, along with 4,000 faculty members. In addition to educational institutions, there are 4,800 members of the council comprised of voluntary and public national, State and local social welfare agencies and related organizations, faculty members, and individuals concerned with social work education.

I appreciate this opportunity to testify before the Labor-HEW Subcommittee on Appropriations, and would like to commend the subcommittee for its consistent commitment to the provision of quality services to people and to the training of qualified personnel. In particular, I would like to commend you for your position in the fiscal year 1975 appropriations bill regarding professional health training programs. The restoration of support for mental health training and social work training under the child welfare provisions of the Social Security Act were important steps toward improving the quality of services to people. Your recognition of the continuing

need for trained professional personnel in the mental health and social service fields at a time when the administration was recommending the elimination or phasing out of professional training programs was greatly appreciated by all who are involved in the delivery of services and the education of human service personnel. We believe that you correctly saw not only the importance of trained personnel, but the weakness of the argument that student assistance programs can adequately meet all professional manpower needs.

We also appreciate your action in failing to pass requested rescissions for fiscal year 1975 in professional training programs, particularly mental health and child welfare programs.

Particularly important to the schools and programs of social work was the strong commitment reflected in the committee report on the fiscal year 1975 appropriations bill to long-term, degree-granting programs. In both the SRS child welfare budget item for social work training and the mental health training program, the administration sought to direct those programs toward short-term training, shortsighted in our view. In SRS, the entire budget in fiscal year 1974 was directed at short-term training. Experience, I think, has shown it has not been very effective. This year about 75 percent of the SRS training funds for child welfare training are being spent on long-term, degree-granting programs in social work. The remainder is being spent on short-term training and on experimental or national priority projects. We think this balance is appropriate and urge that your report on child welfare training in SRS reflect your intent that the balance between long-term, degree-granting training and other training needs be maintained in the same proportions as in fiscal year 1975. We also hope that the report will broadly characterize the training effort under the child welfare training program to include graduate and undergraduate training in social work for the training of personnel to provide services to families and children in order to prevent problems of child abuse and neglect; to maintain families intact in order to prevent institutionalization; and to improve foster care, child care, and to improve institutional care where required.

For fiscal year 1976, we are recommending the continuation of the child welfare training program at the level of $8.9 million. There is no question that the demand for trained social service personnel to provide services to families and their children in order to improve the welfare of children is growing. The enactment of title XX of the Social Security Act last year, ending years of ambiguity about the social service program, will create a greater demand for trained personnel in the field of child welfare. Most title XX funds are focused on children's services such as child care and foster care, according to a Touche Ross study of 3 years ago. The recent growth in programs and in the need for programs in the field of child abuse and neglect further documents the need for more personnel in this field.

A recent University of Michigan study, "Social Work Personnel in the 1970's, further documents the need for trained social work personnel. It indicates that 53,000 bachelors and masters students in social work were graduated in the years 1970–73. It estimates the total number of openings for social workers with bachelor or masters degrees in the decade of the seventies to be 180,000. Thus, the rate of graduates

must be expanded to meet this demand. At current rates, there will be a shortfall of about 50,000 by 1980. This estimate is based on Department of Labor data and analysis contained in Tomorrows Manpower Needs. About 60 percent of the estimated need is in the field of services to families and children. Growth in programs such as title XX of the Social Security Act, child abuse and neglect, health services to children under national health insurance, or the present programs under titles V and XIX of the Social Security Act, confirm the estimates in the Michigan study sponsored by the council on social work education.

While the data and projected program growth in services indicate a shortfall in supply of trained social workers by 1980, we are not urging an expanded program in child welfare training, but a continuation of the $8.9 million level of fiscal year 1975 with strong report language as to the need to maintain the fiscal year 1975 balance between long-term and short-term social work training. We believe this level, which is about 5 percent higher than fiscal year 1974, will be adequate and we appreciate the problems created for this subcommittee by growing deficits.

I would like to turn to mental health training at this point. This year's level of funding was about 10 percent below the fiscal year 1974 level and the core disciplines of psychiatry, psychology, social work and nursing, all received cuts. While we are cognizant of the problems which deficits create for our economy, we do not believe that the mental health training program should be phased down as it has been for the last few years. In fiscal year 1972, the program was at a level of $120 million, while now it is at a level of $94 million. Yet, the current economic crisis alone is creating increased demand for mental health services. National health insurance will also stimulate future demand. The deinstitutionalization program encouraged by Congress and the administration creates major new demands for professional personnel to provide community based mental health services to the mentally ill and retarded.

The hard data also supports the need for more trained mental health personnel, particularly social workers. A recent NIMH study on the staffing of mental health facilities shows that 18 percent of full time staff are social workers. "Staffing of Mental Health Facilities 1972," NIMH. Correspondingly, 5 percent of full time mental health facility staff were psychiatrists, and 5 percent psychologists, according to the same study. About 22,000 social workers were in positions in mental health facilities in 1972. About 40 percent of those were in community based mental health programs.

Another very important fact: in treatment centers for emotionally disturbed children, social workers are by far the predominant professional service providers. In addition, social workers represent 24 percent of the staff of outpatient clinics and centers, the area of mental health services growing most rapidly.

The University of Michigan study and the Labor Department projections on which it is, to some extent, based, show a growing demand for social workers in the field of mental health also.

For these reasons, we urge you to support the mental health training program at a minimum level of $110 million, the level appropriated

in fiscal year 1974. Do not continue the phase down of this important training program. As you know, the Coalition for Health Funding has recommended this level also. The Mental Health Manpower Coalition has recommended $125 million. We believe this to be a needed level to assure the growth in manpower needed by 1980, but $110 million would be a reasonable minimum.

Thank you for allowing us to testify. I am available to answer questions.

Mr. FLOOD. Thank you.

Mr. SLAVIN. Thank you.

TRAINING AND RESEARCH IN THE REHABILITATION SERVICES ADMINISTRATION

WITNESS

JOSEPH SZUHAY, PRESIDENT, COUNCIL OF REHABILITATION COUNSELOR EDUCATORS; COORDINATOR OF THE REHABILITATION COUNSELING PROGRAM, UNIVERSITY OF SCRANTON, PENNSYLVANIA

Mr. FLOOD. The Council of Rehabilitation Counselor Educators.

Mr. SZUHAY. Mr. Chairman. My name is Joseph Szuhay, and I am president of the Council of Rehabilitation Counselor Educators. I am also coordinator of the rehabilitation counseling program at the University of Scranton in Pennsylvania. There are presently 83 rehabilitation counseling training programs in the United States.

My testimony today relates solely to the training and research items in the Rehabilitation Services Administration (RSA) budget. With regard to the Federal-State rehabilitation program and the innovation and expansion grant program, we fully support the position taken by the Council of States Administrators of Vocational Rehabilitation. We also support the request for facility improvement and staffing grants of the International Association of Rehabilitation Facilities. However, our major interest is the training program and our schools receive about 25 percent of the training support provided by RSA.

Due to the efforts of this subcommittee, the rehabilitation training program is alive and functioning. Efforts to phase out the program have ended and the major focus now must be on providing an adequate and consistent base of funding, enabling forward funding, and implementing peer review of training activities.

With regard to the level of funding, we are still troubled by the constant failure of HEW to spend in 1 year what is appropriated for training in that year. The Department constantly shuffles money from one year to another. Thus, it is impossible to hold HEW accountable for spending taxpayers' money in the training area. We are constantly confused by the difference between appropriations and program levels. In fiscal year 1975, $22 million was appropriated, and this subcommittee required that $6 million of fiscal year 1974 funds be expended in fiscal year 1975 in order to bring the program level to about $28

million. This is what the interested groups desired as well—a program level of about $27.7 million which represents the fiscal year 1972 level of funding. But, HEW then attempted to rescind $6 million and although the rescission failed, that $6 million will not affect the program level in fiscal year 1975—it will be obligated in fiscal year 1975 but expended in fiscal year 1976. The result again—a program level of only $22 million, not $28 million.

Now, the administration is requesting $22 million for fiscal year 1976. Together with the $6 million obligated in fiscal year 1975 but expended in fiscal year 1976, this appropriation will supposedly bring about a program level of $28 million. But, HEW never did this in fiscal year 1975; why should we believe them now? They will only seek to carry forward some part of the $28 million appropriation in order to keep the program level at $22 million.

We believe the only way to at least bring clarity to the financing of this program and to better assure a real program level of $27.7 million in fiscal year 1976 is to appropriate that amount.

Also, we would urge this subcommittee to put this program on a forward funded basis like almost all other education programs. As the fiscal year moves to October 1, for fiscal year 1977 education programs which are not on a forward funded basis, like rehabilitation training, will get their appropriations even further into the operating year. We urge you to include a full fiscal year appropriation in the appropriation for the intermittent quarter between fiscal year 1976 and the new fiscal year 1977. Thus, the appropriation for the quarter from July 1, 1976 to September 30, 1976, would include about $7 million for that quarter, and another $28 million for fiscal year 1977.

With regard to research, we support the Coalition for Health Funding in its request for $32 million. This only equals the fiscal year 1972 level of funding. As you probably know, a substantial part of this program's budget supports research and training centers. The research and training center program has been very effective, but has had only a limited impact since there are only about 14 such centers in the country. Only three of these centers are vocational in focus. An expansion of the research budget would enable the creation of a number of additional centers and would get the existing centers back to their original level. The requirements of the Rehabilitation Act of 1973 that the rehabilitation program focus on the severely disabled necessitates more research with improved vocational training and services for those who formerly were considered too disabled to work. Such research can have enormous economic payoff for the country. It is not ivory tower research, we seek, but applied research.

Finally, section 402.6 of the regulations regarding the rehabilitation program requires the establishment of a program of scientific and peer review for all research, training, and special project activities. HEW has delayed implementation of this program despite congressional interest in it because they claimed they had no funds to cover the administrative costs of such a program. Finally, they decided to use research and training funds, supplementing existing grants, in order to get the peer review program going. This may be a short-term remedy but it is no way to finance the program on a long-term basis.

We therefore recommend that the salaries and expense account of RSA include a specific item to cover the adminitsrative costs of establishing a peer review program for research, training, and special projects. We estimate this item at about $100,000.

We thank you for this opportunity to testify and I am submitting for the record a fact sheet showing the number of rehabilitation counselors trained, the number of applicants for traineeships who could not be funded, and the employment of counseling graduates, 50 percent of whom work for the State rehabilitation agency and another 25 percent of whom work in agencies providing services under contract to the State agency.

Thank you, Mr. Chairman.

[The attachments follow:]

Council of Rehabilitation Counselor Educators

1974-75 Fact Sheet

Introduction

This is the third year that the Council for Rehabilitation Counselor Educators have surveyed university rehabilitation training programs. The 1973 Fact Sheet projected the effect the loss of RSA funds would have on the training of rehabilitation workers whereas the 1974 Fact Sheet reported on the actual effects of the phase-out policy for the 1973-74 academic year. Although RSA funds were restored to the level prior to the phase-out policy, CRCE decided to continue collecting data on a yearly basis in order to maintain up-to-date information on our training programs, and to have current facts ready for presentation to governmental agencies, committees, and other interested bodies.

A Fact Sheet Committee was established this year, charged with revision of the questionnaire. In so far as possible, the revision resulted in a clear, concise questionnaire requesting factual information rather than respondents' impressions or opinions. The questionnaire was sent to 83 training programs initially in late January with follow-ups in February and March, 1975.

Sixty-one (73%) college and university training programs responded to the questionnaire. Three of these programs could provide no data because they were just in the process of being developed. Thus, this report contains data from directors of 58 programs, 47 located in public institutions and 11 located in private institutions. The report contains data from 11 undergraduate, 57 masters, and 16 doctoral programs. Information is provided on students, geographic scope of rehabilitation training, faculty, institutional and RSA support.

Students

A. Applicants

For the 1974-75 academic year, the programs surveyed received 6,063 applications and accepted 2,810 applicants for admission. Of these, 2,386 students entered training programs. Categorical breakdowns and percentages are given in Table 1. The major reason given for accepted applicants not entering training was lack of financial support (52%).

B. Current Students

In addition to the entering students, there were 2,647 continuing students in training for a grand total of 5,033 students in training for rehabilitation work. Categorical breakdowns, including special target groups and percentages, are given in Table 2. Students from special target groups (Black, Handicapped, Latino, Asian-American, American-Indian) account for 20.5 percent of all students. Masters (22%) and undergraduate (18%) programs have a far greater percentage of students in special target groups than do doctoral (5%) programs. Similarly, there is a greater reduction of females in doctoral (21.6%) programs as compared to undergraduate (38%) and masters (38.3%) programs.

With respect to RSA traineeships, there were 2,043 applicants and 1,138 awarded, all but a few awarded to masters level students. Women were awarded 575 (50.5%) traineeships and 328 (28.8%) went to students from special target groups. These percentages of traineeships awarded are significantly greater than the percentages of each group in the overall student population. However,

84 students dropped out of programs this year due to financial reasons, 32 of which were women and 13 from the target groups. The program directors indicated that an additional 507 full-time students could have been accepted this year without an increase in staff if an equal number of more traineeships were available.

C. Graduates

In the past two years (1972-1974), 2,925 students graduated from rehabilitation training programs. The graduates were almost equally divided between those supported by RSA (1,471) and those not receiving RSA traineeships (1,454). Program directors were asked how many of these graduates were working in the rehabilitation field. Data was reported for 3,227 graduates, 302 more than was indicated had graduated. The reason for this discrepancy is that some programs reported also on students who had graduated prior to the past two years. Nevertheless, the data obtained is presented in Table 3.

Several interesting observations can be gleaned from the figures in Table 3. The vast majority of graduates work in programs funded either directly or indirectly by the state/federal rehabilitation program (71%) with many of the remaining graduates performing in rehabilitation related work or continuing their education in rehabilitation training (21%). Moreover, graduates who received RSA traineeships tended to obtain employment in programs funded by the state/federal program (73%) more so than graduates who did not receive RSA support (65%). On the other hand, non RSA supported students tended to work more in rehabilitation jobs not funded by the state/federal program (18% vs. 13%) and, in fact, tended to not work in rehabilitation at all (9% vs. 7%) more so than RSA supported graduates.

Training and Geography

A concern expressed by many members of CRCE was whether rehabilitation was or should be national or regional in scope. To help in answering this question, data was obtained on the geographical areas from which current students resided prior to entering training, graduates resided prior to entering training, and graduates locating rehabilitation employment after completion of training. The results are presented in Table 4. It should be noted that approximately 11 percent of the students enter training programs which are located in an RSA region different from the one in which they reside and that almost 17 percent of the graduates obtain employment in a geographical location different from the RSA region in which the training program is located.

Faculty

The respondents indicated that there were 208 full-time faculty utilized by the training programs, 145 (69.7%) of which were on institutional or hard money budgets and 63 (30.3%) on RSA or soft money budgets. In addition, there were 161 part-time faculty, 125 (77.6%) on institutional budgets and 36 (22.4%) on RSA budgets. The program directors reported that 70 full-time and 3 part-time additional faculty members were needed to adequately cover the present needs of the training programs.

University Support

The percentage of total program budgets currently provided by university funds ranged from 10-100 percent with a mean of 55.7 percent. Included in university resources were travel funds for student supervision (26 programs), recruitment of students (16), recruitment of faculty and staff (27), staff

travel to conventions (32), and student travel to conventions (3). Program directors were also asked how their institutions would react if RSA support were reduced or eliminated. The responses are presented in Table 5. Based on experiences during the past few years when the phase-out policy was in effect, it is assumed that the responses are factual and no longer opinions.

RSA Support

Besides faculty and student support, RSA provides funds for support personnel in the form of clerical staff, research, teaching and work study assistants, and consultants. Only a limited number of such personnel (17%) would be continued by universities if RSA support was eliminated. Likewise, 58% of the programs would have to reduce or eliminate courses. Finally, a substantial number of special enrichment programs, now supported by RSA funds, would be severely cut back or eliminated entirely. The figures on special enrichment programs are presented in Table 6 and again based on experience with the phase-out policy, it can be assumed that these are factual, not opinion. The most profoundly effected would be special workships (82%), in-service training for agencies (77%), and student recruitment (75%).

Implications

The results of the 1974-75 Fact Sheet questionnaire lead to several conclusions, the most prominent ones mentioned here. Rehabilitation training programs receive a good many applications, primarily at the masters level. However, only slightly more than one-third of the applicants can be accepted with the present capabilities of the programs. Additional financial support is needed for faculty, staff, and traineeships. Several program coordinators commented that both faculty and clerical staff need to be bolstered just to meet the current needs of the programs. With respect to traineeships, students from special target groups receive a greater percentage of traineeships than their actual percentage of visibility within the programs. Even so, there are far fewer minority group students than is perhaps desireable. Again, several program directors commented that the precarious availability of RSA traineeships makes it difficult to attract members of the target groups. Another disadvantage is that qualified candidates, especially those of the target groups, have made other plans by the time training programs have been notified of whether or not support will be forthcoming from RSA and how many traineeships will be available. Two implications are clear. First, additional funds for personnel and students is drastically needed if adequate training is to be provided. More student can be trained and there are many desiring such training. However, whether the availability of additional funds should be used to develop new programs or should be provided for the enlargement of the existing, mature programs is a question still to be answered. Second, the ability of training programs to attract qualified members of the target groups via traineeships seems to imply the necessity of a forward funding approach. Programs need to know what is available, financially, in advance so that they can make realistic plans and commitments with prospective students and personnel.

Another finding is that trainees do, in fact, seek and obtain employment in the rehabilitation field upon graduation. The provision of traineeships, including their moral obligation, seems to be working in that those graduates who received RSA support during training appear committed to the field. Gratifying also is that graduates not supported by RSA appear committed to the field. The principle difference seems to be that the former group tend more to work directly or indirectly with the state/federal program.

Furthermore, the training of rehabilitation workers appears national in

cope and not limited to regional boundaries. A significant number of students, better than one-tenth, enter training programs in regions other than the one in which they reside at the time of application. An even more significant number of graduates, almost one-fifth, obtain employment in a region different from the one in which they were trained. It is clear that the trainees do not feel obligated to adhere to any regional constraints.

Finally, the findings imply that the adequate operation of programs is uniquely tied to the availability of RSA support. The reduction of RSA funds would severely reduce, and sometimes eliminate, various aspects of the programs even if university support were continued at the current level.

Submitted by:

Glen O. Geist, Chairman
Fact Sheet Committee
Illinois Institute of Technology

Committee Members:

Lawrence Feinberg, Syracuse University
William Graves, Mississippi State Univ.
Bob Johnson, University of Arizona
Ann Trotter, University of Wisconsin-Madison

TABLE 1

APPLICANTS FOR 1974-5 ACADEMIC YEAR

	Undergraduate	Masters	Doctoral	Total
Applied	860	4,798	405	6,063
Accepted	519	2,197	94	2,810
Entered	490	1,812	84	2,386

TABLE 2

CURRENT STUDENTS

	Undergraduate	Masters	Doctoral	Total	Percentage
Total	1,244	3,590	199	5,033	
Male	771	2,216	156	3,143	62.5
Female	473	1,374	43	1,890	37.5
Black	85	281	6	372	7.4
Handicapped	62	288	-	350	7.0
Latino	4	126	2	132	2.6
Asian-American	23	79	2	104	2.1
American-Indian	53	18	-	71	1.4

TABLE 3

EMPLOYMENT OF GRADUATES

	RSA Supported	Non RSA Supported	Totals
State/federal program (graduates directly funded)	963(48%)	545(45%)	1,508(47%)
Other rehabilitation program (indirectly funded by state/fed. program)	513(25%)	247(20%)	760(24%)
Rehabilitation related work (not directly or indirectly funded by state/fed. program, but who work for enhancement of the handicapped)	253(13%)	221(18%)	474(15%)
Continuing as student for advanced degree in rehabilitation	127(6%)	58(5%)	185(6%)
Not working in rehabilitation	145(7%)	105(9%)	250(8%)
Unknown	15(1%)	35(3%)	50(2%)
Totals	2,016(100%)	1,221(100%)	3,277(102%)*

* The total of 102% is due to rounding off.

TABLE 4

TRAINEE RESIDENCE COMPARED TO REGIONAL LOCATION OF TRAINING PROGRAM

	Geographical Location*		
	State	Region	Elsewhere
Current students prior residence	74.7%	14.7%	10.6%
Graduates prior residence	67.6%	21.3%	11.1%
Graduates employment	62.2%	21.1%	16.7%

* State means the state within which the respective training program is located.

Region means the RSA region within which the respective training program is located.

Elsewhere means outside of the region within which the respective training program is located.

TABLE 5

UNIVERSITY RESPONSE TO REDUCTION IN RSA FUNDS

Response	No. of Programs
Complete withdrawal of university support	4
Continue current level of university support, but no additional funds	39
Increase support to fully compensate for teaching funds, but not for student funds	13
Increase support to fully compensate for both teaching and traineeship funds	1
Provide additional student support, but no increase in faculty funds	1

TABLE 6

EFFECT OF REDUCTION IN RSA FUNDS ON SPECIAL ENRICHMENT PROGRAMS

Program	Currently Offered	Continued by Univ. at Same Level Without RSA Support	Reduced or Eliminated
Agency consulting	29	10	19
Instructional aids	21	6	15
Publications	16	9	7
In-service training for agencies	30	7	23
Extension courses	16	10	6
Special workshops	28	5	23
Student tutoring	5	3	2
Research support	11	3	8
Student recruitment	24	6	18

Program Respondents

University of Alabama
University of Arizona
Arkansas State University
University of Central Arkansas
Boston University
Bowling Green State University
California State University, Fresno
California State University, Sacramento
California State University, San Diego
California State University, San Francisco
University of Connecticut
East Carolina University
Eastern Montana College
University of Flordia
The George Washington University
University of Georgia
Georgia State College
University of Hawaii
Hofstra University
University of Illinois
Illinois Institute of Technology
Indiana University-Purdue University
University of Iowa
Kansas State Teachers College
Kent State University
University of Kentucky
Memphis State University
Michigan State University
Mississippi State University
University of Nebraska
University of New Hampshire
Northeastern University
Northwestern State University
Oklahoma State University
Oregon College of Education
University of Oregon
The Pennsylvania State University
University of Pittsburgh
University of Puerto Rico
The University of Scranton
Seattle University
Seton Hall University
University of Southern California
Southern Illinois University
University of Southwestern Louisiana
University of Southern Mississippi
Springfield College
St. Cloud State College
STate University of New York at Albany
State University of New York at Buffalo
Syracuse University
Texas Technological University
The University of Texas at Dallas
The University of Texas at Austin
University of Utah
Virginia Commonwealth University
Wayne State University
West Virginia University
The University of Wisconsin-Milwaukee
Wright State University

Mr. FLOOD. Thank you.
Mr. SZUHAY. Thank you.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

WITNESSES

JOHN K. MacIVER, MILWAUKEE, WIS., PRESIDENT, NATIONAL COUNCIL ON ALCOHOLISM
MIKE GORMAN, DIRECTOR, WASHINGTON PUBLIC POLICY OFFICE

Mr. FLOOD. Mr. John MacIver, the president of the National Council on Alcoholism.

Mr. GORMAN. I am Mike Gorman. I am here to introduce Mr. MacIver, a distinguished lawyer from Milwaukee in the State of Wisconsin.

Mr. FLOOD. You have been here before.

Mr. GORMAN. Yes, sir.

STATEMENT OF JOHN K. MACIVER

Mr. MACIVER. Mr. Chairman and members of the committee: I could spend the time allotted to me, and 10 times more than that, outlining the severity of the problem of alcoholism in this country today, but I have a feeling that since 1971, when the National Institute on Alcohol Abuse and Alcoholism came into actual being, you have heard from a number of witnesses on the size of the problem of alcoholism, the economic costs to the Nation of this disease, the increasing alarm about teen-age drinking, and so on.

The National Council through its prior presidents has been testifying for years now, predating the alcoholism legislation, always in support of public legislation in this field.

As I say, I could spend the time allotted to me, Mr. Chairman, outlining the severity of the problem but you have heard that many, many times before since 1971.

Mr. FLOOD. You finally made it a drug, anyhow.

Mr. MACIVER. Yes, sir.

Mr. Chairman, rather than a cascade of statistics, let me quote excerpts from a recent letter to a nationally noted syndicated columnist which says more than all the graphs and charts about this disease:

> I'm a teen-ager, one of several kids. Our father is an alcoholic. I can't tell him how I feel, so I wrote it down. I hope you will print my thoughts. My father reads your column every day. It might help him and other fathers who are alcoholics.
>
> I've been watching him die since I was old enough to understand. His death is slow and painful, painful not only for him, but for his wife and family. I think dying slow is much worse than dying suddenly. I don't understand why he does it.
>
> Why should a person want to die before he has to? I know it isn't because he doesn't love us. We have our little disagreements, but doesn't everyone? And I know for sure that he loves my mother. Of course, they argue, but doesn't every married couple?

I don't hold it against him. He's sick.
We love him so very much ! It's killing us watching him die.

In a capsule, this is the problem before us, and some may want to look at the dark side of the moon and say it is all hopeless. I say with all the conviction at my command, as an individual citizen and as president of the largest voluntary organization in the field of alcoholism, that the moneys you have appropriated to the NIAAA have made possible the beginnings of tremendously significant inroads against alcoholism.

Let me cite just a few carefully documented results of what your appropriations have meant to the NIAAA and to the suffering alcoholic in the very short history of this program.

(1) On March 12 of this year, we received the first followup study of alcoholics treated in the alcoholism treatment centers which you funded. There are 44 of these treatment centers at the present time, and in calendar year 1974 they treated approximately 11,000 men, women, and children. The highly prestigious Stanford Research Institute was asked by the administration to do a study in depth of treatment outcome during the past 18 months. The major conclusion of the study pointed out that approximately 70 percent of individuals who went to these alcoholism centers showed varying and, in many cases, dramatic reductions in alcohol intake—including a high percentage in certain categories who achieved total abstention.

For example, the Stanford study noted that among the heaviest drinkers there was a truly remarkable drop in alcoholic consumption from 70 percent to 22 percent. The number of individuals totally abstaining by the last month of the survey was 46 percent, an increase from 12 percent when the survey began 18 months before.

Commenting on the SRI survey, Dr. Morris Chafetz, Director of the NIAAA, described the conclusions of the study as "startling and remarkable * * * It is absolutely the most hopeful kind of data to share with the American public because, if anything, it reaffirms what we have been saying—that alcoholism is a very treatable illness.

(2) NIAAA also maintains its own monitoring system on all phases of its program. These data are in essential accord with the findings of the Stanford survey and are highlighted by remarkable documentation showing that individuals who participated for at least 6 months in either an alcoholism treatment center or a labor-management program showed a 56 percent abstention rate, while drinking drivers reported a 35 percent abstention rate.

Mr. Chairman, these two surveys do not deal with the moderate social drinker. They deal with individuals, both men and women, who have had an average of 11 to 15 years of very heavy drinking. They came into the alcoholism treatment center or the labor-management program in the factory because they were desperate for help.

Mr. Chairman, statistics don't begin to suggest the personal tragedies caused by alcoholism—the broken families, the lost jobs, the heartbroken children, et cetera. All of us know of someone whose life has been smashed by alcohol. But you are the main force which is allowing us to begin to turn the corner—to get a handle on this highly treatable disease.

(3) Let me give you a couple of examples of the impact of what your appropriations have done in the short period of time the institute has been in existence.

(a) The drinking driver program—this is a very modest program considering the size of the problem, with general agreement that approximately 50 percent of our highway deaths and 1 million accidents each year are caused by drunken drivers. The alcohol and public safety branch of the NIAAA has been able to fund only 24 treatment projects aggregating $4 million. Yet, even with this modest sum of money, an independent survey concludes that over 90 percent of these driving while intoxicated—DWI—drivers either significantly reduced their consumption of alcohol or gave up alcohol altogether. Data show that at 6 months after the drinking driver enters a DWI school or other treatment facility he is either abstaining or drinking less than 1 ounce of alcohol per day. The success of this program, even though it is so very limited by funds, is indicated by the fact that the largest number of referrals of alcoholics to all treatment facilities—not only DWI school—now comes from court and jail officials. More and more judges are willing to suspend driving licenses for shorter periods of time if the driver is willing to undergo treatment, because they know revocation of driving licenses, for example, means little or nothing to alcoholic individuals who will ignore any law in their pursuit of alcohol.

Mr. Chairman, we are proud of this small program, but we know that it will have to become many times larger than it is if it is to have any significant impact, but tremendously successful program in this area. Furthermore, the termination of the alcoholism safety action projects of the Department of Transportation—very helpful to the NIAAA but largely restricted to the identification of the drunken driver—means that we will reach an even lesser percentage of individuals than now.

(b) Through your appropriations and your support, the NIAAA has made sensational progress in an area which was once thought hopeless—heavy drinking among the American Indians and Alaska Natives. We are all familiar with the stereotypes that practically all Indians are drunks, that they cannot hold their liquor, and it is therefore hopeless to put them into any kind of treatment program. With your appropriations support, the NIAAA has conducted a modest program in this area since its inception. A January 1975 evaluation of this program points up some remarkable results.

Fifty percent of Indian alcoholism program clients recover and become productive citizens.

Approximately 20 percent get jobs through the program. This is especially important with exceedingly high rates of Indian unemployment.

Most remarkable, approximately 100 Indian Alcoholics Anonymous groups have been established in the past 3 years—an almost unbelievable achievement. One must realize that there were no AA groups among our Indian population prior to the establishment of the Alcoholism Institute.

Is all of this outlined above an expensive program or even one that is a drain on our present besieged economy?

On the contrary. As all of you well know, the Institute on Alcohol Abuse and Alcoholism is one of the smallest Institutes in the Public Health Service.

Furthermore, several independent surveys of its operations have demonstrated that the NIAAA, operating on the very tightest of

budgets, has cut the costs for alcoholism dramatically where its impact has reached.

The most clearcut saving is in hospitalization. Before the advent of NIAAA, the usual handling of the alcoholic was jail or, for the affluent ones, an expensive hospital or sanatorium bed. Among the patients in the alcoholism treatment centers, there were approximately 2,400 less hospitalizations than in the previous year. Managament personnel and workers involved in industrial programs showed an even greater drop in hospitalization, approximating 45 percent. We have no hard figures yet in the labor-management area, but those patients attending the alcoholism treatment centers increased their income by more than $11 million in 1974 alone.

Mr. Chairman, I can assure you that in my own personal experience, and in that of other members of the board of directors of the National Council on Alcoholism, all of these projects I have described operate at a marginal economic level. First of all, early intervention pays off handsomely in reducing project costs. Treating the individual with a long drinking history is more than twice as expensive as treating a patient who has been drinking heavily for less than 5 years.

The NIAAA is now down to the point where its overall cost for treating the drinking driver is $52 per client.

Second, the Institute has made very imaginative use of alcoholism counselors—many of them recovered alcoholics themselves—in staffing their various programs.

Mr. Chairman, I append to this statement the budgetary recommendations of the National Council on Alcoholism for the NIAAA for fiscal year 1976. It is a modest budget, much less than we would like to recommend, but we are aware of the present state of the economy, and I suspect, much less than you may have seen from others making presentations.

If I may, I particularly commend to your attention our recommendation for $85 million for project grants. These are the programs which I have described above. They are people-to-people programs, and they will have the greatest impact in the years to come in reducing the cost of alcoholism.

Mr. Chairman, we go back a long way, long before there was alcoholic legislation, and we are a voluntary board and I think we are sensitive to the incredible demands that are made on this committee and on the Congress at this time, which is one of the reasons we have suggested the figures we did suggest.

I thank you for your attention.

[The attachment follows:]

NIAAA—COMPARISON OF 1976 PROPOSED ASSOCIATION WITH FISCAL 1975 BUDGET

	1975 appropriation	1976 administration request	NCA recommendation
Alcoholism:			
Research	$10,997,000	$9,047,000	$12,000,000
Training	7,847,000	6,958,000	10,500,000
Community programs:			
Project grants and contracts	64,908,000	45,451,000	85,000,000
Grants to States	52,000,000	45,600,000	65,000,000
Management and information	10,163,000	7,143,000	12,000,000
Total alcoholism	145,915,000	114,199,000	184,500,000

Mr. FLOOD. Thank you.
Mr. MACIVER. Thank you.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

WITNESSES

DR. GEORGE E. SCHREINER, PROFESSOR OF MEDICINE, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE; DIRECTOR, RENAL AND ELECTROLYTE DIVISION, GEORGETOWN UNIVERSITY HOSPITAL, WASHINGTON, D.C.

DR. PAUL LACY, MALLINCKRODT PROFESSOR AND CHAIRMAN, DEPARTMENT OF PATHOLOGY, WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, ST. LOUIS, MO.

DR. EVAN CALKINS, DIRECTOR, DEPARTMENT OF MEDICINE, EDWARD J. MEYER MEMORIAL HOSPITAL; PROFESSOR AND CHAIRMAN, DEPARTMENT OF MEDICINE; AND DIRECTOR, ARTHRITIS RESEARCH AND TRAINING PROGRAM, STATE UNIVERSITY OF NEW YORK, BUFFALO

DR. WILLIAM F. DONALDSON, CLINICAL PROFESSOR OF ORTHOPEDIC SURGERY, UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE; PRESIDENT, THE AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS; MEMBER, NATIONAL ARTHRITIS COMMISSION

Mr. FLOOD. Dr. Paul Lacy, School of Medicine, Washington University, St. Louis; Dr. George Schreiner, professor of medicine, Georgetown University; Dr. Evan Calkins, chairman, department of medicine, State University of New York at Buffalo; Dr. William Donaldson, president, American Academy of Orthopaedic Surgeons.

Who takes off?

STATEMENT OF DR. GEORGE E. SCHREINER

Dr. SCHREINER. Mr. Chairman, it is a pleasure to be here. I am Dr. Schreiner, professor of medicine, at Georgetown, and past president of the American Federation of Clinical Research, the American Society of Nephrology, and the American Society for Artificial Internal Organs; National Kidney Foundation, and a number of other medical organizations.

I have with me Dr. Lacy, one of the country's outstanding pathologists and expert in diabetes; Dr. Evan Calkins, who is chairman of the department of medicine, State University of New York at Buffalo, who is an internationally known expert in arthritis and amyloidosis; and Dr. Bill Donaldson, who is an orthopedic surgeon and happens to be from the great State of Pennsylvania. We have a prepared statement and if I may, I would like to submit that.

Mr. FLOOD. Yes, without objection, we will do that.

[Dr. Schreiner's statement follows:]

Mr. Chairman and members of the committee: It is a pleasure to appear before you today as a citizen witness with a deep concern for the funding of programs of the National Institute of Arthritis, Metabolism, and Digestive

Diseases (NIAMDD). My name is Dr. George E. Schreiner. I am professor of medicine at Georgetown University and director of the nephrology division. I am a consultant to the Walter Reed Army Medical Center, the Veterans' Administration, and the NIH. I am past president of the American Federation for Clinical Research, the American Society for Artificial Internal Organs, the American Society of Nephrology, the National Kidney Foundation and I am currently first vice-president of the International Society of Nephrology.

I am a member of such scientific organizations as the American Society for Clinical Investigation, the Society for Experimental Biology, the Association of American Physicians, the American College of Physicians, and the American Clinical and Climatologic Association.

Your committee, in the past, has shown an intelligent and constructive interest in kidney disease, which ranks as the fourth leading cause of death in this country and costs in excess of $1.5 billion each year in treatment and lost manpower.

Kidney and urologic diseases often claim their victims during the height of economic productivity and during the reproductive period in females producing great tragedy in the families which are involved.

As you know, a substantial portion of the financial burden for the maintenance of life in end stage renal disease has been lifted by the passage of the Medicare amendments, which became effective July 1, 1973 and which defined end stage renal disease as a form of disability and made the victims eligible for the disability provisions of Medicare.

The Federal Government through the social security fund is currently supporting this program at the approximate level of $6 million per week. Because of the magnitude of the problem of kidney disease and the enormous economic impact of applying the effective treatment to thousands of afflicted individuals, it is quite obvious that the Federal Government should feel it imperative to spend a proportionate amount of money in locating patients with treatable kidney diseases which might be reversed at an early stage, in learning more about the cause and the mechanisms by which kidney diseases develop, in seeking ways of preventing acute kidney diseases and more importantly in preventing their progression to the chronic stage and in seeking better ways to deliver the care for end stage renal disease which is mandated in the Medicare law.

One of the best channels for such research expenditures would be to embark on a long-range well-defined mission for the National Institute of Arthritis, Metabolism and Digestive Diseases.

I come before you then to suggest that added emphasis be given to a program in the institute which would have the following three specific objectives in addition to those already being supported. No. 1: Intensive coordinated research in the diseases which are most involved in producing end stage renal patients. No. 2: Designing and implementing epidemiologic studies that would tell us something about concentrations of renal disease in ethnic groups, in geographical clusters, in specific ages and sexes, and particular environmental atmospheres. No. 3: Within the National Institute of Arthritis, Metabolism and Digestive Diseases specific programmatic emphasis and continuous overview must be exerted on overlap areas involving other Institutes of NIH and those programs which indirectly relate to kidney disease programs.

Some of these can easily be identified and examples would be (a) hypertension, (b) immunologic diseases of the kidney, (c) diabetes, (d) gout and other metabolic diseases, (e) toxic nephropathies from chemicals in our food and environment, and (f) developmental anomalies such as polycystic disease.

I am sure that in recent weeks you have heard detailed estimates and testimony from officers of the National Kidney Foundation addressing some of these problems in depth.

I would like to add my personal support to the programmatic recommendations put before you by the National Kidney Foundation.

To approach these objectives in depth represents a wider horizon for the Institute and will require some supplemental funds. This Institute traditionally has supported research in kidney disease, nephrology, and urology with extramural research grants as the largest single component of kidney disease—related research among the various Institutes of NIH. In addition, for the past decade, the artificial kidney—chronic uremia program of the NIAMDD established by Congress in 1965 has been devoted specifically to improving artificial kidneys and dialysis methodology and to relevant studies of irreversible kidney failure and

uremia. At the present time, this excellent program supports 75 research and development projects with universities, nonprofit laboratories, and industrial research organizations. The thrust of this program is to focus on several problem areas including clinical trials of more efficient and less costly dialyzers, development of special absorbents for uremic toxin, studies to lucidate the metabolic changes in uremia, and the maintenance of a national registry for all patients undergoing chronic dialysis.

Many research projects are also devoted to an understanding of the pathophysiology of uremia in an effort to prevent or control clinical complications in patients who are maintained by means of an artificial kidney. The future success with practical management of patients with end stage kidney disease and the complications thereof depends in a large part upon such research and the program is particularly concerned with the reduction in cost and the increase in clinical effectiveness for the implementation of the expanded Medicare program.

We are rapidly approaching the point where 20,000 individuals in America will be dependent upon such machines for day-to-day living. Such treatments are carried out in hospitals large and small across the land, in outpatient facilities, in free standing satellite facilities, in the home, in portable traveling units and in a truly remarkable and wide variety of patient-medical settings.

We are very fortunate in nephrology to have an alternate method of treatment for selected patients with end stage renal disease. Throughout the world over 18,000 kidney transplants have been performed with organ survival ranging between 45 percent to 80 percent for 2 years depending upon whether the organs are supplied by cadavers or by matched living donors.

Our rehabilitation of both dialysis and transplant patients has been remarkably good with a very substantial percentage of patients able to return effectively to their previous mode of life or work. Indeed we have a substantial number of Government employees in the Washington area in all walks of life, an economist, a research scientist, a television cameraman, individuals with a wide range of important skills and occupations carrying on their work for the Federal Government after a successful transplantation or with a well-designed dialysis program.

In transplantation we are aiming toward a better understanding of how the cells responsible for immunologic rejection really work and how they call in other cells to help produce the reaction which may ultimately end in rejection of the transplant as a foreign protein. If we can learn enough about this rejection to be able to interrupt it at specific designed points in the process, then the transplant kidneys may function better for a longer period of time. And with each such extension of life, the unit cost for maintaining a patient will be markedly reduced. Some few recipients are now in their second decade following surgical transplantation of a kidney. We must study these long survivals so that we can duplicate it on a predictable and broader segment of the transplant population. We are also working to improve the techniques in harvesting organ donations and preserving cadaver kidneys for proper matching with a suitable recipient for transportation to distant recipients in order to improve the chances for obtaining a near perfect match and in order to extend the time that kidneys might be kept so that someday we will have a true kidney banking mechanism.

Mr. Chairman, the proposed President's budget for this Institute will result in major cutbacks in research on kidney diseases. I am well aware of the economics of inflation and of the necessity to hold down Federal spending. This is the negative side of the coin. However, if one group of diseases—those of the kidney and urinary tract—is the leading cause of absenteeism and loss of productivity in the newest and most rapidly growing segment of the work force, namely women, can we really afford not to do research in that group of diseases? Can we afford to accept the present losses of productivity?

Unlike the majority of chronic diseases, kidney disorders are particularly likely to cause death to patients in their middle, productive years. The social and economic impact of kidney diseases, therefore, is out of proportion to that which one could expect from simple analysis of the bare statistics, though some of the statistics are frightening enough.

Because urinary tract and kidney diseases are very common in the years between 30 and 50, the most productive time of life for most people, it is an economic as well as a health problem. The effects of such disorders result in approximately 770,000 workdays lost and 1.8 million days of bed disability. Additionally, more than $1 billion is spent each year for hospital and nursing home care, professional services, and drugs.

In order to get a greater understanding of kidney disease, much more needs to be done in basic research, the foundation upon which the entire complex of all biomedical science rests. Unless fundamental inquiry is kept strong and continually renewed in strength, there will quickly be nothing to develop and nothing to apply. A flexible science is indispensable to a productive science. I believe that the opportunities for advance in basic science are greater than ever before, and with your endorsement and support, we may well see fruition of vigorous exploration of these opportunities.

The proposed fiscal year 1976 presidential budget is about $25 million below the level of the fiscal year 1975 budget for the NIAMDD. This means that considerably less research than ever before will be supported in the future. This simply does not make economic sense in the face of an expanding young population and our necessary expenditures for treatment.

The needs of this Institute are very great since its responsibilities cover most of the serious and chronic, disabling diseases of mankind. Unfortunately, the administration budget proposed for NIAMDD for fiscal year 1976 is grossly inadequate for the task, particularly in light of the numerous legislative mandates which Congress has put to the Institute such as the National Arthritis Act, the National Diabetes Mellitus Research and Education Act, and the Cooley's Anemia Control Act.

My colleagues and I are submitting to you a citizen's budget which has been carefully thought out to meet the research and training needs of the Institute. We urge you to consider an appropriation sizable enough to turn the Institute program in the directions which I have mentioned and to maintain the enormous progress which has already been achieved. In the citizens' budget we have also asked for a considerable increase in the number of positions and in the manpower ceiling for NIAMDD without which adequate pursuit of ongoing and especially new efforts will be impossible.

FISCAL YEAR 1976 BUDGET PROPOSED BY CITIZENS FOR THE NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

[Dollar amounts in thousands]

	1975 Estimate		1976 President's Budget		1976 Citizens' Proposal	
	Positions	Amount	Positions	Amount	Positions	Amount
Extramural:						
Research grants	.....	$120,421	.....	$103,546	.....	$148,200
Centers	.....	2,816	.....	2,862	.....	4,000
Fellowships	.....	3,386	.....	4,109	.....	6,200
Training	.....	9,088	.....	235	.....	4,700
Research and development contracts	.....	7,405	.....	6,750	.....	8,500
Total extramural	.....	143,116	.....	117,502	.....	171,600
Direct operations:						
Laboratory and clinical research	432	22,709	432	23,462	479	24,902
Epidemiology, biometry and field studies	18	1,289	18	1,298	18	1,298
Research management and program services	116	6,007	106	6,147	119	6,450
Total direct operations	566	30,005	556	30,907	616	32,650
Total	566	173,121	556	148,409	616	204,250

The task ahead of this Institute—solution of multiple, serious health problems—is enormous and only with your support and adequate funding will we be able to achieve a better future less beset by death and disability, so that our fellow citizens already developing chronic kidney disease and our children who face similar prospects might reap the benefits of your compassionate planning.

I ask you to earnestly consider our budget recommendations which basically call for spending a very modest proportion of our current treatment expenditures in the area of basic research, so that hopefully, in the not too distant future, we may witness a constructive reduction of such expenditures through effecting cures and preventing the life threatening conditions which today we must necessarily treat in order to extend productive life.

I do appreciate the opportunity to appear before you to express my views and to join them with those of my colleagues.

Thank you, Mr. Chairman.

Dr. SCHREINER. I would also like to make three very, very brief comments.

One is that the Congress in its wisdom, and you have been very, very cooperative with us over the years and very responsible in your decisionmaking in this area, has seen fit to put into the National Institute for Arthritis, Metabolism, and Digestive Diseases a number of new mandates.

In very recent times these have included the National Arthritis Act, National Diabetes Act, and National Cooley's Anemia Act. At the same time the Office of Management and Budget takes away the money so we are in kind of a position of being a lifeboat in which the captain of the ship, which is you, keeps putting in people and the budget office keeps taking out the seats at the same time, and once in a while makes holes in the bottom.

The second point I want to make is that, again thanks to congressional wisdom, we have lifted the enormous financial burden of kidney disease from the American people by covering end stage kidney disease treatment under the disability provisions of medicare.

We are now spending out of social security $6 million a week for the care of end stage renal disease. It makes simple good sense that there should be a proportionate research approach to the diseases that produce end stage kidney disease.

If we can prolong a life even for 1 year we are saving enormous amounts of the taxpayers' money out of the Social Security Trust Fund. Therefore, we would like to see the National Institute of Arthritis, Metabolism, and Digestive Diseases stress the major diseases that lead to end-stage kidney diseases and also continue the artificial kidney and transplantation programs which have been so effective in treating this form of disease which, as you know, hits many young people in their most economical productive years and women in their reproductive years and causes many disasters within families.

The third quick point I want to make is that we have prepared a citizens' budget which is very realistic and not extravagant at all. It calls for restoring some of the inordinate cuts that have been made in the administration budget so we can hold our own in research and training and in the artificial kidney contract program. It calls for restoring some of the job slots which are absolutely vital in order to administer the Institute.

Mr. Chairman, we are glad to be a lifeboat. We are glad to have you put people in it. We would just like you to put back some of the seats.

Thank you, sir.

Mr. FLOOD. All right.

Who is next?

STATEMENT OF DR. PAUL LACY

Dr. LACY. I am Dr. Lacy, chairman of the department of pathology at Washington University.

I have a prepared statement and then if I may I would like to make a few additional comments.

Mr. FLOOD. Yes.

[Dr. Lacy's statement follows:]

Mr. Chairman and members of the committee: I appear before you today to speak on behalf of the research and training activities of the National Institute of Arthritis, Metabolism, and Digestive Diseases, and particularly its diabetes program. My name is Paul E. Lacy, and I am a doctor of medicine, having obtained my degree from the Ohio State University School of Medicine. I am the Mallinckrodt professor and chairman of the department of pathology at the Washington University School of Medicine in St. Louis, and pathologist-in-chief of the Barnes and Allied Hospitals and St. Louis Children's Hospital. I am a winner of the Banting Award from the American Diabetes Association and the British Diabetes Association, and I was recently appointed to the National Commission on Diabetes by the Secretary of Health, Education, and Welfare. I am thoroughly familiar with the activities of the National Institute of Arthritis, Metabolism, and Digestive Diseases, having served as a member, and, subsequently, as chairman of the NIH Diabetes and Training Grants Committee. I am a member of the American Diabetes Association, International Academy of Pathology, and many other professional organizations.

Mr. Chairman and members of the committee: I consider it a privilege to testify before you today on behalf of the National Institute of Arthritis, Metabolism, and Digestive Diseases. Because of your past interest and concern the battle being waged by our Federal Government against disease and disability has been so productive. I commend you specifically for the continuous support you have given to the vital programs of the National Institutes of Health (NIH). This world-renowned biomedical research agency has become the veritable symbol of our country's efforts to achieve better health for everyone. Through its support of biomedical research, research training, and construction of research facilities, as well as through its own intramural laboratory and clinical research, the NIH has made—and will continue to make—valuable contributions toward man's conquest of disease.

My specific intent today is to discuss the progress being made by one of the NIH components, the National Institute of Arthritis, Metabolism, and Digestive Diseases or the NIAMDD. This Institute is performing admirably its task of obtaining new biomedical scientific knowledge needed to control the many and diverse diseases within its province of responsibility, the first of which, historically, are the arthritis disorders, which are probably responsible for more crippling and discomfort than any of the other ills of man. In addition to research on arthritis and diseases of metabolism such as diabetes, disorders for which the Institute was originally established, it has continued to expand its activities in other major research areas. These now include the digestive diseases such as peptic ulcer, many hereditary metabolic disorders such as cystic fibrosis, endocrine gland diseases, disorders of the blood, liver, bone, and diseases of the kidney and urinary tract, orthopedics, dermatology, nutrition, and many others. It is self-evident that this is an extremely broad area of responsibility. I am sure that in the future the Institute will continue to approach its many research problems with confidence that it can aid materially in solving some of the major physical ills of mankind.

The solution of these ills will be no small task, as the complexities of biomedical research are exceeded only by the complexities of the human body itself. Productive laboratory experiments and clinical trials require time, labor, patience, diligence, persistence, and the drive to go on despite frustrations and seeming dead-ends. These laborious and meticulous processes, however, provide the foundation on which progress in medicine is built. And this lifepreserving progress will continue to occur as long as research institutions such as the National Institute of Arthritis, Metabolism, and Digestive Diseases are enabled to carry on their work.

In discussing the specific accomplishments of this Institute during the past year and the directions of future research, I will devote my time largely to diabetes research because this is my own special field of interest. For almost 20 years, my research efforts have focused primarily on diabetes and related problems. I consider this to be one of the more fascinating and challenging fields of medicine today. Because of the hereditary aspects of diabetes and the fact that it involves many of the body's organ systems, the study of this disorder encompasses the fields of biochemistry and metabolism, pathology, medicine,

genetics, neurology, ophthalmology, nephrology and others. Although the research of recent years has yielded important information about the disease process and valuable new methods of treatment, basically diabetes still remains an enigma.

The disorder results from a built-in error in the body's metabolism. Individuals affected by this serious disease are predisposed to it by their hereditary background. The most obvious chemical defect in diabetes is the body's inability to metabolize carbohydrates normally. As a result, the diabetic is unable to utilize efficiently the carbohydrates he consumes, that is turn them into heat or energy needed for normal body functioning, or store them in form of glycogen. Instead, the carbohydrates, converted into glucose, accumulate in blood and tissues and spill over into the urine. Primarily, this occurs because of a diminished activity or availability of insulin, a hormone produced by the pancreas, although many other factors are now known to be involved. Not only may there be an eventual decreased production of insulin, but there may also be initial periods of overproduction of insulin, stimulated by a basic impairment in the normal activity of this hormone. Moreover, there is a growing belief that a hormone antagonistic in its actions to those of insulin—glucagon—which is produced in abnormally large quantities in dabetes, contributes to the abnormal metabolsm and disease picture in this disease. Disturbances in the metabolism of fats and proteins accompany the defect in carbohydrate utilization. Side by side with these basic metabolic disturbances are the many well-known, serious clinical symptoms and pathologic manifestations in the body of the diabetic patient, which involve the large and small blood vessels of the body and underly the many serious complications of diabetes, from premature coronary heart disease through blindness.

Authorities now estimate that there are approximately four and one-half million diabetics in the United States alone. Another 5 million in our country are potential diabetics, persons who, because of an inherited proclivity, may develop the disease sometime during their lives. Of the total world population, 30 million are suffering from diabetes, and a large segment of the Earth's population carries the inherited trait for it.

As I noted earlier, I am a member of the National Commission on Diabetes. This body was established by the National Diabetes Mellitus Research and Education Act enacted by the Congress in July 1974. The Commission is formulating a long-range plan for a coordinated research effort by seven Institutes of the National Institutes of Health against diabetes. The plan will be forwarded to the Congress when it is completed later this year.

I should note at this point that this legislation, with respect to funding, provides authorizations only. Provision of funds in support of the purposes of the act will depend ultimately on your recommendations and the appropriations process in the House and Senate, once the national diabetes plan has been drawn up.

Furthermore, a lack of funding for the enhanced diabetes activities will simply draw needed funds and personnel from other essential Institute areas. In the meanwhile the Institute badly requires funds and additional manpower to begin enhanced diabetes-related activities. The currently proposed President's budget for fiscal year 1976 is $25 million below the level of the fiscal year 1975 budget of the Institute and does not suffice to continue its ongoing research and training activities. Needless to say, it does not begin to permit any enhanced activities in diabetes—which the Congress has voted in the National Diabetes Act. I would urge you most strongly to view with favor the plan drawn up by the National Commission on Diabetes when it is submitted to you for appropriation recommendations. It would indeed be tragic if the Congress for any reason fails to appropriate the funds necessary to implement and follow through to completion the major provisions of this particular legislation.

The past year has been a highly productive one in diabetes research, and the National Institute of Arthritis, Metabolism, and Digestive Diseases has played a vital role in this progress. Studies conducted in Bethesda or supported by the Institute and carried out at other biomedical research centers have continued to increase in a very meaningful and useful way the body of knowledge concerning this complicated disease.

This ongoing research has several major thrusts, and I would like to mention each one briefly. The first, and most important to me, concerns attempts to ameliorate or even "cure" diabetes via transplantation of healthy insulin-

producing "beta" cells. My colleague at Washington University, Dr. Walter Ballinger, and I have been involved in such research for the past few years, during which time we have overcome many obstacles. There are many more obstacles to overcome, however.

I can report to you now that we have achieved some success in actually "curing" diabetes by implanting such cells into the livers of diabetic rats via injection into the portal vein. This approach has led to a marked fall in blood sugar levels and abnormal urine output, restoration of weight gain, and near-normal results in specific diabetes tests. This clinical improvement in the diabetic state has remained for 18 months.

More recently, transplantation of beta cells from normal monkeys to diabetic monkeys has resulted in improvement of the diabetic state in the animals. This animal model now can be used for additional long-term studies before similar transplantation procedures in human subjects are considered. Such research in humans at the present time would be premature, since techniques must be developed for the mass isolation and preservation of human islets, the optimum site of transplantation must be established and the problem of tissue incompatibility must be pursued through animal experimentation.

Another area of diabetes research I would like to mention is the idea that diabetes may result from a lack of insulin coupled with an excess of glucagon, instead of from insulin deficiency alone. Glucagon is a hormone produced in the pancreas that stimulates release of sugar from the liver and tends to elevate blood-sugar levels.

Dr. Roger Unger, a NIAMDD grantee at the University of Texas, was the first to propose that diabetes is characterized by an excess of glucagon. Many other investigators have verified this and glucagon excess has been linked to susceptibility to infection, to which diabetic patients are prone, and to diabetic ketoacidosis, a severe complication of uncontrolled diabetes which requires emergency therapy.

More recently, other Institute-supported scientists have shown that infusion of a hormone secreted by the brain—somatostatin—results in a lowering of both blood glucago and sugar levels. Moreover, preliminary experiments indicate that somatostatin combined with insulin may be more effective than insulin alone in decreasing elevated blood-sugar levels in diabetic patients, suggesting that somatostatin may prove to be a useful therapeutic adjunct to insulin. This ongoing research is also revealing several new aspects of the mechanism of the natural history of diabetes.

One of the most basic and valuable activities of NIH and NIAMDD, next to their direct research studies and broad support of extramural research, has been the effective training program which has continually brought promising young scientists into the forefront of research and academic teaching of medicine. Many of the advances in our knowledge of diabetes and many of the top teachers and practitioners in this field are the direct or indirect product of the diabetes training program of NIAMDD.

Intelligent planning for the education and training of manpower for future care of diabetic patients is obviously desirable and, in fact, essential. What is required now is provision for a continuing supply of highly motivated individuals for teaching and research so that our understanding of diabetes continues to grow and our new insights are disseminated in usable, stimulating forms to undergraduates, interns, and residents, and all practicing physicians dealing with this complex metabolic disorder. It is to these young scientists that my generation of physicians must look to insure that the millions of dollars and the years of dedicated service we have already invested in campaigns against disease are not wasted.

I am sure that it is obvious from what I have said so far that I support fully the programs of the National Institute of Arthritis, Metabolism, and Digestive Diseases and the vital role thay play in the advancement of American medicine. Unfortunately, the administration budget for fiscal year 1976 for the Institute is woefully inadequate; it does not even permit the Institute to continue what it has started in vital biomedical research. Unlike many another enterprise, biomedical research cannot be turned on and turned off at will like a water faucet. The lead-time to obtain meaningful advances in biomedical research is exceedingly long; if it is interrupted arbitrarily through fiscal restrictions or the shifting of biomedical research money from one field to another, then precious years of preparation are lost, momentum is lost, promising future research workers are lost.

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Mr. Chairman and members of the committee, I am fully in accord with the citizens' budget introduced by my colleague, Dr. Schreiner. This budget although realistically on the lean side, would still permit the Institute to maintain its current research momentum. My colleagues and I urge you to study it seriously when you formulate your own recommendations for the fiscal year 1976 budget for this Institute. If you, like we do, believe in the need for a better future with regard to health—if not for us then for our children—I am sure you will do all in your power to support the continued productive activities of this Institute with an adequate and realistic budget along the lines proposed in the citizens' budget. I also urge you strongly to include in the language of your budget recommendations ample provision for additional positions for this Institute and to increase the manpower ceiling for the Institute accordingly. Without them, NIAMDD cannot begin to embark on any of the new activities which are included in its marching orders in the new National Diabetes and Arthritis Acts.

Again, Mr. Chairman and members of the committee, I would like to express my appreciation for your continued interest and support and for the privilege of testifying here today.

Dr. LACY. What I would like to do in these few minutes is to hit the highlights of some of the research accomplishments in diabetes.

As you may know, the problems that face the diabetic today are the complications of the disease, complications affecting the eye with blindness, the kidney with renal failure, the cardiovascular system with myocardial infarction.

Also, as you may know, these complications go on in spite of our present form of therapy with insulin. So the key question is if these are complications where is the primary defect in the diabetic subject?

From the evidence available now it appears that it is in the islet cells of the pancreas. These are the cells that produce insulin. Stated simply, it appears that these cells are sluggish in their responsiveness to blood sugar.

They don't put the insulin out fast enough or quick enough to permit the body to handle sugar normally. So the long-term objective in the research in this area is to find out what are these defects, and knowing them, try to prevent them, correct them, and change them if we can.

On the way to achieving that objective obviously you have to know how the normal islet cell responds to blood sugar, and this is an area in which I have been working for some period of time.

Very simply stated, the advances that have been made in the past few years are fantastic. It is now apparent the sugar molecule reacts with the surface of the islet cell, turns on the movement of little packets of insulin inside the cell, which then dumps the insulin to the outside into the blood, in a beautifully organized system; in the diabetic something is wrong, and this process is imperfect.

There are still defects in our knowledge of this area, but nevertheless it is now possible to go to the normal human islet to see whether the animal is like man and then, secondly, to proceed toward the diabetic. That is a long-term objective.

What can you do on a short-term basis? I have said the defect is in the islet cells so that the obvious approach is to replace the defective cells.

My colleague and I, Dr. Ballinger, have attempted just that, to isolate islet cells from a normal rat, put them into diabetic animals, and revert their diabetic state to normal.

This opens the way toward research in man but in leading toward

man there are still many, many problems. There are problems of getting out a sufficiently large number of islets, transplanting them into the right place in the diabetic, and also there is the incompatibility problem which results in transplant rejection, so all this is still in the experimental stage.

The second way would be to create an artificial islet cell which would sense the level of glucose in the blood and would inject the necessary amount of insulin. The same problems apply as in islet transplantation, and all this is under investigation in many laboratories now with promise for the future but not yet ready for application in man.

The third area that I want to mention because it is a very new one is that it has been shown recently that in the diabetic subject there is a hormone, another hormone produced by the islet cell, that is antagonistic to insulin and therefore may be involved in causation of diabetes—in addition to lack of insulin or sufficient insulin action. It is called glucagon. It is found in very high levels in the diabetic.

As so often happens in basic research, in a totally unrelated area there has been a substance isolated from the brain and it has been shown this substance will cut off this hormone glucagon, will lower its secretion by the islets, so it opens a new way then of approaching the disease.

You could use this substance secreted by the brain, and is called somatostatin, together with insulin in the therapy of the diabetic. Also in some cases there is the possibility that somatostatin might decrease what is causing the complications in the diabetic.

These are only some of the highlights of the area but I hope they do give you a flavor of what is going on. I hope they also indicate the diversity of medical personnel involved, experts in biochemistry, physiology, and I could go on and on and on.

All this indicates the need for manpower in this area. It also indicates the need for funds for this basic research. A comment on basic research funding: You cannot turn it on one year and turn it off the next. A basic research laboratory has highly skilled professional personnel and highly skilled technical personnel using sophisticated equipment.

If there is no funding that laboratory is dismembered and it requires, even if you get the funds 6 months later, about 2 years to reestablish where you were before. So I support the citizens' budget introduced earlier by Dr. Schreiner.

The curtailment in the President's budget, of $25 million from the current budget would have a drastic effect on ongoing research.

My last point, as you may know, I am a member of the National Diabetes Commission. From a personal standpoint this has been a gratifying experience because for the first time I have been able to hear from the public of diabetic patients and I am amazed at what they say. They understand.

They understand the need for basic research in this area. They understand that a cure is not around the corner. It is a long way down the line and they accept this and they also understand the need for adequate funding.

As a final point, we will be submitting a plan from the National Diabetes Commission at the end of the year. I hope when you consider

that plan that you will provide the necessary funding but not by taking it from other disease areas in this Institute, which is responsible for multiple disease areas. Also, I hope that in deciding the fiscal year 1976 budget you will be certain to include a sufficient number of new positions and a rise in the Institute's manpower ceiling so that there are adequate numbers of personnel positions in this Institute to implement the plan, and to carry on its important work in all disease areas.

I thank you very much for your kind attention and for your continued interest and support of this area.

STATEMENT OF DR. EVAN CALKINS

Dr. CALKINS. Mr. Flood, my name is Evan Calkins.

I am chairman of the department of medicine at State University of New York at Buffalo. For the last 23 or 24 years my particular area of interest has been in rheumatology or arthritis, a field in which I became interested when I was in Boston and have continued to maintain an interest in this in Buffalo where I am now chairman of the department.

I have also been fortunate enough in serving as president of the American Rheumatism Association.

I have prepared a summary of my testimony which, if I might say, I would like to give to the secretary for recording in the minutes, if I may.

Mr. FLOOD. Yes, that will be done.

[Dr. Calkins' statement follows:]

Mr. Chairman and members of the committee, I appear before you today to speak on behalf of the activities of the National Institute of Arthritis, Metabolism, and Digestive Diseases. My name is Evan Calkins and I am a doctor of medicine. I earned my degree at Harvard Medical School. I am professor and chairman of the department of medicine and director of the arthritis research and training program at the State University of New York at Buffalo. I am also director of the department of medicine at the Edward J. Meyer Memorial Hospital at Buffalo, N.Y. I was formerly director of the arthritis unit at the Massachusetts General Hospital and a member of the faculty at Harvard Medical School. I am a former president of the American Rheumatism Association. My experience in the past has included internship and residency at the Johns Hopkins Hospital, chief residency in medicine at the Massachusetts General Hospital, and a National Research Council fellow in biochemistry at Harvard Medical School. I am presently a member of the American Rheumatism Association, the Central Society for Clinical Research, the American Society for Clinical Investigation, the Association of American Physicians, and other organizations. I am also a member and have served as secretary-treasurer of the Association of Professors of Medicine, an organization which includes the chairmen of all of the medical schoools in this country.

I have been associated with the extramural program of the National Institute of Arthritis, Metabolism, and Digestive Diseases as a member of the Arthritis Training Grants Committee from 1958 to 1962. On that committee, we reviewed applications for graduate training grants and advised the Council of the Institute on matters relating to training in the connective tissue diseases. I also served as a member and subsequently chairman of the Program Project Committee of the NIAMDD. This committee reviewed applications and conducted site visits on centers seeking support for interdisciplinary research programs related to the entire range of scientific and clinical areas in which the NIAMDD maintains an interest. As a member of the special study section (to evaluate physician manpower), Division of Research Grants of the NIH (1969–71), I was privileged to visit many of our newer medical schools and consider requests

for support of experimental programs aimed at improving our national reservoir of medical and scientific manpower. I have also served as a member of a special committee established to review experimental interdisciplinary programs seeking to provide broad scientific training to young investigators interested in the various areas of scientific concern of the NIAMDD.

Throughout the past 20 or more years, my primary concern has been medical education, and the interface between patient care, medical education, and biomedical research.

I appreciate the opportunity to speak to you today. I thought that I would focus my discussion under five main points.

1. Arthritis is a major national problem affecting 20 million Americans.
2. We are making progress, in this difficult field, stemming directly from our widening knowledge of biomedical research in arthritis and related areas.
3. The most effective care of the arthritis patient requires a team approach—physicians, surgeons, immunologists, and members of the health-related professions.
4. The inadequacy of resources presently available to us to develop arthritis teams in our major medical centers across the country, is a primary problem. This shortage has been compounded by major reductions in research training funds and in grant support for individual investigators.
5. The need for the appropriation of funds to implement the National Arthritis Act (Public Law 93-640) is immediate.

I. THE SIZE OF THE PROBLEM

Arthritis is a big problem. An estimated 20 million Americans suffer from one or more of the many forms of arthritis; 3.5 million people are so seriously disabled from the various forms of arthritis that their major activities are severely limited. This compares with an estimated 3.6 million who are similarly limited in activity as a result of heart disease. Approximately 1 million people, in this country, are reported to be unable to work because of arthritis. Disability payments due to arthritis are rapidly approaching $750 million annually and are expected to climb to more than $1 billion annually by the end of the decade.

Several years ago, a cost of illness study of arthritis estimated that, in terms of income loss, plus the cost of treatment, arthritis is a $9 billion economic millstone. A staggering $400 million of this amount, incidentally, is spent each year on worthless cures and quackery.

In terms of suffering, and of cost, arthritis is clearly a major national health problem.

II. BASIC RESEARCH

The key to progress in the fight against arthritis.

During the years that I have been privileged to spend as a physician and rheumatologist, I have seen enormous developments in the field of rheumatology. These include a much greater understanding of the nature of these diseases, and also, and even more important, a much more effective approach to treatment.

I cannot, of course, attempt to cite all of these advances, but I would like to mention as an example, the vital role played by immunology in many of the forms of arthritis, especially rheumatoid arthritis and related disorders. This relationship can best be illustrated by considering one of the major forms of connective tissue diseases, systemic lupus erythematosus, a rheumatoid arthritis-like condition which is found primarily in young women, and which is being seen with increasing frequency. Starting with the demonstration of the so-called "LE cell" approximately 20 years ago, researchers have shown that this disease, lupus erythematosus, is caused by a so-called "autoimmune reaction", in which a person developes antibodies to components of his or her own tissue. In the case of this particular disease, the antibodies may be to any of a number of components of the cell—the nucleus, the nucleolus, the cytoplasm, and so forth.

Step by step, researchers have shown precisely how the antibodies combine with the cellular components and act so as to cause damage to vital organs.

It has now become possible to predict, on the basis of these immunologic events, which organs will be involved, and, to some extent, when. For example, if we consider two patients with what appears, clinically, to be the same disease, one may be able to enjoy a long symptom-free life, while the other may face a rapid development of fatal complications. Yes, arthritis can be fatal. We can now begin

to predict, based on our immunological studies, who will follow one course and who will follow the other.

These developments are not being carried a step further. By careful followup of our patients in the light of these immunologic data, it is becoming clear that the immunologic changes antedate and anticipate the clinical developments. By gearing our so-called "immunosupressive therapy" to these laboratory changes, we are able to prevent the flareup of disease which would otherwise occur. In this manner, the modern rheumatologist, backed by the appropriate laboratory support, is able to contribute significantly to the well-being and longer life of his patients.

Another example, which has probably been stressed in former presentations before this group, are the great advances now possible in the treatment of gout. As a result of the research conducted over the course of the past 20 years or so, it is now possible to prevent the painful arthritis which formerly accompanied gout, and also to prevent the kidney complications of gout which, in former years, caused premature death of many patients.

Parallel advances are being made in several of the other rheumatic diseases. Significant advances are now beginning to be made in that particularly stubborn condition—rhematoid arthritis. Specially, as with systemic lupus erythematosus, we are beginning to learn which patients are apt to go on to exhibit the destructive crippling effects of this disease, and we are also learning how vigorous medical management, early in the disease, can help prevent or at least defer these complications.

We are also learning how appropriate surgical intervention, early in the course of disease, can significantly lessen the eventual crippling. And when crippling does occur, we have totally new approaches to management as a result of the dramatic advances in the field of reconstructive surgery.

III. THE TEAM APPROACH

These advances carry with them a great responsibility—the responsibility of making them available to the many, many arthritis patients across our country. In former days, it was not quite so important as it is today to make the correct diagnosis of the type of arthritis. Once the diagnosis was made, there was not much that we could do about it.

Now these new approaches to management require a much more sophisticated approach to the problem. The diagnosis must be correctly established and systematic program of management must be designed—a program which inevitably relies on several related disciplines. As a result, it is very difficult, if not impossible, for patients with severe arthritis to receive effective treatment by a single physician. Instead, we must rely on teams, which include a variety of specialists. Specifically, a team of this sort should include several physicians especially trained as rheumatologists; at least one orthopedic surgeon, skilled in this particular area; a competent immunologist, alert to the rapid developments in this field; possibly a pediatrician, since many of our patients are children; a physiatrist—a physician specially interested in rehabilitation, together with necessary support personnel—physical therapists and occupational therapists, a rheumatology nurse practitioner, and part-time social worker. The social worker is important because of the serious disruption frequently caused by these severe crippling diseases on the entire household of which the arthritis patient is a member.

Of course, teams of this sort cannot be established in every town across the country. Every major population center, however, should have an effective team of this sort to aid practicing physicians in the care of their patients. For obvious reasons, most such centers are and should be associated with medical schools, where they can benefit from the participate in the spirit of inquiry characteristic of university medicine. Furthermore, in the medical school setting, these centers can contribute, most effectively, to the education of physicians, nurses, and the various forms of health related specialists.

Our goal, therefore, is the establishment of arthritis centers in as many as possible of the 114 medical schools across the country.

IV. WHERE DO WE STAND NOW?

Our present starting point in quantitative terms is fairly advantageous. Seventy-six of these medical schools (67 percent) already have some form of

rheumatology program. On the other hand, approximately one-fifth of these programs rely solely on a single full-time rheumatologist—scarcely the sort of team which we believe is necessary for the task at hand. Approximately one-half of all medical schools have staff of two or more rheumatologists which is, at least, a good start.

On the other hand, 38 medical schools, approximately one-third of the total, have no full-time rheumatologist on their faculty. Twenty-nine of these are State schools, and the rest are private. In certain cities, Boston, New York, Philadelphia, Baltimore, and Los Angeles, all of the medical schools have rheumatology programs. Yet there are vast areas of the country with no regional rheumatology program at all.

More significant than the lack of rheumatology programs, is the fact that, over the past 5 years, a dwindling number of programs have been able to maintain effective research and training activities because of lack of support.

Let us look, for the moment, at the number of research grants, in rheumatology, currently funded by the NIAMDD.

ARTHRITIS RESEARCH GRANTS, 1975

	Total grants	Estimated number of investigators per grant	Total investigators
Program project	9	15	135
Individual	[1] 152		152
Total			287

[1] This figure is to be compared with 167 individual grants in 1974.

In other words, throughout our country, there appear to be at the most 287 researchers, funded by NIAMDD, who concern themselves with the problem of arthritis. This a pretty small group to be tackling a problem of this magnitude. It might also be noted that the institutions receiving these arthritis grants were confined to 29 of the 50 States. 54 percent of the research support went to 22 (30%) of the institutions.

Another perspective is provided by a study of the number of investigators-in-training in our country today. The next table shows the number of rheumatology fellows currently being trained in our various teaching hospitals. A survey was conducted by the Arthritis Foundation of a number of teaching hospitals across the country. One hundred and fifteen hospitals responded.

TEACHING HOSPITALS WHICH HAVE ARTHRITIS RESEARCH FELLOWS

	Number	Percent
Teaching hospitals:		
With arthritis research fellows average fellows per hospital (1.6)	21	18
Without research fellows	94	87
Without clinical fellows	66	58

Since, by definition, one cannot have research fellows without having funded research, these data suggest that the research effort, in rheumatology, is concentrated among approximately 25 percent of the university-based units. Seventy-five percent of the units have no research fellows.

In addition, the total number of young people training themselves to contribute to education and research in this field is perilously small. In the 115 responding institutions, the total number of research fellows was only 34. Since, even with the best training program, a certain number of these fellows will not go on to academic careers, it is clear that the need for an immediate increase in the available manpower for the expanded research mission detailed in the National Arthritis Act should be at the highest priority.

Of course, this shortage of young people who are committed to careers in arthri-

tis research could have been predicted by those who have been watching the course of the NIH training grants program which for so many years provided the Nation with outstanding biomedical research talent in this field. The next table shows the trend which has taken place since the early days of the second Nixon administration.

Arthritis training grants

1973	24
1974	24
1975	15
1976	7

There does not seem to be any conclusion which one can draw other than that there has been a deliberate attempt by the recent administration to discourage medical research, with the notable exception of cancer and heart. It has even seemed possible that it was decided to accomplish this objective by the specific avenue of cutting of training grants and other support to young investigators. For if one keeps new people from entering medical research, applications for research support will clearly fall off.

IV. A NEW APPROACH—THE NATIONAL ARTHRITIS ACT

Fortunately, Congress has, at last, taken a decisive initial step to begin to close this gap between the magnitude of the need and the modesty of our effort in arthritis research. The act represents a Federal commitment to confront the massive problem of arthritis in this country by a magnitude twice that presently provided by the NIAMDD.

Time does not permit me to detail all of the features of this act, but I would like to mention just a few. First, it establishes a National Commission on Arthritis and Related Musculoskeletal Diseases—which has just held its second meeting—and authorizes this commission to undertake a broad study of how best to launch a major attack against arthritis. We hope that the House conferences will accept the Senate amendment to the second supplemental appropriation bill for fiscal year 1975 which would provide $300,000 to support the activities of this arthritis commission.

Second, it acknowledges that, to get the program underway, attention at the outset should be devoted to the development of arthritis centers which have the capability to develop a broad interdisciplinary approach to the management of rheumatic diseases—teams of the sort which I have outlined above. In many instances, these centers would emerge from those arthritis programs which currently maintain effective research and educational activities, some of which are now fighting, against considerable odds, for their continued existence. In the committee's consideration for support of these new centers, I would like to recommend the addition of funding, in amounts of up to $750,000 a year, for each center, in order to permit it to stabilize its present strength, to broaden its research base, and to undertake quality education programs at all levels. These should include medical students, house staff, future investigations, members of health related professions, and physicians in communities neighboring to the center. Funds should be provided which will insure at least four research and clinical fellows for each center.

Third, the act authorizes limited grants in the amount of $75,000 to $100,000 to medical schools which do not have effective arthritis units at the present time. It should be noted that, under this program, a school may select a promising faculty member, and enable that person to undergo further training in the area of rheumatology so that he or she will be qualified to start up or expand an arthritis unit.

I must stress the fact that this act, which holds so much promise, will be effective only if it is given funds. In addition to the funds required for the extramural programs of the sort outlined above, it is extremely important that additional support be provided for the intramural activities of the NIAMDD. We estimate that administrative aspects of the extramural grants program, outlined in the National Arthritis Act, will require approximately five additional positions. An additional three positions would be necessitated by contract activities incident to this program. I understand that legislation authorizing a somewhat similar program in the area of diabetes has also been requested. This, too, would require between five and eight additional administrative staff positions. In addition, the intramural program of the NIAMDD should be

strengthened in order to provide personnel for the intramural orthopaedic research program proposed in the National Arthritic Act. I therefore am asking you to include in your recommendation for fiscal year 1976, an increase in the manpower ceiling of the institute of at least 30 positions. It would be most unfortunate also, if, through failure to provide additional funding for these positions, it should be necessary to further deplete the research personnel who are, at present, carrying out the important intramural research mission of the NIAMDD.

In conclusion, Mr. Chairman, on behalf of those of us who are committed to the fight against arthritis, I would like to express my appreciation to Congress for recognizing the need for a stronger program to combat the crippling and life threatening diseases which we include under the term arthritis, through passage of the National Arthritis Act. We now hope that this initial step can be coupled with authorization of the funding necessary to make this important program a reality. I am familiar with the citizen's budget introduced by my colleague Dr. Schreiner, and am in accord with it. I am also familiar with the proposed administration budget for fiscal year 1976 which is $25 million below the current fiscal year 1975 level of expenditure of the institute of $173 million. The proposed budget of $148.4 million means a severe reduction in this institute's important work. The citizen's budget represents realistically the true fiscal and manpower needs of this institute and of our national biomedical research effort. I seriously commend it for your consideration when you formulate the fiscal year 1976 budget for this institute.

Mr. Chairman and members of the committee, I appreciate your continual interest and support and the privilege of testifying here today.

Dr. CALKINS. Rather than reiterating those points I thought I might just outline what I have tried to say in the written statement with a few points of emphasis.

First, I wish to stress that which I know something about, and with which I know you are familiar, and that is the importance of arthritis to citizens of this country. We estimate that at least 20 million Americans have various forms of arthritis, which is a group of diseases of many kinds, many sorts, and affects a lot of people.

Three million six hundred thousand people are limited in their activities to a significant degree because of arthritis. One million are unable to work because of arthritis, and we have estimated that $750 million is required annually for disability payments for people disabled due to an arthritis.

We feel many of these people could be restored to useful life with further developments in this field.

Second, I wish to stress the importance of basic as well as applied research in the development of our attack against arthritis, and to present three examples of many that could ge given: gout, lupus erythematous, which is a fatal disease particularly affecting young women, and the more common and very crippling disease, rheumatoid arthritis—all are examples where both basic and clinical research are paying off in significant improvements in our ability to treat and to attack these problems.

Third, I have emphasized that in this complicated field we can really make progress only as a result of a team approach—with a mixed team such as for example the team you see before you today, although we happen to be interested in different facets of medicine, one is a pathologist, two happen to be internists, and one is a surgeon.

This is the kind of team that is being used now to approach many of these chronic diseases, and to this team in the area of rheumatology we need to add some input in immunology, a very important basic science that relates to this field, and also people that are skilled in pediatrics because many of our arthritic patients are children.

It is the team approach in research that has made it possible for us to move ahead in this field.

The remaining three points have related to our ability to muster this team. When I began in this field about 22 years ago there were only three centers in the country that had any real capability to attack the problem of arthritis. That was the time when this institute began to develop its program of support in this area.

Initially a great deal of progress has been made through the arthritis training program which I am sure you are familiar with and which was very important in developing our ability to attack arthritis in many centers around the country.

I took this opportunity to review the present status of the manpower status of rheumatologists, our ability to approach this problem. We now have at least one rheumatologist in 76 medical schools of the 120 medical schools in the country, but in many of these schools the rheumatologist is all by himself and it is only about 25 of these centers where we have a real ability to approach this problem in any kind of a broad-scale fashion.

In these 25 centers the funding, in recent years, is seriously limited due to the limited NIH support. I am happy to say that several of these centers are in your State of Pennsylvania and one center is now being established in Mr. Obey's State of Wisconsin where Dr. McCarthy, one of our colleagues in rheumatology, has recently been appointed chairman of the department of medicine.

We would like to see the development of more arthritis centers. We would like to see the development of a broader frame of support so that the benefits of a team approach can be brought to Americans across the country. It provides for a commission which will review the no centers of this sort.

We would like to see improved support for the basic research in this field which will enable us to do a better job. It is in this regard that we are very enthusiastic about the National Arthitis Act which was developed by Congress and signed by President Ford, I believe it was in December.

This act will substantially strengthen our attack against arthritis across the country. It provides for a commission which will review the problem, for core support to permit these centers to become more stable and develop their educational as well as research programs, and for seed money support for new centers and new programs in areas where we do not have any.

Again, we are concerned about the budgetary prospects of this institute as indicated by Dr. Schreiner. The curtailment in the budget that is proposed under the President's budget would be a drastic disappointment both for continuation of the present research and training programs and it would seem to provide little, if any, prospects for any funding for the National Arthritis Act or for the National Diabetes Act and for the expanded program in Cooley's anemia, all new programs which have been mandated by the Congress.

So I would like to lend my full support to the citizens' budget which was recommended in Dr. Schreiner's testimony and is presented in more detail there and I would like to also emphasize the need to provide for additional manpower positions, both intramurally and for the research management and program services in the Institute.

If we are going to even maintain our present programs or begin new ones we must have some more provision for additional manpower at the Institute. At the present time they are able to maintain their major operation only by drastic curtailing of other operations such as the clinical research unit at the Indian Health Service Hospital in Phoenix, which conducts a productive research program among the Indians in arthritis, diabetes, and digestive diseases, and the arthritis pathology program of the Institute which had to be abandoned because of a decrease in the manpower ceiling alotted to the Institute.

We do need an increase in the manpower authorization for the Institute and we need your earnest consideration of the citizens' budget which I would like to commend to you.

Thank you, sir, for this opportunity to testify.

Mr. FLOOD. Thank you.

STATEMENT OF DR. WILLIAM DONALDSON

Dr. DONALDSON. Mr. Chairman, Congressman Conte, it is a pleasure to appear before you today.

I am Dr. William Donaldson. I am president of the American Academy of Orthopaedic Surgeons and clinical professor of orthopedic surgery and member of the National Arthritis Commission.

I, too, have written testimony which I will submit for the record and I would like to take just a few minutes to highlight certain portions of that testimony.

We were all pleased when Congress passed the National Arthritis Act and, as you are well aware, the orthopedists and rheumatologists work in close cooperation in this particular area of endeavor.

If the provisions of the act and the recommendations of the Arthritis Commission are going to have their full impact on our attack on arthritis, there must be an increase in the manpower ceiling of this Institute, in NIAMDD, to accomplish these things and we would strongly urge that your committee direct the establishment of the position of Associate Director for Arthritis and Related Musculoskeletal Diseases as provided for in the act and that the necessary staff and funds be appropriated.

In addition, this act calls for an intramural program in orthopedic surgery. This is a new provision and again will require new staffing. A chief is needed for the new intramural program in orthopedics and at least two professional associates and appropriate supporting staff, and, as noted in the Arthritis Act, the minimum amount of budget for this should be $500,000.

I would like to take just a few minutes to present an example of the type of research that will be performed in this Institute, in the intramural program specifically. That has to do with joint replacement, a subject which you, Mr. Chairman, are well aware of.

I attended the Lasker awards when you were the featured speaker and Dr. John Charnley received one of these awards for development of the first successful artificial hip joint. Probably one of the most exciting things that has occurred in medicine in many years has been the development of such total joint replacement.

Our successes are greatest in the hip and then in the knee, and then

as we go to spread this exciting surgical rehabilitation to other joints we find many problems to be solved.

Among these are included the design of the prostheses, but even in the hip where we have had such outstanding success we are still dealing with problems such as wear.

When one looks at the total hip joint replacement the metal ball is mirrorlike in appearance and shiny. The plastic socket looks smooth and without any irregularities. Yet microscopically these are not so. Their surfaces are irregular and, therefore, as time passes, wear does occur and this has a detrimental effect upon the joint.

So we need to develop better surfaces. Particularly as we start applying this technique to older but yet very active athletic type of individuals who demand more of their joints, we find that wear is becoming an increasing problem.

We would hope eventually to be able to apply this technique to the younger person with the expectation that the replaced joint would in fact last him for the rest of his life and not have to be replaced.

We have an additional problem in these artificial joints in that they tend to loosen over time and this again is in part related to the tremendous amount of stress that the more active person applies to the implanted joint but also to the fact that the material that we use to fix the artificial part to the bony structure is not in fact a glue.

Therefore, the bonding between the implant and the bony surface is imperfect and stays there only because of the irregularity of the surface. There is current research going on to find not only new materials but also materials which are porrous, that human tissue will grow into, a honeycomblike structure, so that eventually the fixation of the implant is better.

Then we still have the problem of breakage with repeated use, due to stress that everybody applies to their hip joints as they go about their normal activities, and particularly if they try to do laboring type of work this does cause fatigue in the metal and in a certain percentage of cases the metal then breaks and, of course, then the implant is defective.

This is one of the types of exciting research that can be done now within the NIAMDD and particularly in the future intramural program. I, too, would like to recommend to you the citizens' budget as presented by Dr. Schreiner. We do appreciate your past efforts on behalf of this Institute.

Thank you.

[Dr. Donaldson's statement follows:]

Mr. Chairman, I am Dr. William F. Donaldson, the current president of the American Academy of Orthopaedic Surgeons, a society of over 6,800 orthopedic surgeons. I am clinical professor of orthopedic surgery at the University of Pittsburgh School of Medicine and a member of the National Arthritis Commission. With me is Dr. Edward Henderson, professor of orthopedic surgery at the Mayo School of Medicine, and chairman of the Mayo Clinic's department of orthopedic surgery. He is the first vice president of the American Academy of Orthopaedic Surgeons and will succeed me as president.

It is a pleasure to appear before you and the committee to present information relative to the appropriations for the National Institutes of Health and, in particular, the National Institute of Arthritis, Metabolism, and Digestive Diseases. I am familiar with the citizen's budget introduced in previous testimony by Dr. Schriener and I support it.

Orthopedic surgery is that branch of medicine concerned with the care of the disabilities, illnesses, and deformities that can befall the musculoskeletal system. A significant portion of our endeavors have a close relationship to and are often performed in coorperation with the rheumatologists. I am aware of their needs and support the testimony presented today by Dr. Calkins.

Research in the field of orthopedic surgery deserves significantly more support than it has received to date. We were all most gratified when the Congress, in its wisdom, recognized this need and directed the establishment of an intramural orthopedic program within the NIAMDD as a provision within the National Arthritis Act of 1974. I wish to speak first to the need for an appropriation specifically earmarked to enable this intramural program to become a reality. To initiate this most important step to advance orthopedic surgery, and thereby improve the care of our citizens, there should be established within the NIAMDD additional positions of a Chief of the intramural orthopedic program, two professional associates, and the appropriate supporting staff. A budget of at least $500,000 for fiscal year 1976 would appear to be the very minimum requirement. Among the projects that this intramural program will address itself to are the design of new and improved artificial joint implants, the biomechanics of joint function, the changes that occur in a joint that may develop or has developed osteoarthritis, and improved modalities in fracture treatment.

The presence of an intramural program in orthopedic surgery will materially enhance the already productive work being performed within the intramural program in arthritis. Close coordination and cooperation will occur between these two programs in their areas of mutual interest. To further this type of cooperative coordinated effort, both within the Institute and without in the extramural activities of the NIAMD, it is most important that the new additional positions and an appropriate increase in the manpower ceiling for the Institute be directed by you to fill the position of Associate Director for Arthritis and Related Musculoskeletal Disease as provided for in the National Arthritis Act of 1974.

As a member of the National Arthritis Commission, I have been deeply involved in its activities. I can assure you that it is a hard-working commission that will produce a report which will provide the means for the implementation of the attack on arthritis, the sole intent of the law. Adequate appropriations, as previously mentioned, are required so that the well-thought-out provisions of the act which Congress passed last year may become a reality. Certainly the amounts suggested appear appropriate but represent modest sums in proportion to the medical problems involving over 20 million of our citizens who have arthritis. As a direct result of the implementation provisions in the National Arthritis Act, the suffering, the disability, the economic loss to our citizens and to our Nation will be significantly reduced. The lives of our patients suffering from arthritis will become more productive, persons will be returned to employment, disabilities will be reduced or eradicated, and the cost of medical care for these patients reduced.

Earlier I stated that orthopedic research deserves your support. I would like to expand upon this by illustrating some of our successes, some of our needs, and indicate where at present we are falling short of these perceived needs of our patients.

One of the landmarks in the history of medicine has been the development of the total joint replacement and its application to our patients, particularly those with arthritis. Total hip joint replacement has become the most successful way of rehabilitating joints severely damaged by arthritis. While our successes are many and the procedure is developing widespread acceptance, there are still many unsolved problems with which orthopedic research must deal. Wear of the parts is still a problem, particularly when the procedure is applied to younger people who are more active, more demanding of their hip joints. A person severely afflicted by rheumatoid arthritis, while markedly benefiting from a successful procedure, is often severely limited by other joint difficulties or by systemic involvement. We must develop joints which will last a lifetime for the active, athletic younger working person whose hip joint is damaged and replacement is required. In addition to wear, we also have the problem of fixation of these implanted artificial parts. New fixation materials must be developed. Current experience shows that the use of ceramics or cintered metals, while exciting, is far from practical for clinical application. As this modality of treatment is applied to other joints, we have new design problems to solve. For example, we

have a greater problem in dealing with the stability of the knee joint and in developing an appropriate arc of motion in it than we do in the hip. As we try to expand this technique to the ankle, the shoulder, the elbow, the wrist, and the fingers that are severely damaged by disease or by trauma, we are faced with a new series of problems requiring extensive investigation before this most exciting means of surgical rehabilitation can be successfully applied. Cooperative investigations with bioengineers to meet these needs are mandatory.

Our current understanding of how joints function and what goes wrong to cause the development of osteoarthritis is woefully meager. Osteoarthritis is the most common form of arthritis affecting the citizens of this country. It is no longer acceptable to say that this is just a part of growing old. Too many of our citizens suffer, are disabled, are limited in their activities, and are limited in their employability to tolerate such indifference. This was well recognized by the Congress as evidenced by the provisions of the National Arthritis Act. Current efforts must be expanded to provide further understanding of the biomechanics of joint function, of alterations in gait, and of the physical, chemical, and cellular changes that occur in the joints afflicted with osteoarthritis. These studies should eventually lead to the understanding of what can be done to reduce the incidence and lessen or eliminate the disability that occurs with the degeneration of joints damaged by trauma, by athletic endeavor, by disease, and by everyday activities that all of us engage in.

Another area of research opportunity I would like to highlight is fracture healing. In this country over 2 million fractures occur each year. Recent work suggests that fracture healing may be accelerated by passing an electrical current across the fracture site. Such studies are a necessity if we are going to reduce the morbidity, the time lost from work, the residual disability in patients unfortunate enough to have an accident. The economic return to the Nation would more than justify the endeavor.

Next, I would like to stress the need to develop young, emerging, research workers in orthopedic surgery. Through some mechanism such as the training grant program, funds must be made available to support our young investigators, our most valuable commodity in meeting these research needs. Finally, I would urge the establishment of a musculoskeletal study section withing the NIH. Research in orthopedic surgery and the musculoskeletal system is so vital a part of our understanding of the diseases, injuries, deformities, and disabilities that effect our citizens that it deserves its own study section.

It has been a pleasure to appear before you today and to present the needs of the orthopedic surgeons of this country.

Mr. FLOOD. Thank you, Doctor.

Mr. CONTE. Mr. Chairman, may I ask a question not related to this subject?

Dr. Donaldson, what is the premium now for malpractice insurance for orthopedic doctors in the Pittsburgh area?

Dr. DONALDSON. The premium in the Pittsburgh area was just raised to $5,000 but my colleagues down in the eastern part of the State, in Philadelphia and the surrounding counties, are going to be paying $15,000 for their premium.

Mr. CONTE. That is outrageous. I have been taking an active interest in this. I filed legislation. I think we are going to have to do something pretty fast.

Dr. DONALDSON. We certainly appreciate your efforts and that of the others attempting to do something about this. Our academy has been active about this and a vast majority of my personal time has been spent in efforts to try to reach some solutions to this problem. In Pennsylvania we are not nearly as bad off as in other States.

Mr. CONTE. New York?

Dr. DONALDSON. New York, and California, and Michigan, Wisconsin. It is a terrible problem that it materially interfering with the duty of health care professionals.

Mr. FLOOD. The Pennsylvania General Assembly was on this just last week.

Dr. DONALDSON. There is a bill before the State house there is an attempt to change some of the factors that contribute to the tremendous cost.

Mr. CONTE. Getting back to the subject matter, I have two rather bad knees and both have been operated on for bone chips. How successful is a complete joint replacement in the knee?

Dr. DONALDSON. As I indicated, our successes with a knee are not nearly as complete as they are with the hip, and the difficulty with the knee is that the knee, instead of being just a simple hinge, has a more complex arc of motion. That is one consideration.

Secondly, the knee is not nearly as stable as the hip and, therefore, the design problems are much greater, although we are beginning to design better artificial knees. You are a fairly young and active-looking person and at the moment I would think that there should be a lot more developmental work done before knee replacement is considered unless your activity had become too badly interfered with.

Mr. CONTE. Thank you.

Mr. FLOOD. Thank you very much.

AFTERNOON SESSION

NATIONAL INSTITUTE ON AGING

WITNESS

JOHN B. MARTIN, LEGISLATIVE CONSULTANT, NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. FLOOD. Mr. John Martin, legislative consultant for the National Retired Teachers Association and the American Association of Retired Persons.

Mr. MARTIN. Thank you, Mr. Chairman.

I am John B. Martin, legislative consultant for the National Retired Teachers Association and the American Association of Retired Persons.

I appreciate this opportunity to testify on the proposed fiscal year 1976 budget as it relates to programs for older Americans.

The 1976 appropriations for the Older Americans Act and the National Institute on Aging provide a real test of whether the Administration is going to move forward with programs for older persons or permit the programs to drift backward. There has never been a time since the Administration on Aging was created when it seemed more necessary to move forward than the present. Throughout the country older persons are suffering increasing difficulties as a result of the rising cost of living which, in most cases, are not compensated for by increases in income. The result of increasing costs of medical care, increasing rents, increasing costs of food, and other miscellaneous expenses has simply meant that more and more older persons have not had sufficient funds to buy adequate meals or to provide nutritious food.

The progress made in increasing social security benefits, which had

substantially reduced the number of older people in the poverty category, appears to have been reversed and we are today steadily increasing the numbers of those who fall below the poverty threshold. This would seem to be true despite the automatic cost-of-living increases in SSI and in social security benefits. Consequently, a great deal hangs on the actions of the subcommittee in considering the appropriations for the Older Americans Act and the National Institute on Aging. The Comprehensive Older Americans Act Amendments of 1973 have provided a network of strategically located area agencies on aging which, through a coordinated delivery system of social services including nutrition, can be integrated into an effective program for safeguarding our older people. This network has materially increased the capacity to plan for and to carry out coordinated programs in the several parts of the Nation.

Dr. DONALDSON. Thank you.

However, the absolute necessity with respect to such plans is sound financial support and the President's fiscal 1975 budget fails to meet an adequacy test in this regard. The budget is essentially the same as the budget requested for 1975, but this is in fact a cutback of some $42 million below the appropriation made by Congress for 1975. It represents a 17-percent reduction from the fiscal 1975 appropriation of $245 million. It indicates a growing difference of opinion between Congress and the executive as to how these programs for older persons ought to be funded. We do not quarrel with the administration's request for aid to the Vietnamese refugees. Nevertheless we think it is an unfortunate fact that the request for Vietnamese refugees should be more than twice the amount requested for older American programs under the Older Americans Act. This is not in keeping with the needs of the situation for coping with problems of our own people.

The pending Amendments of 1975 for the Older Americans Act, which have already passed the House, contain a number of new features which require comment at this time upon the assumption that these provisions or something like them will be finally adopted. In particular, we direct attention to the new title VIII proposed which would mandate action with respect to homemaker programs, legal service programs, renovation and conversion of homes, and transportation. We note that these programs are all categorical in nature and that they are thrust into the title III program since funding of these programs is designed to come from title III appropriation.

It is contemplated that any State which has a State plan approved under section 305 shall use at least 20 percent of the funds allotted to such State under section 303(b)(2) from amounts appropriated under section 303(a) to carry out programs described in parts B, C, D, or E of title VIII in any fiscal year in which such State receives any such funds. Furthermore, the bill which passed the House provides that any expenditures made by any State agency or area agency in accordance with section 807(a) shall be in addition to and not in lieu of any expenditures for such services. There is at least some question as to any program under title III. This means that many of the programs now in effect must be continued and the 20 percent be added to present expenditurers for such services. There is at least some question as to whether this may disrupt the smooth functioning of the requirements

for coordinating service delivery. Be that as it may, it is clear that the appropriation for title III must be substantially increased and, for this reason, we urge that the appropriation for 1974 amount to full funding under an authorization of $180 million of the fiscal year ending June 30, 1976.

Title VII nutrition program for group meals and meals on wheels, represents a program which has been fully tested and which can and should be expanded rapidly to meet the need for good nutrition on the part of older isolated persons. The program is not merely a matter of food. The program promotes increased socialization by those benefiting from it and serves people who are particularly withdrawn and who do not have incentives to prepare meals alone and eat them alone over long periods of time. The elements of socialization in the program are in some instances more valuable than the food itself. The program is a human service program which feeds both the body and the spirit and the latter may be the most important part of its effect.

The appropriation for title VII has previously been authorized at a maximum of $200 million for the 1976 fiscal year. The program will reach a $150 million level by June 30, 1975, in accordance with congressional direction, provided funds may also be drawn from forward-funded money. The question before us, however, is what level of funding should apply to 1976 and in this regard we believe that it is desirable to appropriate for fiscal year 1976 not less than $125 million and to use from forward-funded money another $75 million to bring the total funding for this nutrition program to $200 million by June 30, 1976, the full funded level permitted by the authorization.

It is important also to recognize that there are a number of authorizations in the Older Americans Act which have been persistently ignored by the administration and which are needed if we are going to fill out a well-rounded program of services for the elderly. This is particularly true in the area of training where the administration has consistently endeavored to cut back on training development. The introduction of the area-agency-on-aging concept has added greatly to the need for trained gerontologists and has added both a need for career persons who have advanced training and advanced degrees as well as those who need short-term, on-the-job training. The administration proposed to cut this back to zero in the 1975 appropriation and Congress disagreed. The administration is still asking for 1976 that training be eliminated and we hope that Congress will disagree again to the extent of $8 million which is permissible under the authorization of such sums as may be necessary for 1976.

Related to this budgetary question is the question of whether any funds should be appropriated for multidisciplinary centers of gerontology. This has never been funded though there has been a such sums as may be necessary authorization since it was added to the Older Americans Act of 1973. The development of such centers of gerontology is an essential part of adequate training in this field. Centers of this nature provide incentives to students to enter the field and to take training. In the absence of such multidisciplinary centers training is apt to be sporadic and, in many cases, inadequate.

Much the same is true with respect to the provisions of funding for the development of senior centers throughout the country. At the pres-

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ent time there are over 5,000 senior centers in the Nation which vary greatly from high caliber multipurpose centers to those with single-purpose programs. The important fact, however, is that these centers have gained much from common experience and now provide a focal point for the furnishing of services for older persons in many parts of the country. We heartily support the senior-center concept and feel that it adds greatly to the opportunities to coordinate programs and ought to be funded.

One other matter deserves careful consideration by the subcommittee. This relates to title IX of the Older Americans Act which provides funds for part-time jobs for older workers in the low-income category who have poor employment prospects. It is our understanding that the Labor Department expects to spend the $12 million appropriated in fiscal 1975 during the first 15 weeks of fiscal 1976 which will bring the program to late September. It is our belief that the sum of $30 million ought to be appropriated for fiscal 1976 unless a comparable amount is available from the Emergency Employment Act for 1975 now pending action at the White House.

If this should be vetoed, and a veto is being rumored, then $30 million more will be needed and we hope that the committee will provide that amount to give the program a $42 million base for fiscal 1976.

This program has functioned well as Operation Mainstream and under title IX. It will continue to serve a substantial portion of the older population with poor employment prospects if properly funded. In the absence of such funding it is our experience that sponsors under CETA are not inclined to furnish opportunities for the older worker and, without a categorical program such as this, little or no employment will be available. The alternative, of course, for people in this category is to draw on welfare funds since they have little or no other resources. What we are saying in short is that we believe the program ought to be carried on a $42 million level and we believe also that some further increase would be justified in the latter stages of 1976 if unemployment remains at the existing high level.

I also want to comment on the appropriation for the National Institute on Aging in the National Institutes of Health recently created by Congress but not yet funded as a separate institute. The subcommittee has had an excellent presentation on this subject from Dr. Marott Sinex, chairman of the Department of Biochemistry at Boston University School of Medicine and Co-director of the Gerontology Center there. I need not repeat all of the arguments which he made to the subcommittee, but I do wish to emphasize that NRTA and AARP feel most strongly that, without adequate continuing funds for research, little or nothing will be done in this field. We feel that the expenditure involved is small compared with the policy implications of any action which can be taken through research to explore the whole area of senile dementia and of possible longer life.

In the matter of senile dementia, all of us have had the experience of visiting nursing homes peopled by older persons whose minds have deteriorated. There is no more pathetic spectacle than able-bodied persons whose minds are now disoriented. We believe that this area of research is and should be a priority area and that it deserves the attention of Congress. Finally, every effort should be made to fund

the program sufficiently to enable the new Institute on Aging to catch up with the very large backlog of approved projects. They are being held up with no money to fund them.

We think it is most unfortunate that this legislation establishing a National Institute on Aging has been on the books as long as it has without the appointment of a director and without being able to function as a proper Institute. The situation creates confusion for the National Institute of Child Health and Human Development and certainly fails to permit the new Institute on Aging to go forward in an orderly and effective manner.

The committee has received Dr. Sinex's recommendations for funding at a level of $32 million and we are satisfied that this amount of money can be properly used in the light of the facts outlined in his testimony regarding backlogs of approved projects. Certainly it is important that the Institute be funded at a higher level than the $16.2 million proposed by the administration for fiscal 1976. This would permit only a small portion of approved projects to be gotten underway. It would not permit a fully effective extramural program Congress has seen fit to establish the National Institute on Aging. Now it is time that it have an adequate appropriation of its own and time that the administration give it support both in terms of personnel slots and in terms of funds to carry on the important work of the Institute now being delayed.

Mr. Chairman, if you have any questions, I will be glad to try to answer them.

Mr. FLOOD. Thank you.

Mr. MARTIN. Thank you, sir.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

WITNESS

JAMES A. FLYNN, MEMBER, LORENZ, FINN, GIARDINO & LAMBOS, ON BEHALF OF THE NEW YORK SHIPPING ASSOCIATION, INC., ON LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

Mr. FLOOD. Mr. James A. Flynn, New York Shipping Association.

Mr. FLYNN. Mr. Chairman, my name is James A. Flynn. I am a member of the firm of Lorenz, Finn, Giardino & Lambos. I appear here on behalf of the New York Shipping Association, Inc.

The New York Shipping Association, Inc., represents employers of the approximately 15,000 longshore workers handling cargo in the Port of New York and New Jersey.

The Department of Labor budget for fiscal 1976 proposes the imposition of a user charge on each longshore or other maritime industry employer who is self-insured under the act, except for the District of Columbia, who has paid compensation or medical benefits during the calendar year prior to the user charge assessment. The alleged authority for this user charge is based on title 31 of the United States Code, section 483, and an Office of Management and Budget circular which directs Federal agencies to follow the general policy of making a reasonable charge to each identifiable recipient for a measurable unit of Government service or property from which the user of the service derives a special benefit.

We strongly oppose the imposition of the user charge on our industry to pay for administration of the Longshoremen's and Harbor Workers' Compensation Act. Such a charge is discriminatory, unfair, lacks statutory authority, and would impose a serious economic burden on an industry that is already paying far more for workers' compensation than most.

It is discriminatory in that the longshore industry has been singled out for this special treatment. The Longshoremen's and Harbor Workers' Compensation Act is also the Worker Compensation Law for the District of Columbia. The Department of Labor does not, however, propose to impose a user charge on employers in the District of Columbia for the administration of the same law. We do not understand the reason for this lack of evenhanded treatment.

It is unfair in that Congress has mandated only 2 years ago that the longshore industry pay the highest levels of workmen's compensation in the Nation. At the present time an injured longshoreman can receive a weekly compensation payment of up to $261. That amount will increase to about $300 on October 1, 1975. This amount exceeds by over $100 the maximum weekly benefit rate of all but two State systems. Moreover, the amounts of awards for permanent injuries now provided for by the Longshore Act is triple those of over 85 percent of the State systems. These very high levels of benefits were based on a system under which the cost of administration was to be from general treasury revenues.

These high level of benefits result in a so-called "manual rate" of premium in the New York area of the Port of New York of $34 per $100 of payroll. In other words, for every $100 of payroll of longshore workers the employer must pay a compensation premium of $34.

Many employers pay far more than this since the manual rate is further adjusted to reflect each employer's individual experience. To add to this the further burden of paying for the cost of administration of the act would result in compensation costs of almost confiscatory levels of premiums.

Furthermore, establishment of a user charge concept would remove an important fiscal restraint in administration of the act. Now, funding for administration must compete with other government programs. This results in incentive to keep each program at reasonable cost levels to permit the limited available funds to be fairly allocated among all programs. If a user charge is imposed, this important restraint is removed. The Secretary would have little incentive to keep the costs of its administration at reasonable levels since such funds would not be competing with other Department programs. We believe it is basically unsound to supply any Government agency with such a blank check authorization from any industry or business.

In an obvious effort to meet this criticism, the Department has stated that the application of the user charge would be advantageous to the maritime and insurance industries affected in that the contributors to the assessment will be afforded an opportunity to provide input into the administration and legislative functions of the program. The Department fails to state the nature of the opportunity that would be so provided and, of course, any such input would not be binding.

We also note that in the outline of legislation that the Department now proposes, there is not the slightest mention of any procedure for providing on-going input into the program by either industry or labor. That legislation merely provides for authority for the imposition of the charge, the procedures for its assessment, and the penalties that would be invoked for failure to pay the assessment.

We further question the rather unusual procedure adopted by the Department in seeking this very significant and substantive change in the act. On the one hand the Department cites statutory authority that it claims it now possesses under section 483a of title 31.

It then proposes, on the other hand, to amend the act by so-called "technical" amendments to specifically provide authority to assess the user charge.

In the meantime it asks this committee, in the form of an appropriation bill, to in effect give prior approval for such an amendment. We understand, Mr. Chairman, that the inappropriateness of seeking substantive changes in the law through the vehicle of an appropriation bill has been pointed out to the Department.

Moreover, section 483a of title 31, does not provide the Department with authority to impose a user charge in this area. That statute grants authority to governmental agencies to impose fees for the rendition of special benefits, such services which include:

> Any work, service, publication, report, document, benefit, privilege, authority, use, franchise, license, permit, certificate, registration, or similar things of value or utility performed, furnished, provided, granted, prepared, or issued by any Federal Agency.

It is difficult to understand the application of that provision to the administration of the longshore compensation system. Workers' compensation systems are not the limited, special services which section 483a contemplates. Most workers in the United States are covered by either State or Federal compensation systems. These are broad social programs whose primary purpose is to help the injured worker by providing him with compensation for lost wages and permanent injuries caused by industrial accidents or illness. Their direct beneficiaries are, of course, the injured workers and compensation benefits are paid for by employers.

The complete inappropriateness of section 483a to authorize the imposition of a user charge shows up in the assessment formula proposed by the Department. Under section 483a, the amount of the charge or fee is to be based on, among other factors, the value of the services to the recipient. Contrary to this requirement, the Department here proposes to assess the longshore industry not on the basis of any benefit received but on the basis of a statutory obligation imposed on employers to pay for compensation benefits.

We believe further that recent Supreme Court decisions clearly demonstrate the lack of statutory authority for such a charge under section 483a. These cases are *Federal Power Commission* v. *New England Power Company* (415 U.S. 345) and *National Cable Television* v. *United States* (415 U.S. 336).

In the first case, the Federal Power Commission imposed an annual assessment pursuant to section 483a against jurisdictional electrical utilities in proportion to their wholesale sales and against all natural

gas companies with operating revenues of $1 million or more in proportion to their deliveries of natural gas in interstate commerce.

The Court of Appeals for the District of Columbia set aside that portion of the Commission's order establishing such charges. In a majority opinion affirming this decision, the Supreme Court held that although section 483a authorizes Federal agencies to prescribe a fee for services provided certain listed entities, whole industries were not in the category of those who may be assessed. The purpose of the act, the Court held, was to apply only to specific charges for specific services to specific individuals or companies making an application for same.

Particularly relevant is the Court's quotation with approval of a circular of the Office of Management and Budget that no charge should be made for services rendered when "the service can be primarily considered as benefiting broadly the general public". We think that applies to longshore or other workers' compensation systems.

In *National Cable Television* case, the Court had before it the validity of a fee imposed by the Federal Communication Commission pursuant to section 483a of 30 cents per subscriber on commercial antenna television systems. The issue before the Court was whether the fee assessment was in part to recoup costs to the Commission for its oversight of the commercial antenna television systems. If so, the Court reasoned, broadcasters would be paying not only for benefits they received but for the protective services of the Commission rendered to the general public. The Court pointed out that if the latter was the case, a serious constitutional issue would be raised. To quote the Court:

> A "fee" connotes a "benefit" and the Act [Section 483a] by its use of the standard "value to the recipient" carries that connotation. The addition of "public policy or interest served, and other pertinent facts," if read literally, carries an agency far from its customary orbit and puts it in search of revenue in the manner of an Appropriations Committee of the House.

In short, it was the Court's position that if the amount of the fee authorized by section 483a is based upon some broad policy or interest served, it would be in the nature of taxation, a legislative function belonging solely to the Congress.

Here, contrary to these Supreme Court decisions, the Department of Labor seeks to impose a charge on an entire industry, based not on the value or worth of services received by that industry, but rather on the basis of obligations imposed on that industry by law to provide at substantial cost compensation benefits.

We respectfully submit that both decisions of the Supreme Court would bar the imposition of user charge in this area.

Our industry fully supports many of the worthwhile programs for which the Department seeks additional staff. A reduction of the present case backlog, increased efforts at vocational rehabilitation, and monitoring the quality of medical care received by injured workers, are valid and worthwhile purposes. The obligation to provide these services are now imposed on the Department by the act and we urge that the Congress provide adequate funds to permit the Department to fully carry out all of these responsibilities and obligations.

We respectfully submit, however, that these programs should be funded from General Treasury revenues. In this way Congress would continue to have direct control over the size, nature and quality of the administration of the longshore compensation system.

Mr. FLOOD. Thank you.

Mr. FLYNN. Thank you, Mr. Chairman.

NATIONAL HEART AND LUNG INSTITUTE

WITNESS

DR. ISADORE ROSENFELD, CLINICAL ASSOCIATE PROFESSOR OF MEDICINE, CORNELL UNIVERSITY MEDICAL COLLEGE, NEW YORK, N.Y.

Mr. FLOOD. Dr. Isadore Rosenfeld of New York.

Dr. ROSENFELD. I am Dr. Isadore Rosenfeld, clinical associate professor of medicine, Cornell University Medical College, past member of the National Heart and Lung Institute task force on arteriosclerosis, and currently on the joint U.S.–U.S.S.R. collaborative team working in the area of sudden cardiac death. I wish to thank you for the opportunity to appear before you ance again on behalf of the National Heart and Lung Institute and the national heart, lung, blood vessel and blood program.

I have submitted a statement for the record and if I may I would like to take a few minutes to highlight some of the more important areas.

Mr. FLOOD. Very well.

Dr. ROSENFELD. The facts and figures are contained in my prepared statement.

As I indicated in the past, I am a practicing cardiologist and my perspective is basically that of a physician actively engaged in the treatment of sick people and in the maintenance of health.

I have a special interest in hypertension, in arteriosclerosis, and in sudden cardiac death, and to that end I will be making my second trip on behalf of the National Heart and Lung Institute to Russia on June 6.

Not much has changed, Mr. Chairman, in the last few years. Disorders of the heart, blood vessels, lungs and blood continue to be a major source of death, perhaps some 2 percent less than when we last met.

There are 30 million Americans estimated to be suffering from one form or another of these diseases and the economic cost is said to be in the neighborhood of $40 billion annually.

The enactment of the National Heart, Blood Vessel, Lung and Blood Act of 1972 bears witness to the recognition by the President, by the Congress, and by this committee, and yourself as to the magnitude of the problem.

I understand the act to be a mandate to the medical and scientific commmunity that we must look for additional leads to eliminate the first heart attack, the first stroke, and the terrible number of sudden deaths that occur each year.

In response to the act the National Heart and Lung Institute initiated or proposed a 5-year national plan and this was developed within the guidelines provided by the legislation in terms of its intent, program content, and level of proposed fiscal resources.

During the last 2 years the Heart and Lung Institute has geared up to help effect the legislation. I am sure that you know that today, some 3 or 4 years after enactment of the legislation, the program is substantially short of many of its major goals.

This has been due to lack of funding. Last year the act authorized $520 million and this was nowhere close to being realized. In 1973, $400 million was authorized and not granted.

I understand that there have been conflicting pressures on this committee and on Congress for allocation of funds but I would like to point out to you one or two areas in which the result of lack of funding has had an enormous detrimental impact on our health and on our medical problems.

After the act was published in 1972 and in response to solicitations from the National Heart and Lung Institute, scientists from all over the country submitted research protocols containing what they believed to be the germs of ideas to eradicate, to find the cause, and the cure, and the prevention of heart disease and stroke.

These proposals were reviewed by the Heart and Lung Institute, deemed worthy of support, but never funded. The result has been a dropping out of the medical research community of hundreds and hundreds of research scientists who have had to look elsewhere for their livelihood.

It has also meant the discouragement of the best brains in the country, the young men coming out of medical school, postgraduate training, who go into industry or go into private practice and no longer devote their energies to research.

I think this is a terrible pity for the country and for the health future of our citizenry.

The act authorized the establishment of up to 30 centers in heart, lung, and blood diseases to focus on ways of treating, on research, on curing these great killers. In the past 3 years of the 30 authorized by the act, only three centers have been established, and this gives you some idea of the magnitude of the impact which the funding deficit has on the biomedical community.

I don't want to leave the impression that nothing is being done. The moneys that have been granted have been judiciously used.

You might ask how is it being used and what have you in fact done? Well, with the money made available we have launched a high blood pressure campaign. This involves an education program across the country to educate people about the importance of having their blood pressure taken and treated. We have a hypertension detection and followup program in many communities throughout the country.

Hypertension is the one disease that we can easily diagnose and easily treat, and recent evidence has, Mr. Chairman, shown, as I am sure you know, that treatment of this silent killer can result in enormous reduction in stroke and heart failure and kidney disease.

There is a nationwide network of lipid research clinics now operative in which people with abnormal blood fats are being treated and

will be followed for a number of years to see whether modification of the diet will reduce death from heart disease and stroke.

There is a multiple risk factor intervention trial being carried on. The concept here is that we know that reducing blood pressure saves lives. We know that stopping cigarette smoking saves lives. We think but we don't know whether correcting lipid or abnormal cholesterol will save lives.

Does 1 plus 1 plus 1 equal 3, or if you treat them all together simultaneously will there be a much more dramatic reduction of death and morbidity from heart disease and stroke?

So this is another ongoing program.

Where can we use additional moneys? We can use the moneys to build the centers that this committee and Congress authorized. We can use additional money for noninvasive instrumentation. I don't know whether you have visited any of the wonderful hospitals in this area recently, but to diagnose the progress of arteriosclerosis in the brain or in the heart or in the kidneys one has to do horribly uncomfortable, painful, sometimes hazardous, invasive procedures.

We need a major thrust in the development of noninvasive, safe, accurate procedures as, for example, the use of sonar or computerized radiographic techniques or radioactive scanning.

These are all not on the horizon, but actually here, and we need the extra funding to develop these techniques.

Another area is coronary artery bypass surgery. I am sure, Mr. Chairman, that some of your friends have had this operation. Maybe 50,000 were done in the United States last year. Don't let anybody tell you that we have all the answers for this operation. I am not sure that the people, many of whom are being operated on today, need the operation. We are not sure which ones do need it and under what circumstances.

A major research thrust is really indicated in this area.

The problem of sudden cardiac death is one that is of enormous importance. No matter how much we improve our capability of treating patients once they arrive in the hospital with a heart attack, we will only be touching the tip of the iceberg, because 60 percent of people who have heart attacks die virtually instantly.

We can't get them to the hospital. There is nothing we can do for them. We need a crash program to identify those people who are vulnerable especially to sudden death, what makes them vulnerable, and how can we intervene before the chest pain or the sudden death occurs.

I ask this committee for an additional $10 million in funding for this critical program. There are 1 million to 1¼ million Americans sustaining heart attacks each year.

In conclusion, Mr. Chairman, I would like to apprise you of an interesting development with aspirin. I am sure everybody in this room has at some time or other had aspirin.

Several years ago in Boston, it turned out that a well trained observer noted that patients who for one reason or another were taking aspirin because they had arthritis or aches and pains seemed to have a lesser incidence of heart disease and stroke.

This prompted a scientific study and indeed the evidence did suggest that aspirin played some protective role. It turned out that it played

this protective role by interfering with the coagulation mechanism within the blood.

There are several studies ongoing now which suggest again that there maye be a very significant impact by aspirin on the mortality rate after somebody has already had a stroke or heart attack.

I am asking this committee favorably to consider an additional primary prevention study using aspirin in patients who have not yet had their heart attack or stroke but who are deemed vulnerable to these risks by virtue of high cholesterol, high blood pressure, and cigarette smoking.

That is the substance of my presentation. I would like before getting up to make one plea for the continuation of support for basic research. Targeted research is very important. We identify a problem and try to solve it. But, we must never abandon the support for the investigation or who goes out on his own without direction and applies fundamental techniques of basic research because the true answer to our problems may lie in those areas.

Thank you very much.

[Dr. Rosenfeld's statement follows:]

Mr. Chairman, members of the committee, I am Dr. Isadore Rosenfeld, clinical associate professor of medicine, Cornell University Medical College, past member of the National Heart and Lung Institute Task Force on Arteriosclerosis, and currently on the joint U.S.-U.S.S.R. collaborative team working in the area of sudden cardiac death. I wish to thank you for the opportunity to appear before you once again on behalf of the National Heart and Lung Institute and the National Heart, Lung, Blood Vessel and Blood Program.

As a practicing cardiologist, my perspective is that of a physician actively engaged in clinical practice, and therefore, oriented toward patient care—that is, treatment of acute illness and maintenance of health. I have a special interest in hypertension, arteriosclerosis, and sudden cardiac death—and in programs aimed at determining their causes and effecting their prevention and cure. To this end, I will be making my second visit to the U.S.S.R. on June 6, to reassess progress in these fields with members of the Soviet scientific community.

Disorders of the heart, blood vessels, lungs, and blood continue to cause more death and suffering among our people than all other diseases combined, heart disease being the leading killer. Thus, more than 30 million Americans are so afflicted, with untold suffering, enormous loss of productivity and at a real annual economic cost well in excess of $40 billion. Obviously, enactment of the National Heart, Blood Vessel, Lung, and Blood Act of 1972 bears witness to the recognition by the President, the Congress, and this committee of the magnitude of the problem. As the National Heart and Lung Advisory Council stated in its initial report to Congress, "The maturation of many research-proven ideas, methods and technologies, viewed in relation to the increasing health problems of heart, blood vessels, lung, and blood diseases, convinces the Council that the next few years could bring significant new discoveries and health benefits for the American people." In more simple terms, this means that the time is ripe to develop and apply all our present considerable knowledge in the cardiovascular field, look for additional leads so that we can eliminate or delay the stroke, the heart attack, and the sudden death which, together, hit more than 1 million Americans each and every year.

As you know, such targeted national efforts, as envisioned by the act of 1972, have, in the past, yielded gratifying, even spectacular, results. For the most part, Federal drives to bring about specific biologic research developments were initiated, primarily, in response to acute requirements during national or military emergencies. Thus, in 1943, President Franklin D. Roosevelt set up a Government bureau, the Office of Scientific Research and Development, which included a section to assist in the development of medical discoveries. Specific steps were taken on a national level to create optimal conditions for collaboration among scientists in several countries to insure rapid dissemination of important new information. This resulted in such significant biomedical research advances as, for example,

the rapid development and availability of penicillin and the use of replacement blood and blood fractions. Subsequent to World War II, other mission-oriented national research efforts were initiated at the NIH against a number of important diseases, the classic example of which is the case of the production of polio vaccine. The implementation of the results of these targeted efforts, during and after the war, continues daily to save the lives of countless Americans.

As I reviewed with you last year, a 5-year national plan was developed by the NHLI in response to your legislation of 1972, and to implement the will of Congress. This plan was developed within the guidelines provided by the legislation in terms of its intent, program content, and level of proposed fiscal resources. During the last 2 years, the NHLI has made rapid progress in gearing up to effect the program, based on the increased funding authorized for it. However, today, almost 4 years after enactment of the legislation, the program is substantially short of the full potential intended by the law. Many of the projects identified in the initial program plan in 1973, and also in the 1974 update of that plan, have not been developed because of lack of funds. I would remind you again, as I did last year, that while the act authorized $400 million in fiscal year 1973, $460 million in fiscal year 1974, and $520 million for 1975, the budget of the Institute has not even approached these figures in any of those years. Obviously then, the program will not realize the full, long-range potential intended by you in drafting the 1972 legislation, unless it is backed now, even at this late date, by adequate financial, social, and individual commitment of the Government, the public, and the biomedical community.

I realize that the conflicting pressures exerted upon Congress by many different groups and lobbies, in the setting of the tightened monetary policies of the past few years, have placed very real constraints upon the ability of this committee and of the Congress to implement the National Heart, Blood Vessel, Lung and Blood Act as originally conceived, but it is important that we not lose sight of the goals and priorities that we scientists and you public servants have set jointly for the benefit of the Nation as a whole.

It is vital that this committee understands the full implications of the reduced funding of recent years. After the act was published, and in response to solicitation from the NHLI, scientists from every part of the country submitted research protocols directed at attacking the problems of the heart, lungs, circulation, and blood. Who knows but that the answers we are looking for may be in any one of these ideas? After screening and evaluation of these research proposals, many of them were approved, but went unfunded, and today are not in the laboratory, where they belong, but on the shelf of scientific frustration. This is especially unfortunate in regard to the protocols dealing with thrombosis—the clotting mechanism within blood vessels—and in blood banking. This failure to fund means that there are scores of brilliant scientists with exciting ideas just cooling their heels, or, what is even more devastating, leaving the field of research for other more practical activities in which they can earn their livelihood.

Another vital area of investigation inadequately explored because of lack of funding involves techniques to reduce infarct size. In a heart attack, the survival and subsequent strength of the heart depends on the amount of heart muscle actually destroyed. We are beginning to learn how to assess the size of the damaged area and are developing methods to minimize that size. All this is literally a matter of life and death to hundreds of thousands of Americans each year, yet we have not been able to proceed as vigorously as we are able because of lack of funding!

Let me offer yet another example of the failure to comply with the intent of Congress. The Act of 1972 states that the NHLI shall (not may or should), but shall institute programs of prevention, control, and education, with respect to diseases of the heart, lungs, blood vessels, and blood. In the area of hypertension, where thousands of lives could be spared by teaching people about the importance of blood pressure control, much more could be done in the way of education, screening, and treatment. Even though some progress has been made, we can and must do more. Again, the act states that up to 15 national centers for study of diseases of the heart, blood vessels, and blood may be established, as well as up to 15 additional centers for lung diseases. Thus far, there is one center for heart, one for blood, and one for lungs—a total of 3 centers where a need exists for 30!

You may rightly ask, "What, then, has been done during the first 2 years of the program?" The answer is much, because of the judicious use of the limited

resources and funds, manpower, facilities, and equipment. These would not have been possible without the act. I would like to tell you about some of the developments which are of particular interest to me as a physician primarily concerned with improved care of my patients.

HIGH BLOOD PRESSURE

We now know beyond any question that normalization of high blood pressure dramatically reduces the risk of stroke, heart failure, and other manifestations of arteriosclerosis. It may surprise you that the proof of this seemingly evident fact was only recently obtained. We have many agents to lower blood pressure safely and effectively but we must educate people to have their pressures taken and then to stay with the treatment. This is not easy to do because hypertension is a silent killer and does not usually cause symptoms until very late—too late in the course of the disease. We have to educate doctors, some of whom cling to the antiquated notion that high blood pressure can be benign. We have to instruct other medical and even paramedical personnel in the routine use of the pharmacological agents that are available for treatment in maintenance community programs. Through a nationwide campaign to increase awareness of hypertension and its dire consequences, the American people are being encouraged to avail themselves of existing facilities to detect, diagnose, and, where required, to treat hypertension. This campaign is being accomplished through the national high blood pressure education program, which now has the active support of numerous local community organizations throughout the country. A significant degree of coordination has been developed, both within the Federal Government and the private sector, as exemplified by successful mounting of National High Blood Pressure Month, during May of 1974 and 1975; development and promulgation of nationally recognized standards for screening, evaluation, therapy, and education of hypertensive patients; development of an education research program; community consultation services, high blood pressure information centers, mass media education campaigns, and an ongoing cooperative professional education effort designed to reach physicians, nurses, dentists, pharmacists, and other health personnel.

As part of the clinical research programs of the NHLI, representative segments of the American population are now being screened and treated for hypertension under such programs as the hypertension and detection followup program. The purpose of this activity is to determine the extent to which overall mortality and morbidity, associated with elevated blood pressure in the general population, can be reduced by a systematic program of (a) detection and (b) antihypertensive drug management. In 14 selected communities across the United States, more than 160,000 persons, age 30–69, have been screened for high blood pressure and more than 11,000 have entered the program. The results of this study are expected to show the potential for saving lives when large numbers of persons are screened to detect hypertension, and then treatment is instituted. New methods applicable to whole communities are being devised for such screening and treatment, using paramedical technicians and nurses, and thus sparing the more limited physician population for more sophisticated tasks.

LIPID RESEARCH CLINICS

A continent-wide network of lipid research clinics and their support facilities are involved in a study to determine whether reducing blood cholesterol levels in patients with a chronic type of blood fat disorder characterized by high blood lipid levels—type II hyperlipoproteinemia—can slow down or prevent the development of premature coronary artery disease. Completion of recruitment of subjects for this 7-year trial is projected for January 1976. Initially, physician and laboratory referral of prospective subjects was emphasized. More recently, newer recruitment strategies are being used to speed up detection of suitable cases. These include industrial and blood bank screening, media support and other more creative case finding techniques. Given ongoing congressional funding, we will soon know whether we must really give up our bacon and eggs, ice cream and marbled steaks, whether we are really eating our way into the grave or being led on a wild goose chase away from the true causes of premature arteriosclerosis by focusing on the cholesterol problem.

MULTIPLE RISK FACTOR INTERVENTION TRIAL

The purpose of another ongoing largescale study, the multiple risk factor intervention trial, is to determine whether or not a preventive program, directed at the simultaneous reduction of serum cholesterol and elevated blood pressure, together with elimination of cigarette smoking among apparently "healthy" men, age 35–37, will result in a significant impact on the incidence of myocardial infraction and death from coronary heart disease. The rationale for this multiple attack concept is this. We know that control of hypertension is effective. We know that elimination of tobacco is beneficial. We don't know about cholesterol as yet. But it may be that control of all three at the same time will have a much more significant effect than control of only one. Our current assessment of the effectiveness of risk factor interpretation is based on a "one-at-a-time" approach. It may be that 1+1+1 is much more than 3. To determine their eligibility for participation in this trial, more than 150,000 men have already been screened for these coronary heart disease risk factors. Of this group, more than 13,000 have been found to be at increased risk and have expressed willingness to participate in this 6-year research effort. Of these, only 5,000 have met all the eligibity criteria; that is, despite their augmented triple risk (high blood pressure, elevated cholesterol and cigarette smoking), they do not yet have any manifestations of disease. These 5,000 persons have been enrolled in the primary prevention clinical trials. As a result of this screening program, not only were 5,000 volunteers enrolled, but 8,000 persons were also found to have evidence of vascular disease, with or without symptoms. Although they have not been accepted for the study, they have been referred for diagnosis and treatment. Twenty clinical centers in 14 areas of the country are now carrying out the recruitment effort. It is anticipated that, in order to achieve the population necessary for the study, in excess of 400,000 men will eventually be screened throughout the country.

NATIONAL RESEARCH AND DEMONSTRATION CENTERS

The three national research and demonstration centers, one for heart, one for blood and one for lung, which have just been initiated, will serve as focal points in the attack on those diseases. Trained personnel, information and public education will emanate from these centers to the geographic areas which they serve—and, indeed, until more centers can be established, the rest of the country.

All these detection and screening programs have had the additional effect of improving clinical and research capabilities at many hospitals around the country—an important byproduct of the act. A large number of America's best biomedical brains, in many disciplines, are also being supported in the quest for answers to basic questions as to what causes hypertension, arteriosclerosis, high blood fats—why some of us are more vulnerable than others. This work is crucial to the development of the fundamental knowledge necessary to build on our current capabilities.

I would now like to turn to some of the new opportunities that have emerged and for which I would urge the committee to provide additional funds.

HYPERTENSION

Although the hypertension detection and followup program is still ongoing, it would be useful to employ its effective techniques and principles in an expanded setting. A task force of the national high blood pressure program has recommended that consulting teams be provided to assist more communities in planning their own high blood pressure control programs, using the experience of the HDFP. An adequate program, including the necessary elements of enumeration, detection, verification, referral, followup and special management services in about 10 communities would require about $7 million additional.

You and I think of hypertension control as simply going to our doctor, discovering we have high blood pressure and accepting the necessary treatment. But think of our many fellow Americans who, for one reason or another, usually economic or educational, do not see a doctor except when they are seriously ill. The check-up is a phenomenon that has not yet filtered down to large segments of the less privileged or informed community. A great need exists to characterize the special factors of community organization, resources and functions which can be effectively channeled into community hypertension control, particularly among high risk groups, such as the blacks. No existing program is directed at seeking

systematic knowledge of these fundamental issues at the community level. For example, what is the best way to organize, educate, motivate, treat and then keep in treatment those persons who have no access to other medical care? How can community programs be coordinated with medical centers or clinics to maintain high blood pressure control? A budget of approximately $2 million a year for the next 5 years is required to initiate this vital program.

DIET

The role of diet in the prevention of a number of cardiovascular diseases is currently under study in several NHLI programs. However, better methods of collecting, recording, processing, and interpreting information on food intake are fundamental to our analyses and understanding of the effects of diet on health. Improved methods of nutrition counseling and education are also needed to enhance the effectiveness of any prevention and control programs that may emerge. To launch a number of specific activities in this area would require at least $3 million for the coming year.

NONINVASIVE INSTRUMENTATION

We must be able to monitor what is happening in the arteries which supply the critical organs of the body—tne brain, heart, kidneys, and legs. Instrumentation is probably the most important single constraint for the effective recognition of silent or early arteriosclerosis, and its insidious progress. At the present time, our studies correlating the effect of risk factor control on the development of arteriosclerosis depend on the end-points of stroke, heart attack, or death. We desperately need convenient, safe, noninvasive, and sensitive instrumentation for diagnosis and monitoring of the atherosclerotic plaques as they develop. Currently used invasive techniques are, for the most part, painful or uncomfortable, and occasionally hazardous. Most healthy individuals quite properly are unwilling to be studied in this manner and certainly not more than once. The ability to safely determine the results of therapy or lifestyle change on the development of arteriosclerosis, without having to wait for a crisis event, would also enormously decrease the time, rigorous demands, and costs of clinical trials. We have some exciting and important leads that must be followed through in this area of noninvasive testing, for example, radioactive imaging, use of sonar techniques, new computerized X-ray devices (already being used for the brain) and others. An additional $10 million is required for this area of research.

REDUCTION OF HEART ATTACK

The doctor's most important goal in treating patients with an acute heart attack is first to save life and then to minimize the amount of damage to the heart muscle. On this depends the successful rehabilitation of the postcoronary patient. There are currently many promising leads in treatment to reduce the amount of heart muscle destruction. These involve manipulation of the circulation and blood pressure during the acute stage. New noninvasive approaches are being developed to measure the amount of damage actually sustained by the heart. This involves radioactive scanning, as well as biochemical analyses of the blood. I recommend that an additional $10 million be made available to expand these very important lines of new research, since we are, I believe, very close to payoff in this vital area.

CORONARY ARTERY BYPASS SURGERY

I would estimate, conservatively, that at least 25,000 coronary artery bypass operations were carried out in the United States last year. The correct figure may be closer to 50,000. Who among us doesn't know of someone who has had this procedure done? The long-term effect on life and the specific indications for the bypass operation remain ill defined. In a substantial number of individuals with severe angina pectoris—pain in the heart—this operation provides dramatic relief of symptoms. But does it prolong life? And to what extent? Enough to warrant the pain and risk of surgery?

When should bypass surgery be done? Will operating during an acute heart attack prevent death or extensive damage? Should surgery be done when a coronary occlusion is about to happen, that is, when the patient's angina becomes

unstable? All these questions are vital and confront patients and physicians like me every single day. I do not have the answers. I must have them. The only way we are going to get them is by continuing and setting up more long-term studies to determine the outcome of this type of surgery. A central registry for each operation should be established. I recommend that at least $5 million be provided to help answer these questions. This is a matter of the highest priority.

SUDDEN CARDIAC DEATH

Sudden cardiac death is another area where there is need for a significantly increased effort. We still have about 1.25 million heart attacks a year in the United States. Prior to the advent of the coronary care unit concept, the death rate in hospital following myocardial infarction was about 1 in 3. Today, it is more like 1 in 5 and, in the very best medical centers, it may be in the order of 1 in 7. If this is true, then why has the overall death from heart attacks not been turned downward more sharply. The answer lies in the fact that perhaps as many as 60 percent, a clear majority, in any event, of heart attack victims who die, do so before they reach medical attention. A considerable number, perhaps as many as a third, die almost instantly. This is true not only in the United States, but in the U.S.S.R. as well. Therefore, despite the considerable advances made in the inhospital therapy of heart attacks, the fact remains that about 60 percent of these patients are not being reached at all—and this limits the impact of any scientific advances in treatment. It is very clear, therefore, that we must first learn to identify those persons who are at high risk for sudden death. We must then develop facilities for reaching them quickly, as with the coronary ambulance program so sucecssful in Seattle, and, most importantly, we must learn how to prevent the suddent death in these vulnerable persons. This requires the development of new drugs to control electrical instability in the heart, the basic cause of such sudden death. It would recommend that this line of research be given a very high priority in funding with an additional $10 million.

PRIMARY PREVENTION STUDY WITH ASPIRIN

In 1970, the task force on arteriosclerosis was apprised of an exciting new observation. Patients who, for one reason or another, were taking regular doses of aspirin seemed to be protected against heart attacks and strokes. The presumed mechanism for the observed phenomenon was interference by aspirin with the normal clotting mechanism of the blood. Aspirin, the most widely used and least understood pharmacologic agent, in some way reduces the clumping of certain elements in the blood called platelets. This observation generated several small trials, mostly in persons who have already sustained a heart attack or stroke (secondary prevention trials). On a larger scale, studies are now being carried out in this country, Germany, the United Kingdom, and elsewhere, again in patients who have already had heart attacks or strokes. We will know within 3 years the extent of the protection afforded by aspirin in this group of patients.

On the basis of the preliminary observations, some of which suggested a reduction in the death rate as high as 33 percent, many cardiologists are now prescribing daily aspirin to cardiac patients in whom there is no contraindication to this medication. It is now fitting and urgent that a pilot study be undertaken immediately on high risk individuals, as yet free from heart attacks and strokes, to see whether aspirin will prevent the first heart attack or stroke. The same screening mechanism available in the multiple risk factor intervention trial, currently being conducted by the NHLI, could be employed. A double-blind trial, involving approximately 2,000 persons deemed to be at high risk for developing heart attacks or other vascular accidents, using aspirin, would indicate whether the protection is real and substantial, and whether further, larger scale studies are needed. An additional $4 million is needed for such a trial.

BASIC RESEARCH

Finally, I want to stress the importance of basic research related to the total problem of heart, blood vessel, lung, and blood diseases. We must pursue totally new approaches in many areas of prevention and treatment. We must maintain an elite corps of scientists, devoting their total energy to new concepts for the prevention and treatment of cardiovascular disease. I recommend an additional

$30 million be provided for this purpose as our insurance premium in the future of American medical prowess and progress.

In conclusion, I would like to point out that since 1969, deaths from the number one killer, coronary heart disease, have shown a slight decline of about 2 percent per year.

Deaths from stroke, hypertension ,and rheumatic heart disease are also continuing their downward trend. The death rate from emphysema and chronic bronchitis, after years of sharp increase, has leveled off. All this is the result of the funds that you appropriated for research. I urge your continued interest and support so that this momentum not be lost.

The limited resources available to the program during the past 2 years have forced difficult choices among worthy competing needs. I would hope that with easing of economic restrictions, it will now become possible for you to provide more adequate funding. At this moment, the implementation of the national program is resource limited, not idea limited.

Thank you for the opportunity to present my statement. I am enclosing a summary table to indicate the additional funds I am recommending for the specific activities enumerated.

SUMMARY TABLE.—NATIONAL HEART AND LUNG INSTITUTE

Additional funds fiscal year 1976

Activity:	*Millions*
Incorporation of high blood pressure detection, treatment and follow-up programs into ongoing community health programs	$7
Community hypertension control research programs	2
Dietary studies	3
Noninvasive instrumentation	10
Research aimed at reducing heart muscle damage following heart attack	10
Coronary artery bypass studies	5
Prevention of sudden cardiac deaths	10
Primary prevention study with aspirin	4
Basic research	30
Total	81

Mr. FLOOD. Thank you, Doctor.

COMMUNITY SERVICES ADMINISTRATION

WITNESS

ADOLFO ALAYON, PRESIDENT, NATIONAL FEDERATION OF COMMUNITY DEVELOPMENT CREDIT UNIONS

Mr. FLOOD. Adolfo Alayon, president of the National Federation of Community Development Credit Unions.

Mr. ALAYON. Mr. Chairman, members of the Subcommittee on Labor-HEW: My name is Adolfo G. Alayon. I submit this testimony as president of the National Federation of Community Development Credit Unions. The National Federation of Community Development Credit Unions is an association of credit unions which serve low-income communities in both urban and rural areas throughout the United States. It represents over 300 such credit unions whose current membership is estimated to be 186,000.

I am delighted to have the opportunity to submit my testimony in support of the appropriation for the Community Services Administration which is currently under consideration by this distinguished subcommittee.

One does not have to be an economic expert to realize that our economy is suffering through a period of major recession. Economic hardship and restriction are the lot of increasingly wider sectors of our society. We read daily of cutbacks in production; of large-scale employee layoffs; of increasing rates of bankruptcy in marginal businesses and industries. The situation is, as most of the distinguished members of this committee have stated on various occasions, indeed serious.

The growing economic calamity facing the general public, however, is only a shadow of the disaster being experienced by the poor. Even in the boom years of the mid-1960's, large numbers of the poor were unable to find employment in our "full-employment" economy. Now that marginal industries and businesses are going bankrupt and industrial plants are cutting back their labor force, the poor, who can most often find employment only in such enterprises, are facing unemployment and poverty of disastrous magnitudes.

In ths area of increasing poverty and suffering, we must not seek to balance our budgets by eliminating our spending on the poor. We must continue with our national commitment toward eliminating poverty and mitigating its effects. That is why I urge you to approve this appropriation for the Community Services Administration. This Government agency, whose constituency and concern has been and is the poor, is the most logical conduit for continuing our commitment and providing essential services to the poor in this time of economic suffering.

I would like to specifically urge that you approve a current appropriation of $15 million for section 228, Consumer Programs and Cooperatives and that this appropriation be renewed for each year of a 3-year period. The approval and implementation of an authorization for this section can be extremely significant for the low-income consumers of this country.

As I said before, we, as a Nation, are experiencing a severe economic crisis. The consumer, through reduced income, higher prices, and scarcity of commodities, is carrying the burden of the crisis. Low-income consumers have been especially burdened. The energy crisis, inflation, recession, unemployment, et cetera, have all combined to drastically reduce the low-income consumer's standard of living. An appropriation approval for this section would provide communities, under the guidance of the Community Services Administration, with an important tool for mitigating the effects of recession and inflation.

Consumer programs and cooperatives are important to low-income consumers in that they provide the vehicle for such consumers to pool their resources and pull together to reduce their expenses and better their lives. Consumer and cooperative programs have always been an important part of U.S. history. Cooperative stores, financial institutions, and housing developments have consistently been created and used by the poor to improve their position in life and to maximize their available income. Cooperative efforts among poor farmers have been stimulated by hard times and meager income and more importantly by Federal Government encouragement during and immediately after the Great Depression.

In this serious economic crisis, it would be fitting for the Congress

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to once again provide stimulation to this always important movement. Your approval of the appropriation under consideration would provide such stimulation, and would better enable consumers to practice economies of scale and obtain greater benefits for their limited incomes.

I would like to urge this distinguished committee to specifically target, for each year of a 3-year period, $7 million of the above-mentioned $15 million to be used for the strengthening and continued development of community development credit unions.

The community development credit union is one type of cooperative program which can be extremely important in achieving the goals of section 228. It is a consumer-owned neighborhood-based financial institution. Its neighborhood base and member-developed policy insure that it will act to multiply the effect of existing community capital flows for the benefit of low-income areas and residents alike. It represents an already existing, effective way for the poor to pull themselves up by their collective bootstrap.

The community development credit union emphasizes savings and thrift, an important factor in this era of inflation. It extends credit, based on pooled savings to those who have been isolated from traditional sources of credit. It assures that credit is extended for provident purposes and that members are well educated regarding the needs and use of such credit. Its existence and actions keep capital in the community, circulate such saved capital in useful and productive ways and effectively increases the impact of each dollar entering the community.

The community development credit union is also capable of providing much needed low-income consumer services such as food stamp sales, free check cashing, and consumer education information. It can help a member resolve his financial problems and can act as a manager for his financial affairs. It can be the neighborhood source of tax and accounting information and assistance. It can assist low-income people, who are often the last to receive fuel allotments, by assuring member fuel bill payments and thereby obtaining regular customer status for them. The importance of the community development credit union is that each credit union can tailor the provision of such services to the particular needs of its community.

As an agent for community development, the community development credit union can make business loans, home improvement loans, home weatherproofing loans and education loans. It can cosponsor other cooperative neighborhood developments and act as a conduit for outside capital into the area.

In testimony to the Banking and Currency Committee of the U.S. House of Representatives (September 17, 1974), I stated that "community development credit unions can meet the credit needs of the poor; that they can act as a catalyst for change." I ended by testimony by affirming that, "only through cooperative ventures—where service is provided at cost—can the credit needs of economically impacted areas . . . be served." [Testimony is attached.]

Recently, the Credit Union National Association (CUNA) undertook a study of the current status and impact of community developmore credit unions under terms of a grant from OEO, now the Community Services Administration, and with the assistance of the

National Credit Union Administration (CUNA). The CUNA study substantiates what I stated in my earlier testimony and serves as the basis for my statements in support of community development credit unions at today's hearing.

The August 1974 study found that the 202 community-development credit unions included in the survey now serve over 125,000 low-income people throughout the United States. They have total assets of $21,539,000 and have loaned over $81,572,000 since their organization. In 1973, they had an average share account growth rate of 30.7 percent and an asset growth rate of 33.7 percent, both of which are more than twice the rates of growth achieved by traditional credit unions. Rates of growth for loans outstanding were also more than double the rate of traditional credit unions. In the process of demonstrating solid growth and providing needed loan capital, community-development credit unions have enabled low-income consumers to enjoy an aggregate saving of almost $5 million in interest charges. The CUNA study concluded that ". . . (the above facts) suggest that credit unions in our sample are viable economic institutions and have a significant impact on their communities." However, the study noted also that community development credit unions, "have significantly less liquidity than other credit unions of similar size, provide services in excess of those usually provided by credit unions of similar asset size, need significant inputs of capital to overcome low-income individuals short-run inability to save, require additional specialized training and must develop comprehensive business plans which list the route by which the credit union plans to achieve self-sufficiency."

In September of 1973, my testimony to the Banking and Currency Committee of the House of Representatives stated that, "positive action must be taken to provide those credit unions with the capabilities to meet the credit needs of the communities which they serve. Only in this way can we alleviate the economic disaster facing the poor." Those words are as true today as they were then.

By targeting $7 million from section 228 for each year of a 3-year period to the development of community development credit unions, the Congress can assure the development of an innovative program designed to stabilize and strengthen community-development credit unions and their communities. Such a program would require assistance in specialized management and planning, capitalization, planned subsidy, and the acquisition of data processing capability.

The National Federation of Community Development Credit Unions has prepared such a program. The proposal describing this program has already been submitted to the Community Service Administration. I have attached a copy of this proposal to my testimony and I respectfully request that it be included in the record of this subcommittee meeting.

The success of the federation program requires only the three yearly appropriations of $7 million. With such funding, the federation expects that the community credit union movement will, by 1980, achieve:

1. Assets of $85 million.
2. Shares totaling $81 million.
3. Loans outstanding equal $81 million.

4. Data processing capability in all currently viable community-development credit unions.

By that date, the majority of currently existing community-development credit unions will have reached self-sufficiency. Those which are viable but which have not yet reached the state of self-sufficiency will be well on their way to success. The community credit union fund, proposed by the federation as its vehicle for capitalization, will remain as a stimulus for other low-income communities to establish similar credit unions thereby providing for their own economic development.

More specifically, a comprehensive development program, backed by congressional support, would enable community development credit unions to—

1. Satisfy loan demands of their low income members for low cost loans.
2. Increase income.
3. Attract increased membership.
4. Diversify loan portfolios.
5. Provide more services more efficiently.
6. Acquire needed data processing hardware.
7. Obtain operational assistance until they reach self-sufficiency.

In addition, by strengthening community development credit unions, the Congress, on the national level, can—

1. Strengthen the base for building the economic infrastructure needed for initiating rational economic and social development within low income areas.
2. Provide low income communities with an effective means of controlling their financial resources and goals.
3. Increase the impact of each dollar—public and private—entering low income areas by insuring continuing reinvestment in those same areas.
4. Act to inhibit chronic negative flows of income which now drain low income areas.
5. Provide an indigenous source of capital for minority and low income business development.
6. Provide a way for low income people to cooperatively invest in the growth of their own communities.

In closing, I cannot emphasize too strongly the importance of your approval of the authorization for the Community Service Administration. The funding of section 228 and the specific targeting of funds for community development credit unions are both essential to the ability of the low income consumer to survive our present economic situation. I trust that you will seriously consider their importance when making your final decision.

Thank you.

[The attachments follow:]

Mr. Chairman, members of the Banking and Currency Committee, my name is Adolfo G. Alayon. I am the executive director of the consumer action program of Bedford-Stuyvesant, Inc., known as CABS Corp. CABS is an economic development corporation located in the northern Bedford-Stuyvesant, southern Williamsburg area of Brooklyn, N.Y.

I am delighted to have the opportunity to appear before this distinguished committee to discuss the current credit squeeze, its effect on economically im-

pacted areas such as Bedford-Stuyvesant, and our experiences in dealing with and mitigating this problem.

Since the end of World War II, we, in the United States, have experienced a credit revolution. The easy availability of credit has enabled millions of people to buy houses, start businesses, purchase the products of our technological society, to change the whole fabric and style of their lives.

Although our needs and wants create an ever-increasing demand for the expansion of credit, we are faced today with a credit shortage. I am sure that you, as members of this committee, are well aware of the reasons for the shortage and, therefore, I will not spend time discussing them. What is important is the businessman, the industrialist, the enterpreneur, the middle class, those who have traditionally made the most extensive use of credit, are now being asked to refrain from its use.

While the American economy suffers from a credit squeeze, the poor face a credit disaster. For those who have been unable, as yet, to partake in the benefits of our economy, the loss of access to credit only heightens the walls that act as barriers to their entrance into the mainstream of society.

Even when credit has been readily available, lending institutions have failed to meet the community credit needs of impoverished areas such as Bedford-Stuyvesant. Businessmen and consumers of such areas were most often considered the least eligible for credit. Banks have rarely located in these areas. Also, bankers perceived investments in the inner city as high risk and low profit. Mortgages were not approved. Business loans were a rarity. The small consumer-size loans most often needed by inner-city residents were viewed as little or no profit ventures.

Unfortunately, this shortage is occurring at a time when credit demand in the inner city has dramatically increased. Minorities and the poor have been encouraged to help themselves rather than depend on government intervention to improve their lives. Community self-help programs have been advertised as the only way to reverse neighborhood deterioration. Organizations such as CABS have been funded to generate new business development and provide technical expertise to other promising entrepreneurs. All of these—housing renovation, business development, self-advancement—require credit availability.

With credit becoming relatively more expensive for everyone, only those with considerable collateral or very good credit ratings can hope to obtain credit. As a result, the poor's access to the capital needed to buy a house, start a new business, or improve their life has been drastically reduced. They cannot, as others before them, use borrowing capability to increase their economic and social mobility. They must resign themselves to continue life as before or fall into a cycle of endless dependence on the loan shark.

We at CABS have firsthand knowledge of the debilitating effects which a lack of credit has in the inner city. In our consumer advocacy work, we realized that inner-city residents, as consumers of housing, products, or services, had to rely almost entirely on suppliers from outside their own community. They did not have the resources to produce these things for their own consumption. Capital flowed out of the community and consumer goods flowed in, but no economic base for capital investment was ever developed. Efforts by the residents to own or produce the things they consumed were frustrated because of the lack of credit. Thus, one of the major causes of continued deterioration within Bedford-Stuyvesant was the inability of the poor to obtain the credit necessary to purchase and renovate existing housing or to establish and expand business enterprise.

We realized that the success of our efforts to reverse these trends of deterioration and to provide the Bedford-Stuyvesant community with a stake in the society as a whole depended on the ability of the residents to help themselves. Therefore, we established the CABS Demonstration Federal Credit Union. Through member deposits, we intended to pool savings and thereby create the capital from which loans could be made.

From the first, CABS Credit Union was different from most previously existing credit unions. We viewed it not only as a method for pooling member savings for their own benefit but as a tool for economic development. We sought and obtained outside, nonmember deposits and we actively engaged in a business loan program. We used the credit union as a base to arrange a loan pool agreement with an area bank. It has also served as the sponsor for a $2.2 million housing development, a $6 million nursing home project, and a housekeeper vendor agency. These projects have provided more than 700 jobs as well as needed services to our community.

CABS Credit Union has granted $2 million in loans to residents of its 62-block target area during the last 5 years. Each year has seen an increase in membership, assets, and loan volume. Operations for 1972 ended with $587,210 in assets and $500,584 in outstanding loans.

We have been able to answer some part of the credit needs of our area. However, we are being inundated by the fast increasing demand for loans.

During the last 6 months, aside from small consumer size loans, we received applications for $203,400 in mortgage or business loans. An additional $25,500 in business loan applications was received under the loan pool agreement. These have all been solid applications with good prospects for success. Due to our limited resources, however, we have only been able to grant loans totaling $54,400.

We understand that the economists want to cool off the economy. We understand that they are asking the various sectors of the economy to slow their spending, their purchasing, their investment. But, we say to the economists: "How can you slow down if you are not even moving?"

With an aggressive campaign, we feel that we could make $500,000 worth of solid loans within 90 days and $2 million within a year. These loans would go a long way to develop a capital base within the area, reverse trends of deteriorating housing, provide jobs, and create increased community pride. The need and the demand exist, but the supply does not.

Community development credit unions can meet the credit needs of impoverished urban residents. They can act as a catalyst for change. However, positive action must be taken to provide these credit unions with the capabilities to meet the credit needs of the communities which they serve. Only in this way can we alleviate the economic disaster facing the poor.

We think that a community development credit union fund should be established. This would provide the means by which outside investors could channel capital into inner-city credit unions. Tax incentives should then be established to attract those outside deposits and also to cover any differential in profit which the investor might incur by diverting his money from more profitable investments. Restrictions which limit a credit union's ability to grant mortgage loans by imposing a 10-year repayment limit should be lifted. This is essential, for only through access to capital can the poor improve their own lives.

I finally want to make the point that we are not asking you to create or encourage direct competition for the banking industry. As I previously pointed out, banks have never served areas such as Bedford-Stuyvesant. Indeed, it is not profitable for them to do so. Their constituency lies in the areas of greater, more easily realizable profit. This is as it should be for banks are, after all, profit-making enterprises.

We ask for your assistance because only through cooperative ventures—where service is provided at cost—can the credit needs of economically impacted areas such as Bedford-Stuyvesant be served.

Thank you.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

WITNESS

HON. ROBERT DUNCAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. FLOOD. I see we have Congressman Duncan on board. Shall we take you now, Mr. Duncan?

Mr. DUNCAN. Thank you, sir.

Mr. FLOOD. Congressman Robert Duncan, the gentleman from Oregon.

Mr. DUNCAN. Mr. Chairman, I am Bob Duncan, Congressman from the Third District of Oregon. I am appearing here today in connection with the problem I understand has arisen before your committee in which apparently the administration proposes a user charge to finance the administrative costs of administering the Longshoremen's and Harbor Workers' Compensation Act.

I have a prepared statement to submit for the record and, if I may, I'll just simply summarize very briefly my thoughts.

Mr. FLOOD. Yes, sir.

Mr. DUNCAN. Before I start I ought to point out to the committee that during my vacation or absence from the Congress of the United States I practiced law in Oregon. In the course of practicing law my partners and I, and other lawyers around the country, represented industry in an effort, which was finally successful, to overhaul the Longshoremen's and Harbor Workers' Compensation Act.

It took place a couple of years ago. So I really represented the industry participants in that activity. It was an effort that was joined in by substantial parts of organized labor and had the support of the administration at the time.

I have three problems with this effort on the part of the administration to switch administrative costs from the General Treasury to a so-called user charge.

The first one that occurs to me is that it is entirely inappropriate for it to be brought up in front of this committee. It strikes me that it would be subject to a point of order if it should appear in your legislation. That is purely a procedural matter.

Then I go to the merits of the case. I know from my participation that the success in passing that Longshoremen's and Harbor Workers' Compensation Act, which I consider to be a monumental piece of legislation in the field of workmen's compensation, was a very delicately balanced compromise that drew support from the administration, from labor, and from management.

A part of that compromise among these ordinarily contesting factions was that the administrative costs would be paid by the Government. It seems to me to be entirely out of order when a piece of legislation of such magnitude is finally passed, for the Government then to come in and say:

> Well, yes, we agreed to that a couple of years ago, but now the bill is passed, now we are concerned about the financing and we need the money. Therefore we are no longer going to live up to what this tacit agreement was.

I am not saying that it was spelled out in words of blood, but it certainly was an understanding and agreement.

I just don't think that the Government ought at this point to come around and say:

> No; we aren't going to do what we said we were going to do.

Finally, Mr. Chairman, I have no philosophical objection to user charges. I think where a special benefit is received there is nothing philosophically wrong with the Government levying a special charge. I don't conceive, however, that this proposal falls into that category. I thing an examination of the Supreme Court cases to which I have referred in my statement would convince the committee that this is

really not a proper area for a user charge in the sense of being a specially identifiable service rendered to a specific group, distinct from the benefits that insure to all of us as members of the body politic of the United States.

I have made the more detailed arguments in my statement. I know you have a lot of witnesses to hear. If you have any specific questions I would be glad to try to handle them, sir.

[Mr. Duncan's statement follows:]

PREPARED STATEMENT OF ROBERT B. DUNCAN, THIRD DISTRICT OF OREGON, CONGRESS OF THE UNITED STATES, HOUSE OF REPRESENTATIVES

During the 8-year period between this and my preceding term in the House of Representatives, I practiced law in Portland, Oreg. As part of that practice, I participated in supporting the enactment of those amendments to the Longshoremen's and Harbor Workers' Compensation Act which have created a need for additional administrative funds.

The administration seeks to obtain those funds through the assessment of "user charges" against maritime industry. I appear today to express my opposition to the administration's proposal.

The "user charge" proposal should be rejected for at least two reasons. First, it would be unfair to maritime employers to now overturn one of the understandings through which industry support of the 1972 amendments to the Longshoremen's and Harbor Workers' Compensation Act was obtained. Second, the type of user charge sought here is not, in my opinion as a lawyer, authorized by law. In fact, it appears to be exactly that kind of charge or fee which the Supreme Court has recently ruled is unlawful.

Some short background may be helpful.

Senate bill 2485 was introduced by Senators Yarborough of Texas and Morse of Oregon in 1967. The bill basically sought (1) substantial increases to the benefit levels payable to workers covered under the Longshoremen's Act; and (2) the substitution of administrative expense "user charges" for the existing appropriations funding provisions.

Hearings on S. 2485 were held during November 1967 and January and February 1968. Those hearings demonstrated that the increased benefit levels would be acceptable to industry if (1) The longshoremen's right to sue vessel owners for unseaworthiness—and vessel owners' right to sue stevedore companies for indemnity—were removed; and (2) the administration's proposed "user charges" were deleted. S. 2485 was not enacted.

The need for increased benefit levels by injured maritime workers continued to grow. The introduction of Senate bills 2318 and g25 and House of Representatives bill 12006, and the eventual enactment of 1972's amendments, marked the end of over 12 years of work to improve the benefit levels.

The maritime industry supported the 1972 amendments. That essential support was, in large part, based upon the eventual inclusion of provisions which precluded "unseaworthiness" suits and the accompanying indemnity claims against maritime employers.

The other basis for industry's objections to the 1967 amendments——the administration's proposed adoption of "user charges"—was avoided by the fact that none of the 1971 bills included a "user charge" provision. All bills and of course, the eventual amendments, left the act's appropriations provisions intact.

Acceptance of the current "user charge" proposal would violate one of the understandings which gave rise to industry's support for the 1972 increase in compensation benefit levels. That would be unfair.

My second reason for opposing the user charge proposal is quite simple: The Supreme Court has held that "user charges" analogous to those proposed here are not authorized by the Independent Offices Appropriations Act of 1952.[1]

The Federal Power Commission established the practice of assessing electric

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[1] *National Cable Television* v. *United States*, 415 U.S. 336, 39 L. Ed. 2d 370, 94 S. Ct. 1146 (1974); *Federal Power Commission* v. *New England Power Co.*, 415 U.S. 345, 39 L. Ed. 2d 383, 94 S. Ct. 1151 (1974).

utilities for the costs of administering the Federal Power Act. The assessment was based upon the utilities' wholesale sales and interchange of electricity. In 1973, that assessment totaled $5 million. Similar charges were assessed against natural gas companies.

The authority for the assessments was said to be the Independent Offices Appropriations Act of 1952. The rationale for the assessment was the Federal Power Commission's view that, while its regulatory activities were beneficial to consumers, those activities had provided

* * * the foundation for the sound financial condition which public utilities and natural gas companies have achieved.

New England Power Co. and others brought an action in the Court of Appeals for the District of Columbia to set aside the assessment. The Court of Appeals agreed with New England Power. The Supreme Court affirmed that decision.

The Court of Appeals held that whole industries are not in the category of those which may be assessed, the thrust of the act [The Independent Offices Appropriations Act of 1952. The rationale for the assessment was the Federal specific services to specific individuals or companies. We agree with the Court of Appeals. [415 U.S., at 349.]

The Supreme Court stated that Office of Management and Budget circular No. A–25, September 23, 1959, expressed the proper construction of the Independent Offices Appropriations Act. That circular explained that a reasonable charge "should be made to each identifiable recipient for a measurable unit or amount of Government service or property from which he derives a special benefit."

The circular also states that no charge should be made for services rendered, "when the identification of the ultimate beneficiary is obscure and the service can be primarily considered as benefitting broadly the general public."

[415 U.S., at 350.]

In a companion case, the Supreme Court also struck down the Federal Communications Commission's industrywide administrative cost assessments against Community Antenna Television systems.

In their concurring opinion, Justices Marshall and Brennan discussed the Independent Offices Appropriations Act of 1952 and its legislative history:

The actual language of the appropriation act is quite general, and is certainly capable of varying interpretations but the intended content of the statute's authorization of fees, can be gleaned from this legislative history, it contemplated imposition of application fees, registration fees, and fees for grants of licenses, permits, or other similar authorizations—nothing in the legislative history suggests any broader interpretation—the very lack of debate over this provision of the act and the ease with which it passed compel the more limited interpretation. The committee report itself noted that more basic changes in agency fee practice would have to await further study by congressional committees and additional legislation. H.R. No. 384, 82d Cong., 1st sess. 2–3 (1951). [415 U.S., at 356–357.]

Perhaps the Longshoremen's and Harbor Workers' Compensation Act does provide generalized benefits to its covered employers. Certainly the act benefits injured workers and their dependents. In my opinion, the act also benefits the Nation's society.

Whatever benefit is conferred upon industry, I believe that the Supreme Court would hold it too general to justify imposition of a fee.

The administration's user charge proposal would not pass the Supreme Court's muster. I believe it should be rejected by this subcommittee.

Mr. FLOOD. Thank you very much.

Mr. DUNCAN. Appreciate it.

Mr. Chairman, before I leave may I commend your attention to my former law partner from Portland, Oreg.; Mr. Dennis Lindsey, who will appear, Mr. Wilcox, and Mr. Vickery with whom I worked closely in the preparation of that case at sometime later.

Mr. FLOOD. Thank you.

WITNESS

DR. TOM JONES, NATIONAL ASSOCIATION OF FARMWORKER ORGANIZATIONS

Mr. FLOOD. Dr. Tom Jones, National Association of Farmworker Organizations.

Dr. JONES. Mr. Chairman, my name is Dr. Tom Jones, representative for the National Association of Farmworker Organizations, a national mobilization of farmworker programs throughout the country, which wishes to express its concern to you today on behalf of the more than 2½ million migrant and seasonal farmworkers in the United States. The survival and development of these people once again rests in the hands of this Congress. The NAFO feels that it is critical to retain a specific allocation for title III, part B of the Community Services Act, specifying services for migrant and seasonal farmworkers. This part of the act calls for the Community Services Administration to administer nonmanpower, developmental activities and for the coordination of Federal agencies' operating funds on behalf of migrant and seasonal farmworkers. The designation of CSA as a lead agency with regard to the activities at the Federal level for these itinerant workers and their families is critical if we are to maintain the little ground gained over 10 years of concentrated effort.

For the past 20 years, spokespersons have addressed the Congress on the critical plight of agricultural laborers and their families, and for as many years, the death and misery of these workers and their children has continued to haunt the Nation. Testimony presented over the years, and again today, speaks to the continuing societal separation of migrant and seasonal farmworkers—physically, racially, culturally, and economically—from the mainstream of American life.

It is evident that our present economic and human development policies continue to single out farmworkers and to abandon them to a life of institutionalized poverty. It is outrageous to think that today, as migrant families are leaving their home-base areas in the southern part of this country to travel north, more than 10 times as many witgrant children will die this year as will the children residing in towns to which the migrants will travel and temporarily reside in order to work; that two migrant family members will die for every one nonmigrant death from influenza or pneumonia in those towns; and that in 1975 and 1976, more than twice as many migrants will be stricken with tuberculosis as will nonmigrants. The incentive for all this suffering is less than $2,500 per year for each migrant farmworker family.

Regulatory measures enacted by Congress have continued to be only half-implemented and enforced. Crewleader Registration Act, child labor provisions, social security, workmen's compensation, unemployment insurance, OSHA, minimum wage enforcement, and housing regulations—many of these provisions considered to be basic rights for American citizens and workers under protective covenance of law—either do not come to the farmworker at all or have been extended to him or her only after great struggle by way of community protest and action.

Federal assistance directed at the problems of migrant and seasonal farmworkers is administered by at least eight various Federal agencies on a splintered, uncoordinated basis through numerous programs, each having separate legislative authority and intent. In 1973, the Office of Economic Opportunity's Migrant Division was transferred to the Department of Labor under CETA, Title III, Section 303. The expectation at that time was that the broad-based efforts initiated and refined by the OEO agency over an 8-year history would be maintained and expanded. Instead, CETA Title III, Section 303 funds became restricted in program comprehensiveness and flexibility. Furthermore, migrant and seasonal farmworker-governed organizations have begun to be excluded from the CETA funding processes, opening the door for nonfarmworker-oriented, less effective program conduits at the local and State levels.

There are more than 125 farmworker-governed organizations throughout the United States. Over 5,000 farmworkers and former farmworkers participate on the policy boards and advisory councils of these farmworker organizations. These independent, farmworker-governed organizations constitute through their regional and national associations, the largest representative body of farmworkers in the Nation. Additionally, these organizations reach out to more farmworkers than any public or private organization or group in the United States today.

Farmworker organizations have traditionally been multiagency coordination points at the local level, bringing together segmented programs from a number of agencies into an integrated comprehensive program for the farmworker. Farmworker organizations are also major advocates pressing for the steps necessary to improve the social, physical, educational, and cultural life of these isolated workers.

Often this advocacy would bring farmworker organizations to the doors of Federal and State agencies to work out problems; unfortunately, the plight of the migrant and seasonal farmworker now extends to the disjointed services and second-rate care of the Department of Labor and other major Federal and State agencies. In order to effectively resolve these problems, an objective, neutral lead agency must be designated within the Federal system which can analyze, monitor, and resolve these discrepancies.

Some confusion and misunderstanding has taken place between Congress, the administration and farmworker organizations in the field on this matter of funding; specifically, whether funding to CSA for farmworkers is duplicative of CETA funding.

Since CETA has been funded and as policies have been institutionalized over the past 9 months, the scope of the programs have been increasingly restricted to the point where it becomes apparent that CETA through DOL intends to stratify the 303 funds into a limited manpower training program. This seriously hinders the development of activities critical to working with these families in areas not supported by CETA.

The tragic outcome to this strategy may well mean that farmworker organizations will be forced or otherwise pushed out of this lead role as coordinators and advocates at the local and State level. Additionally, other resources mobilized from these developmental bases would be lost to the organizations and thus, to the families

themselves. Even worse, the fragile coordination mechanisms and working arrangements developed between farmworker organizations, private industry, merchants, community groups and political leaders will also be lost to the workers and their families.

In summary, the role farmworker organizations have played in reform, advocacy, program development and community services for farmworkers has been critical to much of the progress made over the past 10 years. That role has been based on the administration and support of a comprehensive flexible, funding source.

The foundations for viable community development, social service capabilities, and interagency coordination still exist throughout the country, through the farmworker organizations, even though the present anticipated future policies within the Department of Labor threaten the survival and continuation of these services to the families.

Considering the historical lack of performance by DOL with farmworkers, and its relationships to farmworker organizations there needs to be serious and immediate thought to the prudence of DOL being designated or assuming the lead role on behalf of farmworkers in this Nation. DOL seems to be actively declaring its intention to stay out of any coordination or lead role. All voices from DOL speak to the wish to see another agency coordinate and advocate on behalf of farmworkers. HEW has discussed the idea of a national migrant and seasonal farmworker agency within its office, but the idea seems to have cooled off recently; the Department of Agriculture does not have as much responsibility related to farmworkers and its track record is more mediocre than the Department of Labor's. Only one Federal agency has the scope, structure—or at least potential structure, and the legislative mandate to perform the task; clearly the Community Services Administration can and should do the job. Its mandate to be the overall advocate at the Federal level for the poor and disadvantaged, its history of mobilizing other agencies to better serve the poor and the Nation's farmworkers through the old OEO process, indicates that CSA should assume its renewed mandate toward migrant and seasonal farmworkers and their families.

At the time of the budget hearings last year, the Community Services Administration Director suggested the funding of a migrant office within CSA would be duplicative of CETA 303 efforts. He could not have known at that time what restrictions would be forthcoming from DOL–CETA affecting farmworkers. After recent analysis, however, CSA has recently acknowledged the need for additional, more comprehensive efforts within the farmworkers community. An appropriation to the Community Services Administration for farmworkers would not negate or duplicate CETA 303 efforts; the need continues to exist for manpower efforts for farmworkers; with the onus of advocacy and comprehensive programing apart from DOL–CETA, its training activities can be more easily put into context with the entire process of assistance and opportunity demanded of a comprehensive strategy. As these comprehensive strategies are put back into place in local communities, the call for services from special programs like CETA 303 will increase correspondingly; with comprehensive programs operating once again, achievement can begin to replace half-empty promises to the organizations which have resulted in disjointed services to the farmworkers and their families.

The cost incurred in establishing a farmworker division at CSA will be more than offset by the resources which are mobilized by farmworker organizations. Based on past performances, the organizations operating comprehensive strategies similar to that proposed here for CSA, will mobilize additional funds on a dollar-for-dollar match. If CSA does not assume its responsibilities in this area, it is likely that the organizational bases funded through CETA will not provide a broad or flexible enough foundation with which to mobilize, develop and maintain present outside resources reaching farmworkers. Therefore, without this minimal investment, farmworkers stand to lose millions of dollars in fiscal year 1976, which otherwise could have reached them.

Utilization of CSA funds in nonmanpower, developmental activities—as specified in the amended legislation, is critical in the areas of:

Outreach, in areas not related to job or training recruitment;

Information, related to available services other than CETA 303 activities;

Emergency services, in areas of emergency food, transportation, medical care, and protective counsel;

Special higher education models;

Adult education, particularly noninstitutional type—like driver's education in the camps, buying clubs, consumer group education, and action groups;

Day care and child development—for children whose parents are not in CETA 303 activities, and for use as incentive money to mobilize other child development activities;

Media development;

Youthwork—cultural development, arts and literature;

In-stream education—literacy on the road programs, interstate tutor projects, etc.;

Advocacy and issues development facing farmworkers;

Activities and programs for farmworker women;

Activities and programs for senior citizens;

Housing development projects for farm laborers and for families resettling;

Cooperatives and buying clubs—growing, marketing, and purchasing groups;

Economic development projects dovetailing into existing manpower capabilities in CETA;

Program and resource development activities:

Communitywide development and planning;

Farmworker involvement and policy formation on councils and boards; and

Interagency and interorganizational coordination.

This preceding list includes areas that are now, proposed to be or anticipated to be restricted by DOL, CETA, title III, section 303, for farmworkers in fiscal years 1976 and 1977. With CSA administering farmworker, nonmanpower developmental activities, the opportunity for farmworker organizations to provide farmworkers with viable choices of either developing more competitive skills within the farmlabor economic area on moving from the agricultural labor field to year-round stable employment and better economic stability is greatly increased. The operational capabilities of the local farmworker orga-

nizations will be broader and more comprehensive, thus increasing the impact and scope of opportunity and service to the farmworkers themselves.

Based on these critical needs this coming season and in the future years ahead, the National Association of Farmworker Organizations respectfully requests that this subcommittee direct the community services administration in fiscal year 1976 to administer through a national migrant division, comprehensive nonduplicating programs for migrant and seasonal farmworkers at the national level, in areas related to nonmanpower, developmental activities; and to coordinate Federal migrant and seasonal farmworker programs and activities.

We urge Congress to move one step further towards alleviating the conditions farmworkers face each year, by insuring, through the development of a strong, comprehensive, coordinative agency, that all available and appropriate Federal resources are applied to the critical problems of the migrant and seasonal farmworkers harvesting food for this Nation.

Mr. FLOOD. Thank you.

Dr. JONES. Thank you, Mr. Chairman.

HEW HEALTH PROGRAMS

WITNESS

HAYNES RICE, DEPUTY COMMISSIONER OF HEALTH, NEW YORK CITY HEALTH DEPARTMENT

Mr. FLOOD. Mr. Haynes Rice, the deputy commissioner of health, city of New York.

Mr. RICE. Mr. Chairman, I am Haynes Rice, deputy commissioner of health, New York City Health Department representing the providers of New York City's health services. On behalf of the city of New York I would thank you for giving me an opportunity to present our views on the subject of the HEW health program appropriations for fiscal year 1976. I would like to focus on the appropriation recommendations made by the administration which are far from being adequate. First the administration's assumption that constant levels of funding will buy constant levels of services is incredulous, especially in light of inflation—formerly the No. 1 problem of the administration. Now public enemy No. 1 goes unrecognized at least as far as inflation in costs of health services is concerned. Second, the administration budget seeks to transfer to the State and local governments the increases resulting from its cuts on the Federal level.

At a time of recession, unemployment and cutbacks in existing services New York City and other local governments cannot assume new costs. Administration officials themselves have suggested ideas on how to slash city services while simultaneously asking for more local funding of Federal programs in the same breath.

We understand this administration would like to eliminate Federal participation on certain health service programs over the next few years. We ask how this attitude of indifference to the health problems of the urban and rural poor can remedy the tremendous

inequities of the health care system, which these very Federal programs were created to solve? For as the Government deliberates, and then retires to their respective communities, the Nation's poor, the politically unconnected will have to live with these service reducing decisions.

My introductory remarks I will keep brief, for the general public has but 3 days to present its views while administration officials have had a generous 3 months. However, I will indicate what the proposed administration budget cuts would mean for New York City, as well as suggestions for national level funding which would be the bare minimums for program operation.

COMMUNITY HEALTH CENTERS

Mr. Chairman, the community health centers of New York, 18 in State, 9 in New York City, supply a crucial wedge for the city's low income persons in our medically underserved areas. The city's centers until 1974 were seeing patients who were approximately 60-percent medicaid; 40-percent nonmedicaid. Over the past 2 years this figure has dramatically changed to approximately 70-percent nonmedicaid due to the increased number of people now on unemployment insurance.

The administration's proposed 20-percent reduction in financial support will close two of New York City's nine centers placing 75,000 residents who are already medically underserved in a situation with minimal medical alternatives.

Additionally these cutbacks will place 550 people out of jobs adding to the city's already spiraling poverty cycle.

Our city is presently at the bottom line in its appropriations. A recent administration decision has negated any possibility of Federal city aid, and the New York State has vetoed a proposed tax increase.

Mr. FLOOD. New York State Senate?

Mr. RICE. New York City.

Mr. FLOOD. The New York State Senate has vetoed?

Mr. RICE. Yes.

An increase in New York City's contribution to meet and maintain the health centers at fiscal year 1975 level of services, at a time when the city is already cutting back, and laying people off is impossible. In fact the current economic situation mandates an increase in funds and not a decrease.

The administration expects that the cities can raise their reduced share partially through third-party reimbursement. However, a GAO study has already pointed to the fact that neighborhood health centers have already maximized third-party reimbursement.

I would like to point out that because throughout the legislation it is pointed out that perhaps the centers might be able to raise the money that they can collect from third-party reimbursement when the Government study already shows that they are maximizing their effort and are unable to get the people because many of the programs are not covered under medicaid and many of the people seen by this group fall into the working poor class and are not covered by medicaid.

So to say that they can get more money out of medicaid is inconsistent with their own study.

Gentlemen, we are convinced and our documentation proves that the proposed level of funding will significantly reduce the services offered by community health centers throughout our city.

Recommendation: The city of New York recommends that 230 million be appropriated for community health centers.

MATERNAL AND CHILD CARE

Title V of the Social Security Act authorizes this most important program for maternal and child care. Most important because children comprise 40 percent of our population today, but are 100 percent of the population tomorrow, their needs must be our concerns for the future of America. The operation of this program has produced some startling results and to reduce its funding by 3.2 million in New York City would produce irrefutable damage. Since 1968 according to the coalition of health funding, we can measure the success of child health projects through the decline in hospital admissions for children served. In 1968 7.7 percent of the children needed hospitalization. As a result of child care programs the comparable figure in 1974 was 2.4 percent. The average per capital cost decline was from $201 in 1968 to $130 in 1974. If these programs were not provided the medicaid expenditures are up to $300 per child. Maternity and infant care projects have also made a major impact to the reduction of infant mortality in our city.

The projects have successfully demonstrated that women with little education accustomed to emergency and episodic care, will respond to an opportunity to obtain preventive prenatal care. Women who do not receive the full advantage of receiving this type of preventative care have a far greater incidence of infant mortality than those who receive care during their pregnancies. A recent study by the National Academy of Sciences reports that the 1969 New York City rate of 21.9 deaths per 1,000 births could have been reduced to 14.7 per 1,000. These infants of poorer families needed what millions of other more fortunate receive, that is adequate health care. According to the study excess deaths were preventable.

Cuts of this nature we believe are unconscionable. The most assured way to raise medical cost in the future is to cut preventive maternal and child care. We are certain that the dollars needed today, for early treatment are far fewer than those needed tomorrow for hospital and institutional care.

Recommendation: We most strongly recommend that the $3.2 million in cuts be rejected by Congress and at the very least fund these programs at the current fiscal year 1975 funding level, allowing for actual inflation, nationally funded for $295 million, for New York City, $13.5 million.

FAMILY PLANNING PROJECTS

Family planning projects have been characterized as an example of a highly successful program effort, yet the administration has recommended that project funding be reduced by 21 percent.

Even now, in some of our communities women must wait 2 or more months for family planning services; in other communities organized programs simply do not exist or have been drastically reduced due to inflation. Projects that were established several years ago are unable

to expand while experiencing extreme difficulty serving new patients due to the 3-year freeze of family planning projects. In our city where unemployment is high and increasing, the situation is becoming tragic.

Circumstances in our city's family planning clinics are reflected in statistics documenting that women most in need of subsidized services still have the highest incidence of unplanned pregnancy, unwanted childbirth and abortion. Maternal deaths and the number of chronically handicapped children are still greater among those without access to safe reliable methods of contraception.

Obviously a reduction in funds for direct patient services represents a serious reduction of program activity at a time when other public and quasi-public agencies have curtailed services during the last calendar year.

Most significantly this funding cut will entail a reduction of services to the near-poor, nonmedicaid patient who resides in New York City's designated poverty areas; including adolescent's who represents more than 33 percent of patient census.

This funding cut would most assuredly hamper the programs' long-standing effort for quality of care, while simultaneously restraining the competitive pursuit of professional staff.

Recommendation: It is our recommendation that Congress minimally fund family planning projects at $1.6 million for New York City and $10 million nationally.

Mr. Chairman, New York City appreciates this opportunity to present our recommendations to you and the committee; I would be pleased to answer any question you may have.

I would like to add that of the nine centers in New York City, only one is operated by Government. I think that is significant and sort of points to the trend of the family care centers throughout the country, that these are efforts of voluntary hospitals and voluntary agencies to meet the needs of poor people and especially the medically poor, and without the help of Government on the Federal level we cannot expect the States and local governments will assist in this project, so whatever cuts are made to the family care centers are going to be made into the type of service that the people receive.

There is no money on the local level to pick up what the Federal Government is now doing.

Thank you.

Mr. FLOOD. Thank you.

Mr. RICE. Thank you.

NATIONAL INSTITUTE OF MENTAL HEALTH

WITNESSES

JERRY COLE, NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.
MRS. HILDA ROBBINS, CHAIRPERSON, PUBLIC AFFAIRS COMMITTEE
DR. ROBERT L. STUBBLEFIELD, MEDICAL DIRECTOR, THE SILVER HILL FOUNDATION, NEW CANAAN, CONN.

Mr. FLOOD. Mr. Jerry Cole, National Association for Mental Health.

Mr. COLE. Chairman Flood, my name is Jerry W. Cole. I am a resident of Wichita, Kansas. I am here today representing the National

Association for Mental Health. I will be assisted in my testimony today by Dr. Robert Stubblefield, from Connecticut, who will speak on the research portion of the NIMH budget, and by Hilda Robbins, from Fort Washington, Pa., who is the chairperson of our Public Affairs Committee. We are a voluntary association of concerned citizens who speak for the consumers of mental health services.

I am in the insurance business and a principal in the firm of Armfield-Cole Consultants. I am a past president of the Kansas Association for Mental Health and a member of the board of directors of the National Association for Mental Health. I have been an active volunteer for the Mental Health Association for approximately 6 years.

We are going to leave some formal testimony with you today and I will try to be brief in summary remarks.

I want to emphasize in my testimony to you the critical need for continuing adequate appropriations in fiscal year 1976 for the National Institute of Mental Health in manpower, research, administration, and community mental health centers. The recent history of the legislation in this area and the response to this legislation by the administration points up the need for concern on your part that not only the funding of this program is important, but that the intent of Congress to continue the community mental health centers [CMHC] programs be restated in a forceful manner so that there can be no misunderstanding on the part of this administration.

The entire legislative history of the NIMH budget, particularly in the area of the CMHC's, has been to provide for an ongoing program, until the 1,500 centers are achieved by 1980. In spite of this repeated emphasis by the Congress, there would appear to be massive misunderstanding from the administration, that the Federal funding of community mental health centers was only a demonstration program that has successfully proven itself and, therefore, needs no additional Federal support.

The cost of mental illness to our Nation is staggering. It can be measured in both dollars and in human agony; 1 person in 10 will require mental health services during their lifetime. However, only a small percentage of those in need of treatment are able to receive it.

For this Nation to respond adequately to the mental health needs of our people, it is abundantly apparent that funds for research, manpower training, and mental health services will have to be given a high priority. We need to increase the funding because the administration, in recent years, has repeatedly acted to thwart the will of Congress in regard to funding of mental health programs. The administration has used vetoes, impounding of funds, opposition by the Secretary of Health, Education, and Welfare, and apparent deliberate delay of programs to keep our Nation from being on target for completing the development of 1,500 centers by 1980. As a consequence, we must increase the appropriations in fiscal year 1976 to bring us back on schedule—the schedule that has repeatedly been set by the Congress for complete coverage of every catchment area in this Nation by comprehensive mental health centers.

To do anything less would be grossly unfair to those areas of our country that have not yet received Federal help in establishing comprehensive community mental health centers.

Mental illness provides a unique set of problems that do not respond adequately to the private delivery system. Insurance companies exclude, or limit, coverage for nervous and emotional conditions. An unfortunate stigma attaches itself to those who seek help. A wide area of circumstances work together to make it difficult for funds to be made available from private sources. As a result of these problems, the U.S. Congress has provided legislation to fund manpower training programs, research grants, and funds for the administration of NIMH, as well as CMHC grants.

There are many people today, in our Nation, who have been incapacitated by mental illness and who are presently dependent on public welfare programs for their sustenance, because mental health services are not available to them. Many of these people could be recovered as productive members of society if proper help were only made available to them. Our appeal is not only one of asking you for a humanitarian response, but an appeal that makes long-range economic sense. It has been demonstrated that proper community care can reduce the population of our State hospitals and change some people from tax recipients to taxpayers. At a time of concern with increasing Federal deficits, we believe a program that will restore people to productive lives should receive increased emphasis.

I am going to jump by our specific recommendations, Mr. Chairman, and ask Dr. Stubblefield if he will comment for you on our research needs.

[The balance of the statement and attachments follow:]

RECOMMENDATIONS BY THE NATIONAL ASSOCIATION FOR MENTAL HEALTH FOR THE FISCAL YEAR 1976 BUDGET OF THE NATIONAL INSTITUTE OF MENTAL HEALTH

The following are our budget recommendations:

COMMUNITY MENTAL HEALTH CENTER SERVICES

It is apparent that no Federal grant funds for CMHC's will become available in fiscal year 1975, in time to allocate such money. This is a result of the Presidential veto on December 21, 1974, of the Health Revenue Sharing and Health Services Act of 1974, which authorized funds for CMHC's for fiscal year 1975. Similar legislation has not yet been passed by Congress this year, so no funds have been appropriated for fiscal year 1975.

As a result of the failure to fund CMHC's in fiscal year 1975, the appropriations for mental health services must be increased in the fiscal year 1976 budget, if Congress and the Nation are to keep on target for completing the development of 1,500 centers throughout the country by 1980.

NAMH RECOMMENDATIONS FOR FISCAL YEAR 1976

	Total cost	Number of centers
Planning CMHC programs	$10,000,000	133
Initial operation	200,000,000	208
Education and consultation services	18,000,000	----
Conversion grants	55,000,000	275
Distress grants	30,000,000	60
Facilities assistance	30,000,000	120
Total	343,000,000	----

Authorizations in CMHC legislation passed by the Senate [S. 66] and now under consideration of the House [H.R. 4925] do not provide dollar amounts that would meet our recommendations. These authorization levels will have to be increased substantially if we are to achieve the goal of complete national coverage by 1980.

The number of centers that will require funds will vary according to the category or program. For example, more centers will require initial operations grants than will require facilities assistance, and similarly, fewer centers will require planning grants than conversion grants.

In the introduction of the vetoed Health Revenue Sharing and Health Services Act of 1974, Congress found that—

(1) Community mental health care is the most effective and humane form of care for a majority of mentally ill individuals;

(2) The federally funded community mental health centers have had a major impact on the improvement of mental health care by—

(*a*) Fostering coordination and cooperation between various agencies responsible for mental health care which in turn has resulted in a decrease in overlapping services and more efficient utilization of available resources;

(*b*) Bringing comprehensive community mental health care to all in need within a specific geographic area regardless of ability to pay; and

(*c*) Developing a system of care which insures continuity of care for all patients, and thus are a national resource to which all Americans should enjoy access.

(3) There is currently a shortage and maldistribution of quality community mental health care resources in the United States; and

(4) Until such time as legislation is enacted and becomes effective which insures all Americans financial access to the mental health services which are presently available through community mental health centers, Federal funds should continue to be made available for the purposes of initiating new community mental health centers responsive to community needs and national goals relating to community mental health care.

From the foregoing, it is very clear that Congress intends to finish the task that it started of providing seed money to all of the 1,500 communities throughout the country that need and want mental health services.

RESEARCH

The Federal Government, since 1972, has been following a disastrous policy of cutbacks in federally supported mental health research. This is a shortsighted policy which is already having serious impact on the mental health research effort in this Nation.

Society is generating mental illness more rapidly than it is generating mental health workers. The gap can be closed and the tide of increase in the number of persons suffering from mental illness can be turned back through a substantial increase in the knowledge base of mental science.

Research and research manpower development supported by the National Institute of Mental Health provide the major part of the National Research effort related to serious mental illness. Research supported by State and local government and private foundations represents less than 10 percent of the total effort. The major thrust of the attack on this urgent National problem must be led and coordinated by the Federal Government. Unless the policy of retrenchment on the part of the Federal Government is reversed, the National mental health research effort may well be reduced to a meaningless level. It is indeed foolish to interrupt the course which is underway and which holds great promise.

Despite the relative youth of the NIMH research and research manpower program, the research effort is paying off significantly. For example, much major mental illness can now be significantly controlled, in many cases avoiding the need for long term and expensive hospitalization. Drugs have become inceasingly specific for serious mental illnesses. For example, lithium is now controlling severe depression for thousands of manic-depressive patients. Increasingly refined understanding of biochemical changes in the brain connected with serious depression is leading to continuing improvements in the understanding of causes and treatment for that major category of mental illness—in itself involving 5 to 10 million persons annually, and a reported 20,000 suicides each year.

Research, in recent years, has developed impressive evidence of genetic predispositions in schizophrenia. That is, most geneticists now believe that the disease itself is not inherited but that the genetic vulnerability must be joined with other factors to produce this disabling disease. Much additional research is needed on these factors and their control before we will fully understand what is still one of the major mysteries in mental health and illness.

Fruitful research findings in mental health are by no means restricted to biochemical and biological areas. Psychological and sociological studies have produced evidence of the important effect of early childhood environment on the subsequent capacity of the child to learn, grow, and relate in normal and healthy ways. Other investigations have shown that there is a higher rate of diagnosed serious mental illness among lower income groups than among higher. Psychological and sociological research has important implications for our future understanding of mental illness and quite likely will have increasing impact on the prevention of crime and delinquency.

As we develop new forms of treatment and new systems of mental health service delivery, such as the Community Mental Health Center, research on treatment methods and service delivery becomes increasingly vital.

The most recent official estimate of the direct and indirect cost of mental illness in this country is over $36 billion per year (including costs of treatment, manpower development, lost incomes, et cetera). Again this massive drain on our human and economic resources, the current appropriation of $95 million for the NIMH research program is shameful. Even more shameful is the administration's continuing policy of cutback even in those meager funds.

Federal dollars for NIMH-sponsored research actually decreased from $95.5 million in 1972 to an appropriated $93.2 million in 1975. Considering inflation, this represents an effective decrease of more than 25 percent. If the President's rescission budget had been upheld, the 3-year decrease would have been an even more disastrous 37 percent?

This pattern of reduction over the past several years has already had very serious consequences. It has brought about a curtailment of the scope of investigations into the causes and treatment of mental illness. It has resulted in the loss of potential researchers, the impact of which will only be fully realized in the coming decades. It has destroyed continuity of a number of important ongoing research efforts. It has created a serious morale problem in the mental health research community, with negative impact on vocational choices among an unknown number of potentially productive young scientists and students.

A continuation of the downward trend would lead implacably to a widening of the gap between the number of mentally ill and our ability to treat them effectively. It would tragically postpone impending breakthroughs in our knowledge of the multiple causes of serious mental illness.

If the downward trend in support for mental health research is not dramatically reversed, planning for the many new essential mental health services will be increasingly haphazard and ineffectual, and thus wasteful and uneconomical.

Some evidence of this problem already makes newspaper headlines, as there are reports of thousands of patients released from mental institutions into the communities in poorly planned ways. Effective planning in the area of mental health service must be based on an adequate knowledge and data base. We know that the annual rate of patient care episodes, including placement in mental institutions, for children under 18 years of age has more than doubled between 1966 and 1971. During the same period the rate of patient care episodes increased by over 60 percent in the age group from 25 to 44 years. These things we know, but these are records only of treated mental disorders. For effective planning, monitoring and evaluation of mental health services, far more knowledge and data than are now available must be routinely accessible to planners and mental health administrators. For example, we need better methods for determining the extent of need for specific kinds of mental health services for specific groups and communities. We have relatively little systematic data on the fate of patients released from mental hospitals. We need far more research in cost effectiveness of service delivery. We need to improve our present service evaluation methods and to develop new, more effective methods.

If we are to reverse the destructive downward trend in the national mental health research effort, and if we are to undertake seriously a national commitment to solve the massive problem of mental illness in our society, then a firm public publicy should be enunciated by Congress and by the administration of

support for a substantial increase in our knowledge base in mental health and the mental sciences.

The National Association for Mental Health recommends as a first serious step in this direction an appropriation for the NIMH research program for fiscal year 1976 of $121.4 million of which total $28.650 million should be provided for the NIMH intramural research program and $92.7 million for the mental health research grant program.

We further recommend that a public policy be adopted to invest in research at least 5 percent of the total cost of publicly supported mental health care. This annual amount would be administered by the NIMH for research programs, including the training of research personnel. This implies an early target for the NIMH research program of approximately $200 million, or 5 percent of the $4 billion most recently estimated as the public cost of direct mental health treatment services. Industrial managers now generally believe that a percentage of total budget should be invested in product-oriented research and development, in order to maintain competitive viability. The mental health industry" must develop similar expectations in order for the necessary knowledge and professional base of the "industry" to maintain viability, and for the problem of mental illness to be brought under control and ultimately to be solved.

MANPOWER TRAINING

The NAMH recommends, for fiscal year 1976, $168,119,840 for the training of psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, paraprofessionals, and other mental health specialists. Unless one is thoroughly familiar with all the facts and the extreme needs in this area, this recommendation may appear unrealistic, considering the administration's budget request of only $65 million and an appropriation of only $94.6 million for 1975. In 1972, the administration's budget for manpower training was $120 million. Since that time, the amount requested by the administration has decreased each year. This occurs at a time of increasing need. For example, there are only 3,000 child psychiatrists in the country; however, the number of children in State and county hospitals, now 55,000, has doubled since 1963. In addition, close to 600 community mental health centers have been funded since 1972, also creating a need for many more mental health workers.

Thirty-five percent of the Nation's psychiatric residency training positions are funded through the NIMH mental health manpower program, which is supported by this appropriation. Attached is information from a number of training institutions which demonstrates clearly that the vast majority of psychiatrists trained with these funds go into full or part-time public service as contrasted with private practice.

MANAGEMENT AND INFORMATION

The association recommends $24.13 million for the NIMH management and information budget for fiscal year 1976, which is similar to the NIMH operating level ($23.1 million) in 1974. The 1975 budget passed by Congress was $19.24 million, or $4.89 million less than was needed during fiscal year 1975. At the very least, the fiscal year 1976 budget should equal the amount needed in fiscal year 1975 to provide adequate management and information services by NIMH. A cut of $4.89 million in our recommended amount would result in—

(*a*) Inability to carry out mandates under Disaster Relief Act (Public Law 93-288, section 413);

(*b*) Inability to meet responsibilities for development of approaches to professional standards review, as mandated by Public Law 92-603;

(*c*) Curtailment of CMHC site visitation and technical assistance activities, both of which were identified by the General Accounting Office as being in need of upgrading;

(*d*) Cancellation of several ongoing research contracts, with resultant waste of progress made to date;

(*e*) Abandonment or curtailment of efforts to develop mental health policies relating to national health insurance;

(*f*) Cutbacks in level of mental health statistics and information now being made available to the States.

The impact of these cuts would be devastating on the mental health research, training, and manpower needs outlined above. As an example, the extent to which

national health insurance (NHI) includes mental health coverage for CMHC services is crucial to the continued growth of CMHC's throughout the Nation. Reduction of the capacity of NIMH to develop mental health policies relating to NHI could not come at a more inopportune time.

As another example, it will be necessary to defer or abandon the planning and implementation of technical assistance programs to States and community mental health centers relating to the deinstitutionalization of chronic mental patients.

Exposés concerning the plight of patients released from State mental hospitals occur almost weekly. Efforts by CMHC's to deal with this problem will be seriously curtailed by this cut.

The list could go on. The important point is that these are legitimate costs which must be met if NIMH is to continue functioning adequately in areas related to research, manpower, and services.

IMPACT OF THE RECESSION ON CMHC'S

There is an urgent need for Congress to provide the funds recommended by the National Association for Mental Health. The importance of such funding is reinforced by information we are receiving which indicates that community mental health centers are experiencing an increasing demand on services as a result of the recession. For example, it was reported recently in the Charlotte, N.C., Observer that "a deluge of patients, many of them unemployed people who have grown depressed since losing their jobs, has caused the Mecklenburg County Mental Health Center to stop accepting new patients until next month." The Atlanta Journal reports, "The results of the ever-spiraling unemployment rate are being felt by a wide range of public agencies, including mental health authorities".

A recent publication, "Mental Illness and the Economy," by Dr. M. Harvey Brenner,[1] indicates that added stresses from a downward spiraling economy also show up in an upturn in admissions to State mental hospitals. After comparing mental hospital admissions in New York State with economic cycles for the past 12 years, Brenner concludes, "Economic changes are probably the single most important cause of hospitalization."

CONCLUSION

Mr. Chairman, we are pleased that statements from Congress clearly indicate the intention of funding 1,500 CHMC's by 1980. To meet that target, Congress will have to double its past funding efforts. Centers have demonstrated their value in many ways, not the least of which is providing supportive services to those who are suffering as a result of the economic recession.

Research funds amounting to $121.4 million will be required in fiscal year 1976 if we are to turn around the very damaging downward trend in support for this vital research since 1972, which was $95.5. A comparison of the 1972 figure with the $93.2 million appropriated in fiscal year 1975 represents a disastrous reduction over the past 3 years, especially when inflation is taken into account.

A total of $168 million in fiscal year 1976 is needed for training of psychiatrists, psychologists, social workers, psychiatric nurses, paraprofessionals, and other mental health specialists, if we are to keep pace with the increasing need for additional personnel in CMHC's, children's services, and other mental health facilities.

Last, but very important, NIMH must receive $24 million if it is to continue in a readership role in the development of CMHC's, manpower training, and research.

We believe it is most appropriate that these recommendations, which have been thoroughly studied and responsibly compiled by the only citizers' organization representing the families and consumers of mental health services, be given your most careful consideration.

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[1] Brenner, M. Harvey, "Mental Illness and the Economy," Harvard University Press, Cambridge, Mass.

Residency Training Program

DUKE UNIVERSITY, DURHAM, N.C.—EWALD W. BUSSE, M.D., DIRECTOR

Fifty-three residents have completed training at Duke University within the past five years. Of these, 49 were supported in whole or in part by NIMH training stipends. The 53 residents are now engaged in the following activities:

Full-time public service:
- Public mental hospitals, 7 (14.4%).
- Military service, 4 (9.4%).
- Government work, 8 (16.4%).
- Community mental health, 7 (12.5%).
- Education, 14 (29%).

Part-time public service, 10 (10%).
Solo private practice, 4 (7%).

UNIVERSITY OF PENNSYLVANIA, ALBERT STUNKARD, M.D., DIRECTOR

Forty-eight residents have completed training at the University of Pennsylvania over the past five years; 43 of them supported in whole or in part by NIMH training stipends. Their activities at present are as follows:

Full-time public service:
- Teaching, 15 (31%).
- Military service, 7 (15%).
- Federal or State mental health services, 6 (14%).
- Community mental health centers and clinics, 4 (8%).
- Advanced training, 4 (8%).
- Research, 3 (7%).

Part-time public service: Teaching and private practice, 4 (8%).
Solo private practice, 5 (10%).

EMORY UNIVERSITY, ATLANTA, GA., BERNARD HOLLAND, M.D., DIRECTORS

Fifty-six residents have completed training in the past five years; all of whom received support in whole or in part from NIMH training stipends. Their present activities are as follows:

Full-time public service:	
Community mental health centers	8
Hospitals	2
Military service	15
Education	4
Total (52%)	29
Part-time public service[1] and average percentages:	
3 graduates, 1967	50
5 graduates, 1968	50
10 graduates, 1969	40
3 graduates, 1970	70
6 graduates, 1971	65
27 graduates (48%) 1967–71	55

[1] Public service here includes part-time work in education, community consultation and community mental health centers, clinics, all kinds of hospitals, and research.

CENTRAL STATE GRIFFIN MEMORIAL HOSPITAL, NORMAN, OKLA.—HAYDEN H. DONAHUE, M.D., DIRECTOR

Twenty-six residents have completed training in the last five years of whom 10 were supported in whole or in part by NIMH stipends. The activities of these 10 are summarized below.

Part-time public service:
- Community mental health centers, 2.
- State hospital, 3.

Part-time public service:
- Consultants—State health department, 2.
- Staff, State hospital, 1.

Solo private practice, 2.

Of the 16 other residents who were supported by Oklahoma State stipends, their work is distributed as follows:

Full-time public service: State hospital, 11.
Part-time public service: Consultant to State school, 1.
Solo private practice, 4.

NEW YORK STATE PSYCHIATRIC INSTITUTE, COLUMBIA UNIVERSITY, NEW YORK, N.Y.—LAWRENCE C. KOLB, M.D., DIRECTOR

Eighty-five residents have completed training here in the past 5 years. Of these, 65 were supported in whole or in part by NIMH training stipends. The activities of these 65 at present are as follows:

Full-time public service (Public mental hospitals, military service, community mental health centers, education)	27
Part-time public service and average percentages:	
2 graduates	90
3 graduates	80
7 graduates	70
1 graduate	60
13 graduates	50
3 graduates	40
6 graduates	30
3 graduates	20
38	55
Solo private practice	None
Solo private practice over 50% of time	12

HARVARD MEDICAL SCHOOL, MASSACHUSETTS MENTAL HEALTH CENTER, BOSTON, MASS.—JACK R. EWALT, M.D., DIRECTOR

One hundred thirty-five residents have completed the program in the past 5 years; 46 of these residents received support in whole or in part from NIMH training stipends.

Of these 135, all but 13 have spent some time as full time employees in the following agencies and facilities: military service, public health service, Massachusetts Mental Health Center, Boston State Hospital, Tufts Mental Health Unit, and Cambridge City Hospital.

All of the 135 have spent some time teaching at State and Federal institutions.

At present, only two graduates are known to be in full time private practice.

133 are in full or part time academic or public work. A great many of the graduates now teach one-fourth to one-half time and serve as supervisors of hospitals or clinics.

MENNINGER SCHOOL OF PSYCHIATRY, TOPEKA, KANS.—PHILIP WOLCOTT, M.D., DIRECTOR

One hundred sixty six residents have completed training here in the past five years. Thirty three received NIMH training stipend support. Their activities are distributed thusly:

Full-time public service:
State mental hospital, 5.
State medical school, 2.
Community mental health centers, 3.
Hospitals, 5.

Part-time public service (precise information is not available, but it is our impression that most graduates are doing part time community service work).

Solo private practice, 18.

UNIVERSITY OF COLORADO, DENVER, COLO.—DOUGLAS B. CARTER, M.D., DIRECTOR

Of the 102 graduates of the psychiatric residency training program in the past 5 years, 98 have received support from NIMH stipends. These 98 graduates are now involved in the following activities:

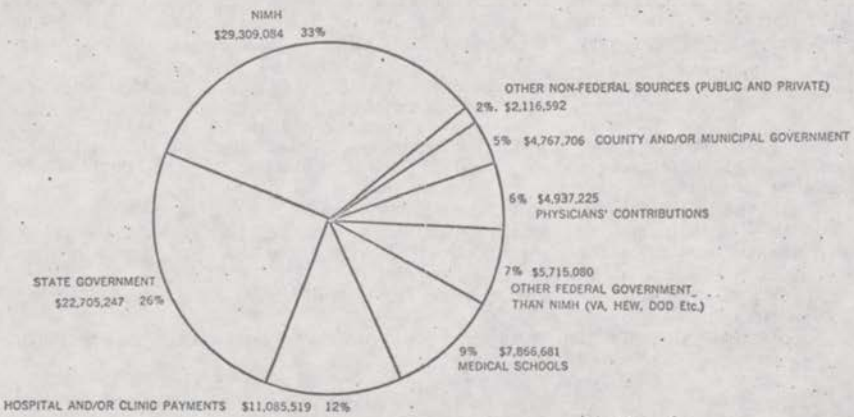
Full-time public service:
- Military or public health, 30.
- Education, 11.
- State hospitals, 9.
- Community mental health centers, 4.
- Alcoholism and drug programs, 1.
- Children's programs, 3.

Part-time public service:
- Education, 6.
- State hospitals, 7.
- Community mental health centers, 17.
- Alcoholism and drug programs, 1.
- Other, 3.

Solo private practice, 6.

NATIONWIDE PATTERN OF TOTAL FINANCIAL SUPPORT FOR PSYCHIATRIC RESIDENCY TRAINING AMONG 239 RESIDENCY TRAINING CENTERS

*Fiscal Year 1971



*Source: Manpower Division, American Psychiatric Association

STATEMENT BY DR. ROBERT STUBBLEFIELD

Dr. STUBBLEFIELD. Chairman Flood, it is a pleasure to speak before you and to the group.

Briefly, I am medical director of the Silver Hill Foundation in New Canaan, Conn. I have served the government in many capacities including acting as a consultant to the Defense Department, Public Health Service, and the Veterans' Administration.

I have worked as the chairman of the Professional Advisory Panel for the National Association of Mental Health for the last 7 years.

I appear before you to plea that you look at the research budget and what has happened to it in the last 3 years.

The Congress has supported it. The administration has held it back. The actual reduction is approximately 25 percent. In this period of time we have made some gains around major mental illness, schizophrenia, depression, and some of the acting out problems. We now have lithium to treat severe depression. We now have the major tranquilizers. We now have expanded social rehabilitation services but the research dollars are not there. The NIMH research program is divided into intramural and extramural. Ninety percent of the related research in basic science comes from the Federal Government; 75 to 80 percent comes from the Federal Government in the clinical study area and 80 to 85 percent in evaluation research.

What I see happening is the imposition of a ceiling which bumps and hurts everyone. I have been for the last 4 years a member of the five-man Council of Scientific Advisers for the NIMH. We have reviewed every program, had to terminate some, cut back others, and endorse others in a budget which has been dropping, especially because of the impact of inflation.

My plea to you and to your colleagues is to add substantially to the intramural research budget and to the extramural research budget. Why the extramural research budget?

At the time those funds were set up there were approximately 84 medical schools in the country. There are now 114 and there soon will be 120. The new schools simply do not have an opportunity to get the teachers, to get the research people, to get the grant programs going to develop the research teaching for the medical students, and nursing students, and others in those health services.

I am going to summarize what I am trying to say. I think our society is getting more complex, as we industrialize, and as we deal with the population explosion, as we deal with the aging, we are asked more questions in psychiatry and psychology and social work, not fewer.

It is quite clear to us in NAMH that this program must be supported at the Federal level. We have studied research programs in six States: Pennsylvania, Connecticut, Massachusetts, Colorado, Oregon, and Florida, and we do not see evidence that the States can and will support basic research. They will support clinical research some. They will support some applied research, but the basic human behavior research that affects psychiatric services will come from the Federal Government.

We urge the committee to look at the research situation even if the mental health center bill does not pass. The need for new knowledge and new understanding is great. Five years ago I could not treat effectively a manic-depressive, depressed type patient or a schizophrenic or an adolescent alcoholic addict in the way I can today because of new knowledge and we need more, not less.

I would be glad to try to answer questions either now or later if you want to submit them to me. It is vital and concerns all of us in the education field, in the health delivery field, and in research itself. We are losing many researchers because they do not see a career pattern and we have lost the thrust and support of research in many centers around the country as they drift away from research.

It is a serious problem and I hope you will give it your attention. I know you, Mr. Flood, are interested. You made the comment at the Lasker dinner in New York, "Tell us what it is and like it is."

It is not good.

Thank you very much.

Mr. FLOOD. Thank you.

Mr. COLE. Thank you, Mr. Chairman.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

WITNESS

THOMAS WILCOX, EXECUTIVE DIRECTOR AND GENERAL COUNSEL, NATIONAL ASSOCIATION OF STEVEDORES

Mr. FLOOD. Mr. Thomas Wilcox, executive director and general counsel, National Association of Stevedores.

Mr. WILCOX. Mr. Chairman, my name is Thomas D. Wilcox.

I would like the record to show that I am authorized also to speak on behalf of the Shipbuilders Council of America, which membership includes all the major shipbuilding companies in the United States, and also the Louisiana Shipbuilding and Repair Association, whose 31 members are engaged in the shipbuilding and repair business in the State of Louisiana, and employ approximately 20,000 people.

At this point I would also like to thank the chairman on behalf of myself and Mr. Hood, the president of the Shipbuilders Council, for inserting into the record earlier the letters which we have previously addressed to you.

As you have indicated, I am the executive director and general counsel of the National Association of Stevedores whose 50 member companies are stevedore companies and marine terminal operators engaged in vessel loading and unloading operations at marine terminal facilities located in ports on all coastal areas of the United States and Hawaii. The member companies are headquartered in 21 States and do business in 25 coastal States. According to Commerce Department figures, the American stevedore industry employs some 65,000 longshoremen daily, who, if injured during the performance of vessel loading or unloading, are entitled to the compensation benefits of the Longshoremen's and Harbor Workers' Compensation Act (LHWCA).

The administration of the LHWCA is the responsibility of the Secretary of Labor, and more particularly the Assistant Secretary of Labor for Employment Standards. Since its enactment in 1927 the cost of administering the act has been borne from funds appropriated by the Congress. Payments of benefits in specially enumerated circumstances to an injured worker or his survivors are made from a special fund to which self-insured employers and insurance carriers make special contributions pursuant to section 44 of the act. The authorized withdrawals from that fund were enumerated in section 44(c)(i) of the act prior to the 1972 amendments, and in section 44(j) (sec. 8(j) of Public Law 92-576) thereafter.

Under present law withdrawals from the special fund may only be made to—

(1) pay adjustments in compensation for certain injuries which occurred before the raise of benefits levels in 1972;

(2) pay injured workers involved in second injuries in special circumstances;

(3) pay additional compensation to workers for vocational rehabilitation;

(4) assist injured workers concerning claim procedures when requested by the worker;

(6) repay to the treasury $2 million deposited into the fund prior to the collection of the assessments;

(7) pay charges for independent medical examinations.

In each section of the act referred to in section 44(j) the Congress specifically provided that the enumerated expenditures could be made from the special fund, and nowhere does the Longshoremen's and Harbor Worker's Compensation Act give the Secretary of Labor authority to assess or tax an employer or its insurance carrier for the cost of general administration of the act.

Notwithstanding that lack of authority the Department of Labor advised the Congress at pages 624 and 625 of the administration's fiscal year 1976 budget proposal that effective as of that year it intended to assess the industry and its insurance carriers the full cost of administering the act in an amount estimated at $3,746,000 for the first year. The Department publicly reiterated its intent in hearings before the Senate Committee on Appropriations in mid-April of this year and before this Committee on May 1. So the Department's intent is clear even though its statutory authority is not.

In keeping with a promise made by former Under Secretary Shubert, the Department on April 15, 1975, sent to segments of the stevedoring industry a paper "Providing additional background and other information about the (user charge) proposal". At this point I would like to say that at all times the Department has kept the stevedore industry advised of its intentions, and we are in no way here pleading surprise as to the Department's intentions.

In fact, since the 1972 amendments, the Department and industry have maintained an effective dialog concerning the LHWCA. However, we do strongly oppose the Department's intentions as members of this committee and the Department well know. A copy of the Department's position enclosed in its April 15 letter is attached to this statement.

Interestingly enough, in that statement, the Department claims no legal authority in the LHWC act to assess the industry. Indeed, it has proposed technical amendments to that act to permit it to carry out its purpose, which proposals presumably are to be considered by the respective labor committees of the House and Senate.

However, this committee, we believe, must inquire as to why the Department is forced to abandon the time-honored procedure of requesting appropriated funds from the Congress to carry out its administrative functions. In particular, does the Department believe it must turn to industry to pay its administrative expenses because the Office of Management and Budget (OMB) refuses to permit it to seek appropriations adequate to carry out the duties entrusted to it by the Congress? Perhaps the OMB is of the opinion that if industry had no

standing to question the Department's budget expenses, it would be far easier to increase staff and expenses at industry's expense rather than to have to convince the Congress that the requested funds are really needed.

In this regard, the Department has carefully selected the chosen payees—the stevedoring and shipbuilding industry—as its announced intention is not to assess employers in the District of Columbia, whose employees are also covered by the act. We doubt that the stevedore and shipbuilding industry derive any special benefit from the act not enjoyed by any other employer whose employees are covered by the act. The intent to exempt one group of employers goes without explanation and appears to us to be completely contrary to the alleged purpose of making industry bear the cost of administration of an act which supposedly gives it some special benefit.

While acknowledging no authority to assess the intended user charge in the LHWCA the Department in its April 15 statement claims that it has authority to do so under 31 U.S.C. section 483 (a) and that the Office of Management and Budget agrees. It is our opinion, and I dare say that of the Supreme Court's that the Department and OMB are clearly in error. On March 4, 1974, the Supreme Court handed down two decisions which are directly contrary to the Department's claim of authority. *National Cable Television Association* v. *Federal Power Commission* 415 U.S. 336 and *Federal Power Commission* v. *New England Power Co.*, 415 U.S. 345. In the latter case at pages 354–355 Justice Marshall in a concurring opinion referred to the intent of Congress when it enacted the statute here involved, to wit:

> There is no thought here to establish a system of fees for fundamental Government services, but only to explore the feasibility and fairness of shifting to special beneficiaries the expense now borne for them by the taxpayer at large.

The assessment proposed by the Department is in fact and law a tax and not a fee as the terms were defined by the Supreme Court in the *National Cable Television* case when it stated at page 340:

> A fee, however, is incident to a voluntary act, that is, a request that a public agency permit an applicant to practice law or construct a house or run a broadcast station.

No action by an employer in fulfilling its duties of reporting injuries and paying compensation therefore under the LHWCA begins to meet the type of activity for which the Congress authorized the assessment of a user charge The Supreme Court in interpreting section 483 (a) of title 31 further stated:

> The Court of Appeals held that whole industries are not in the category of those who may be assessed, the thrust of the act reaching only specific charges for specific services to specific individuals or companies. We agree with the Court of Appeals. (*FPC* v. *New England Power Co. supra* at page 349.)

Also, in the case just cited, the Supreme Court at pages 349–350 quoted from Budget Circular No. A–25, Sept. 23, 1959, which cited examples of governmental activities for which user charges could be assessed. None describe the type of services for which the Department of OMB intend to assess the industry. The examples given by the then Bureau of the Budget included patents, crop insurance, licenses, certificates of necessity and convenience, passports, and after-hour Government inspections. Specifically the circular states that user charges

or fees should be assessed for a governmental service which "performed at the request of the recipient and is above and beyond services regularly received by other members of the same industry or group, or of the general public."

The type of service for which the user charge is to be assessed is explained on page 2 of the Department's April 15, 1975 statement as:

> The service provided in this case is to oversee the insurance industry process of claims adjudication and to work directly with the injured workers and their survivors in giving necessary assistance in obtaining all benefits they are enttiled to receive under the Act as amended by Public Law 92–576.

That service clearly is not one which confers a specal benefit on any industry, and clearly does not conform to the terms of the statute, the Supreme Court cases directly interpreting the statute, nor even the Bureau of the Budget's own interpretation of the statute.

If one were to accept the user charge theory now proposed by OMB and the Department to the effect that present law permits assessing an industry for filing reports and paying compensation to injured workers in compliance with law because in some manner industry derives a special benefit therefrom, then the next steps are not hard to imagine. As to the stevedore and marine terminal industry, it could expect OMB to press for the assessment of user charges to pay for the administrative and inspection functions of OSHA, the Bureau of Customs, the Coast Guard, the Department of Agriculture, the Food and Drug Administration, and Immigration and Naturalization, to name but a few.

Each Government agency mentioned above at one time or another either requires reports from industry or performs inspections at marine facilities operated by stevedore companies or marine terminal operators. As in the case of the administration of the LHWCA the stevedore and marine terminal industry derives no special benefits from those governmental services. However, the Bureau of the Budget did recognize that if those services were rendered after regular working hours, then they became special services rendered upon special request for which the requesting party should be properly assessed. The same reasoning must then be applied to the LHWCA, and unless some member of the industry voluntarily requests some extraordinary service from those who administer the LHWCA, the Secretary of Labor has no statutory authority to assess a user charge against any member of the industry.

Now, just what are the services for which OMB would have the Department assess "user charges"? At page 3 of its April 15 statement the Department states that its principal area of concern is the ever-increasing backlog of LHWCA claims in the Office of Workers' Compensation Programs district offices, and indicates that the bulk of its needs for extra funds—either appropriated or assessments on industry—will be spent on "providing additional human resources" to service that backlog. The Department states—at page 4—concerning the backlog that:

> The extent of the coverage under the amended act is still not clearly defined and is therefore subject to extensive litigation.

As a matter of fact, there are now pending in the U.S. Court of Appeals for the Fourth Circuit no less than four cases which go to the very heart of the dispute over what is the extent of coverage under the

amended act. However, we believe that notwithstanding that dispute additional claims clerks and staff are needed to promptly process claims about which there is no jurisdictional dispute.

We favor the Department having additional staff to administer claims under the act, but we believe that the expenses of additional staff should come from appropriated funds controlled by the Congress and subject to full investigation and not from a tax or user charge assessed against industry which derives no benefits from the act in question.

A very serious and special concern arises from the Department's statement on page 8 of its April 15 statement wherein it is explained that industry is supposed to pay some $844,000 for the Department's legal operations under the act, including the salaries of administrative law judges; staff attorneys who actively oppose the to-be-assessed employer at every level of the administrative and appellate process; and even the salaries of the Benefits Review Board and staff, which hears appeals from the administrative law judge decisions. In essence, the industry is requested to pay directly not only the salaries of opposing counsel for the Government but the salaries of the administrative decisionmakers as well. Thus, in a contested case the industry would pay the salary of his own counsel, the Government investigator, the Government's legal counsel, the law judge, the administrative review panel, and in some cases opposing counsel for the claimant under some theory of deriving a special benefit for so doing.

What possible benefit can a person derive from governmental services which are, in fact, legal opposition at every stage of the judicial process? If the industry were to request the services of the Department's staff and attorneys one might argue that industry should pay the Government, but no rational person can argue that industry should pay the salaries of Government attorneys who oppose the industry at every stage of the administration of the act.

While on the subject of the Department's legal operations we would like to draw the committee's attention to the statement of Assistant Secretary DeLury in his testimony before the committee on May 6, 1975. At page 11 of that statement we are told that of the 56 new positions desired to better administer the LHWCA 24 positions would be used for additional support of the appellate functions.

The National Association of Stevedores and the other groups which I represent today oppose the Department's request for additional positions to handle the so-called appellate functions of the Department to the extent that such positions would be assigned to the Office of the Solicitor. When the act was amended in 1972 the Congress established an administrative review procedure to decide contested cases. A case would first be heard by an administrative law judge and if appealed by either the employer or the employee then the case would be heard by the newly created Benefits Review Board. Appeals from the Board's decision could be taken to the appropriate U.S. court of appeals. Section 21(a) of the LHWCA provides that attorneys appointed by the Secretary shall represent the Board in any court review of the Board's decisions.

However, ever since the 1972 amendments attorneys from the Office of the Solicitor have participated in almost every contested case not

only at the Benefits Review Board level but even before administrative law judges as attorneys for the Director, Office of Workers' Compensation who is directly responsible for administering the act. There is no provision in the LHWCA which permits or authorizes the Director, Office of Workers' Compensation to appear as a party or party in interest in administrative proceedings under the act, and the Secretary is only authorized to provide legal assistance to an injured worker upon request. However, of the 65 reported cases of the Benefits Review Board the Solicitor appeared in 59 on behalf of the Director, Office of Workers' Compensation.

We are unable to discern any statutory authority for such activity by the Solicitor nor any real justification as both employee and employer are represented by counsel of their choice in all proceedings, and if the employee prevails the employer must pay his attorney's fees as approved by the Benefits Review Board. We seriously doubt that the Solicitor needs an additional 24 persons to adequately represent the Benefits Review Board before th U.S. courts of appeals, and as stated before we most strenuously object to paying the Solicitor's attorneys through the OMB proposed "user charge."

Now, at page 3 of its April 15 statement, the Department indicates that industry should favor the user charges because industry "will be afforded an opportunity to provide input into the administrative and legislative functions of the program." The latter is already guaranteed by the Constitution of the United States, and we seriously doubt that the former will be well received by the injured workers. Is industry as a proposed employer or payer of salaries to be permitted to guide the hands of the administrative law judges, the Benefits Review Board, the Deputy Commissioners, or the 13 attorneys of the Office of the Solicitor against whom it litigates daily? Is it fair for industry to have to pay a user charge annually in order to participate in the Department's program while the representatives of persons who derive direct benefits from the act receive the same right at no cost? Obviously the answer to each question is "No!"

The National Association of Stevedores believes that proper, fair, and prompt administration of the LHWC Act is imperative to both employer and employee, and we believe that the Labor Department and the Congress are of the same opinion.

We believe that should the Department prove its need for additional funds and administrative human resources to process LHWCA claims, it should be given them by Congress in the course of normal budgetary procedures and financed from funds appropriated by the Congress.

We believe that both employer and employee should have input in the Department's administration of the act, but that neither the employer nor the employee shall have to pay a special user charge to exercise that right.

To condition a citizen's participation in his Government upon the payment of a special user charge offends the very principles upon which this Government was founded and has so long endured.

In conclusion, we urge this Committee to reject the proposed assessment of a tax or user charge upon the employer, and to direct the Department of Labor to observe the statutory demands of requesting its finances from the Congress and properly justifying its requests. We

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also believe that the Department has been denied the opportunity to properly present its needs to the Congress, and that this committee should give the Department the opportunity to do so now. It may very well be that additional human resources are required by the Department to properly administer the LHWCA, but without having the opportunity to present its case the Congress, the employer, and the potential beneficiary—the employee—will never know.

Thank you very much.

U.S. DEPARTMENT OF LABOR, EMPLOYMENT STANDARDS ADMINISTRATION—PROPOSED CHANGES IN FUNDING THE ADMINISTRATION OF THE LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT THROUGH USER CHARGES OF THE INDUSTRY

Title 31, United States Code 483a, and Office of Management and Budget (OMB) Circular A–25 direct Federal agenices to follow the general policy of making a reasonable charge to each identifiable recipient for a measurable unit of Government service or property from which the user of the service derives a special benefit—or when it becomes apparent that a service is being rendered which provides special benefits to the user beyond those which accrue to the general public. It is the joint opinion of the Department of Labor and OMB the service provided by the Federal Government to the employers served by the Longshoremen's and Harbor Workers' Compensation Act is subject to the policy espoused in law and the policy directive; and further that certain necessary improvements in the administration of the act (and its extensions), including requirements for additional resources, should be financed from such charges rather than through appropriations.

The President's budget for fiscal year 1976 proposes the imposition of a user charge on each longshore or other maritime industry employer who is self-insured under the act as extended (excluding the District of Columbia Workmen's Compensation Act), and each insurance company authorized under the act (and its extensions), who has paid compensation or medical benefits during the calendar year prior to the user charge assessment.

The Department is, in addition to this approach, proposing technical amendments to the Longshore Act, and is including among them an amendment to recover the administrative costs of the act by assessing carriers and self-insurers on a pro rata basis of their benefit payments—similar to the method followed under section 44. Attachment 1 to this paper is a draft of the possible amendments to section 47.

This proposal was explained and discussed with representatives of the stevedoring industry operating on the Atlantic, Pacific, and gulf coasts at a meeting with Under Secretary Richard F. Schubert and other DOL officials in Dallas, Tex., on January 15, 1975. At the meeting the Under Secretary was requested, and agreed to provide the industry more detailed information about the proposal, and to explain the increased level of service contemplated in administering the act and its extensions, through the Office of Workers' Compensation Programs (OWCP), the Office of Administrative Law Judges, and the Benefits Review Board. This would be made possible by increasing the staffs of these various agencies which administer or adjudicate cases coming under the law.

The service provided in this case is to oversee the insurance industry process of claims adjudication and to work directly with the injured workers and their survivors in giving necessary assistance in obtaining all benefits they are entitled to receive under the act as amended by Public Law 92–576 (enacted Oct. 27, 1972). These aspects, and the increased level of service contemplated as a result of the proposed industry assessment, are discussed later in this paper.

The latest assessment made for the special fund established under section 44 of the act, for calendar year 1974, was about 5.5 percent of total benefits paid by self-insured employers and insurance carriers. Inclusion of administrative expenses of the program would increase the assessment figure by an additional 5.5 percent of total compensation benefits paid.

The theory underlying user charges is that the general taxpayer should not bear the burden of administering programs which do not affect the public at large, and that such costs should be borne by the industries served.

The concept of assessing user charges against industries affected by governmental services is well established. Congress, over the years has enacted a number of laws authorizing user charges, and it is an established method of financing services performed by governments. In the area of worker's compensation, assessments for similar programs are not unusual. Excluding the State fund systems, 20 workers' compensation programs are operated with appropriated funds, and 21 States operate with funds assessed against industry.

In the States, the proportion of administrative costs through assessments has been increasing and now amounts to more than 60 percent of the total costs of the agencies where provisions for these costs are in effect. More than $95 million spent on administration of State workers' compensation was financed through the assessment method. A percentage of the insurance premium is generally assessed against the carrier with an equivalent method of assessment against the self-insurer. The assessment method of financing has been suggested in the past by the Council of State Governments in its recommended workers' compensation and rehabilitation law, because it is considered to be a more predictable method of financing than is appropriation.

As indicated in the preceding paragraph, workers' compensation has been the province of the States. The Federal longshore program, which is essentially similar to State workers' compensation programs, involves employees working in areas associated with navigable waterways where State jurisdiction may not exist or may not be determined. In this respect, the Longshore Act substitutes for State laws and provides the protections against damage suits filed by employees common to the concept of workers' compensation law.

PROPOSED METHOD OF ASSESSING USER CHARGES FOR ADMINISTERING THE LONGSHORE ACT

Of the States using the assessment method, most base their assessment on premiums—only three States, New York, Mississippi, and Kansas, base theirs on compensation payments. Under the proposed assessment of a user charge under the Longshore Act, the method of assessment would be patterned after the present method of a pro rata assessment of carrier/self-insurers as provided by section 44 of the amended Longshore Act. In other words, the amount of benefits paid as compensation and medical expenses a company pays as compared to the sum of all payments made, would determine the percentage share it would pay as an assessment for administrative expenses, since administrative expenses occur only when an injury has been sustained and benefits must be paid. The amount of premiums collected by an insurance carrier would not determine its assessment per se, however, since the amount of losses or benefits paid would be the determinative factor.

The proposed method based on the one in use under this act is fair, and should, in effect, encourage healthy competition among companies to improve their safety records vis-a-vis one another. The result would be that the companies with the best safety records, that is, whose benefit payments are less than those of the industry in general, will pay a proportionately smaller amount as a user charge.

The application of user charges under the Longshore Act will be advantageous to the maritime and insurance industries affected, in that the contributors to the assessments will be afforded an opportunity to provide input into the administrative and legislative functions of the program.

Should the proposed user charges be adopted as a method of funding the administration of the Longshore Act, several areas either presently causing adverse effects on the OWCP district offices' effective administration of the law, or in which the mandate of Congress is not fully carried out, will be corrected by providing additional human resources for processing cases or other related activities. The principal area of concern is the ever-increasing backlogs in the OWCP district offices. This will be discussed in the following section. Other areas which merit the direction of increased resources, which will be discussed in this paper, are vocational rehabilitation and monitoring of medical services provided to injured workers.

(1) Reduction of LHWC backlogs

The Office of Worker's Compensation Programs (OWCP) of the Employment Standards Administration, administers the Longshore Act and related statutes. The major operating goal in administering the act is to provide the service specified by law in the most effective manner possible. This includes the protection

of the rights of all parties, and insuring that all parties meet their responsibilities. The impact of the 1972 amendments to the Longshore Act provided by Public Law 92–576 has been twofold: The extension of coverage to shoreside areas adjoining the navigable waters has caused a numerical increase in the number of injuries reported under the act; and the additional responsibilities to injured employees contemplated by the congressional intent and mandated by the amended law, increases the responsibility to injured employees and their survivors. The timely processing of the increased caseloads affected by these changes in the law has been less successful as time passes, and all of the 13 OWCP district offices strategically located in various port cities are now working with unacceptably high backlogs of pending actions. In discussing the present increased workload of the district offices, it is appropriate to mention the historical trend prior to 1972. During fiscal years 1969 to 1972, a generally declining number of injuries was being reported each year under the Longshore Act. During fiscal year 1972, fewer than 58,000 injuries were reported under the act, whereas in fiscal year 1969, over 83,000 injuries were reported. Following the enactment of Public Law 92–576, the number of injuries reported under the act rose to 91,204 during fiscal year 1973, when the act was in effect only 7 months of the fiscal year. During fiscal year 1974, the number of reported injuries rose to 136,818 (see attachment II for a breakdown by district offices of injuries, indicating their origin as either covered by the provisions of the preamendments act, or covered by the extended coverage of the act).

The enormous increase occurred, even though the precise limits of the extended jurisdiction were not clarified in the legislation, and the extent of the coverage under the amended act is still not clearly defined and is therefore subject to extensive litigation. However, the increase in workload of the district offices due to injuries now being reported under the extended coverage, is unquestionable. During the period between February 1973 and June 1974, inclusive, 46 percent of the injuries reported came under the extended coverage to the shoreside areas where maritime work is performed. The change from 1972 to 1974 (end of fiscal year) represented an increase of 109.8 percent for all injuries; and the lost time injuries reported increased by 86.5 percent between those years.

A second factor contributing to the increase in the district offices' backlogs—an increase of 461.2 percent from 1972 to 1974 (end of fiscal year) has been the increase in the district offices' responsibilities toward injured employees or persons covered by the compensation law. The amended law requires, among other things, close supervision of medical services provided claimants, assistance to claimants in filing and proceeding with claims, providing information and assistance in obtaining vocational rehabilitation services, and other actions required on the part of the Department as envisaged by the Congress.

For fiscal year 1976, the Department's proposal provides the resources to service the increased caseload, since the 1972 amendments and provides the additional services directed by Congress or contemplated when it passed this legislation. These services would have had the effect of getting workers back into the job market more quickly. The steadily rising backlog is depicited by the following: At the end of fiscal year 1972 (June 30, 1972) district offices reported a total backlog of 1,998 cases. At the end of fiscal year 1973 (June 30, 1973), the backlog figure had risen to 6,848 cases, and on June 30, 1974, had reached 11,213 cases. At the end of December 1974 (the latest complete figures available) the district offices reported a total backlog of 13,252 cases.

The ESA is committed to providing prompt and efficient service to injured employees, and to insuring that the rights provided all parties under the law and regulations including employers are protected.

(2) Vocational rehabilitation

The return of injured employees to their regular work, wherever possible, is a basic goal of all workers' compensation systems. It is of utmost importance to an injured employee, provides benefits to the employer, and ultimately benefits society as a whole through the return of a productive worker. It is not always possible, however, to return a worker to his or her old job, and a disabled employee may require retraining for other work he or she is capable of doing. It is recognized that the resources the Department presently has available for this effort are inadequate to meet the need. The 1972 amendments require the Department of Labor not only to provide information on rehabilitation to employees receiving compensation, but to assist them in an active way in obtaining the best such services available.

At present OWCP has only one employee in the national office engaged entirely in vocational rehabilitation services. In those joint FECA-longshore

district offices where a vocational rehabilitation specialist is located, the specialist devotes some of his or her time to assisting Longshore Act claimants. This provides a very limited service at best. It is estimated that with adequate staffing, the following numbers of cases could be processed each year:

Boston, 134 to 264 cases.
New York, 31 to 62 cases.
Baltimore and Norfolk, 142 to 286 cases.
Jacksonville, 25 to 51 cases.
New Orleans, 140 to 280 cases.
Chicago and Cleveland, 19 to 28 cases.
San Francisco, 58 to 116 cases.
Seattle, 25 to 51 cases.

A rehabilitation staff of nine additional professionals is proposed to provide these required vocational rehabilitation services. The expected increase in the professional staff of rehabilitation specialists is intended to provide a structured, comprehensive rehabilitation program. The effort would be directed to both medical and vocational aspects of rehabilitation, and would draw to some extent on experience gained in a pilot program which has operated under the District of Columbia Compensation Act since 1971. The overall aim of the program is to achieve the swiftest possible restoration of the injured worker to employment with a minimum residual disability.

(3) *Medical services*

Section 7 of the Longshore Act was amended in 1972 to provide, in effect, that an injured employee may choose his or her own treating physician from those authorized by the Secretary of Labor. The amended section further requires the Department of Labor to actively supervise the mediacl care rendered injured employees, to require periodic reports as to the medical care being rendered to employees, to determine the necessity, character, and sufficiency of medical aid furnished or to be furnished, and may, on its own initiative or at the request of the employer, order a change of physicians when such change is desirable or necessary in the interest of the employee. The first provision has, by regulation, been interpreted as giving employees free choice from among qualified physicians within a reasonable distance to the employees' residence or principal place of work. While the OWCP has not fully surveyed the results of this intepretation, no serious problems have apparently been created by it. Requests have been received, however, to include chiropractors within the meaning of "qualified physicians," and this matter is under review at present. Any change in the policy with regard to authorized treating physicians will be indicated by a change in section 702.404 of the regulations, published in title 20 of the Code of Federal Regulations.

The OWCP has issued instructions and procedures to its district offices with respect to various aspects of medical care—initial choice of physicians, change of physicians, evaluation of medical questions, utilization of impartial medical examinations, duties of employees with respect to special examinations, and other aspects of medical care under this section. In addition, the OWCP has issued notices to self-insured employers and insurance carriers authorized under the act advising them of the medical provisions of the amended law (dated November 15, 1972), on the authorization of medical care by employers (dated January 25, 1973), and about the conduct of impartial medical examinations for disability determinations or other questions of a medical nature (dated August 12, 1974). Should any changes be made in procedures relating to medical management or regarding providing medical services to injured employee, either due to policy changes or required because of legal decisions in contested cases the OWCP will immediately advise the industry and other interested parties.

The medical monitoring function is essentially that of obtaining and conducting a careful and continuing review of medical reports to insure prompt and proper medical care—with the view of returning the disabled employee to employment as early as possible.

COST OF ADMINISTERING THE LONGSHORE ACT

While financial data are not readily available for the Longshore Act program, a 1967 survey of closed cases showed that administrative costs for the program were running at about 5.5 percent of benefit payments. The current actual total for administrative costs of $3,736,000. The costs reflect a decentralized, nationwide program, with requirements for services establishing a quasi-

judicial appeals system housed within the Department of Labor and extensive monitoring of claims once received. It compares favorably with New York and Oregon, two States with extensive directed action elements built into their systems which make them comparable to the federally administered program.

The following is an explanation of the costing of the fiscal year 1976 budget estimates for administration of the Longshoremen's and Harbor Workers' Compensation Act and its extensions (excluding the District of Columbia Workmen's Compensation Act). ESA costs for fiscal year 1976 will be $2,892,000 for 132 positions. The total includes approximately nine claims examining rehabilitation technicians and clericals.

The work performed by a claims examiner includes an initial review of all injury reports and a review of all lost-time cases. If the case is a controverted one (form LS–207 filed), the examiner works with both the company and the claimant toward a resolution of the disputed issues. The examiner may hold an informal conference with both parties to make a recommendation on the issue.

In each case where compensation is being paid, the 1972 amendments require that the claims examiner monitor the medical care the employee receives to determine the quality and/or appropriateness of the care. In addition, each lost-time case is to be screened within a short time after its receipt for referral to rehabilitation. Every claimant is entitled to receive assistance in proceeding with his/her claim, and to receive counsel on his/her rights under the act, et cetera. The examiner is also charged with keeping insurance companies and employers apprised of their rights and responsibilities under the law.

Clerical positions associated with the program include claims assistants who can perform the review of no lost-time injuries and the first review of lost-time injuries, and typists to work on correspondence, coordinate conference scheduling, log materials, and maintain the case call-up system.

Insurance clerks maintain the card-file record of coverage written as required under the act. Mail and file clerks jacket and log the injury reports and cases as they arrive and insure that additional correspondence is routed to the proper claims examiner.

The rehabilitation officer is charged with active direction of each employee's rehabilitation program and with giving the employee advice, counsel, and aid in job placement. One officer will be located in most of the regional district offices and one in the national office for coordination of the program. Rehabilitation is a proven cost saver. It removes injured workers from the compensation rolls sooner than otherwise and returns them to the work force, in many instances, into more productive jobs. It has been proven that in many cases where action is taken quickly, very little actual retraining is needed to get the person back into the work force.

Legal support for the program totals 30 positions. (Since the 1972 amendments, there has been a requirement for attorneys, administrative law judges, and the Benefits Review Board and staff.) The positions are used to conduct the formal hearings which were formerly handled by the Deputy Commissioners, and the quasi-judicial appellate responsibilities of the Benefits Review Board created by the act. Costs for these positions are about $844,000.

These 30 positions include 13 for the Office of the Solicitor, 13 for administrative law judges, and 4 for the Benefits Review Board based on the relative needs for legal support at each level.

CONCLUSION

The foregoing represents the Department of Labor's position with respect to financing administration of the Longshoremen's and Harbor Workers' Compenstaion Act through imposing user charges on the affected industries and providing the proposed increases in personnel. It is the belief of the Department that this position is sound, and that it represents a practical method of financing a more effective Federal workers' compensation program. There are ample precedents for utilizing this method of financing, and acceptance of the proposal and implementation along the lines described in this paper are recommended.

SPECIFICATIONS FOR LEGISLATION TO AMEND THE LONGSHOREMEN'S AND HARBOR WORKER'S COMPENSATION ACT TO RECOVER ADMINISTRATIVE COSTS OF THE ACT THROUGH ASSESSMENTS TO CARRIERS AND SELF-INSURERS

Amend section 47 of the Longshoremen's and Harbor Worker's Compensation Act to make the following revisions:

1. Provide for the recovery of the full cost of administering the Longshoremen's and Harbor Worker's Compensation Act through assessments to cariers and self-insurers operating under the act. The costs to be recovered shall include (*a*) direct program costs (including salaries and contingent expenses for monitoring of claims, provisions of medical monitoring, and rehabiiltative services), (*b*) legal and appellate (costs incurred by the SOL, Office of Administrative Law Judges, and Benefits Review Board), and (*c*) ESA and departmental overhead. As part of the annual budget submission of the Department of Labor, the Secretary will explain the derivation of costs.

2. Give the Secretary of Labor with the approval of the Director of OMB the authority to assess carriers and self-insurers their proportionate fair share of the costs of administration of the Longshore Act.

3. Require that each carrier and self-insurer be assessed on the basis of total compensation benefit payments made during the preceding 12 months as determined by the Secretary.

4. Provide that at such times as the Secretary shall prescribe by regulation, but at least once annually, the Secretary shall estimate the year's costs of administering the workers' compensation provisions of the act and prorate the costs among insurance carriers and self-insurers operating under the act. (This could be accomplished to amending section 44(c)(2) of the act pertaining to assessments for the special fund to give the Secretary authority to establish billing procedures consistent with Government fiscal periods and to permit joint assessments for the fund and for administrative costs.)

5. Provide that assessments paid by the carriers or self-insurers be deposited in the salaries and expense account of the agency administering the Longshore Act program.

6. Include provision that each insurance carrier or self-insurer assessed under the act be given written notice of its assessment by certified or registered mail.

7. Require the payment of assessments by carriers or self-insurers within such time as the Secretary shall prescribe by regulation.

8. Include penalty provision to provide that any insurance carrier or self-insurer who fails to pay the assessment levied by the Secretary could be suspended or disqualified from insuring or acting as a self-insurer under the act.

9. Make user charges provisions applicable to all extensions and future extensions of the Longshore Act, with the exception of the District of Columbia Compensation Act. It is our intent to also exclude from administrative costs to be borne by the insurance carriers and self-insurers the costs of administering the War Claims Act of 1948 and the War Hazards Compensation Act, under which liability for the payment of compensation claims is assumed by the Federal Government.

EFFECT OF 1972 AMENDMENTS ON INJURIES REPORTED UNDER LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT—COMPARISON OF OLD AND EXTENDED COVERAGE, FEBRUARY 1973–JUNE 1974 [1]

District office	Injuries reported							
	Old coverage [2]		Extended coverage [3]		Coverage undetermined [4]		Total [5]	
	Number	Percent of total	Number	Percent of total	Number	Percent of total	Number	Percent
Boston	20,963	50	19,857	48	917	2	41,737	100
New York	8,114	71	3,154	27	173	2	11,441	100
Philadelphia	3,375	39	5,221	60	55	1	8,651	100
Baltimore	5,301	33	10,672	67	52	(6)	16,025	100
Norfolk	10,799	52	15,069	58	4	(6)	25,872	100
Jacksonville	5,647	58	3,938	41	75	1	9,660	100
New Orleans	17,590	70	7,446	30	123	(6)	25,159	100
Houston	8,572	40	12,729	60	4	(6)	21,305	100
Cleveland	1,814	67	768	29	112	4	2,694	100
Chicago	1,520	76	346	17	142	7	2,008	100
San Francisco	8,454	75	2,533	23	183	2	11,170	100
Seattle	5,295	54	4,381	45	143	1	9,819	100
Honolulu	576	72	211	27	8	1	795	100
Total	98,020	53	86,325	46	1,991	1	186,336	100

[1] Statistics on coverage not available before February 1973.
[2] Coverage in effect before 1972 amendments—aboard vessel or over water.
[3] Shoreside coverage added by 1972 amendments.
[4] Type of coverage (old or extended) unable to be determined.
[5] Total injuries reported including fatalities, from item 3 of form LS–3.
[6] Less than 0.05 percent.

Mr. FLOOD. Thank you.

HEALTH CARE FUNDING

WITNESS

HAROLD SCHARFSTEIN, ON BEHALF OF DR. JOHN HOLLOMAN, PRESIDENT, HEALTH & HOSPITAL CORP. OF NEW YORK CITY

Mr. FLOOD. Dr. John Holloman, president, New York City Health & Hospital Corp.

Mr. SCHARFSTEIN. Mr. Chairman, my name is Harold Scharfstein, I am director of reimbursement for the New York Health & Hospital Corp. Dr. Holloman regrets not being here this afternoon due to the severe fiscal crisis in New York which impacts on the Health and Hospital Corp. I do have a brief prepared statement which I would like to enter into the record.

Mr. Chairman, on behalf of Dr. John L. S. Holloman, president of the New York City Health & Hospital Corp., I respectfully request this committee's reconsideration of the proposed Federal cutbacks in health care funding. The combined impact of reduced funding for maternal and infant care programs, family planning projects, child and youth programs, neighborhood health centers, and the reduction in Federal matching of medicaid services, will have disastrous effects on the working poor of New York City.

With both State and city officials fighting to balance their budgets for fiscal year 1976, there is absolutely no chance for these cutbacks to be absorbed through increased spending by New York State and New York City. Federal cutbacks in health care financing, coming at a time when New York City is facing a fiscal crisis, and unemployment in the city has reached the 11 percent mark, will find the city unable to provide health care services to that part of our population most in need.

As you are no doubt aware, the Health & Hospital Corp. has been asked to make severe cutbacks in its operating budget for fiscal year 1976. It is estimated that $3.9 million—314(E) funds—that support services provided by neighborhood health centers in the city would be cut leaving approximately 75,000 people in need of ambulatory care services. We see no way that these services could be provided by the corporation. In addition, if the Federal Government reduced its matching for medicaid covered services, the corporation estimates that it would lose another $35 million causing further reduction in services to our patient population.

Mr. Chairman, we are asking that there be no cuts in present Federal programs financing health care services until a comprehensive national health insurance plan is enacted.

Thank you.

Mr. SCHARFSTEIN. The proposed cutbacks for the maternal and infant care programs, family projects, child and youth programs, neighborhood health centers and the proposed reduction in Federal matching of medicaid services would be critical in the city of New York. Many of these programs are ambulatory care programs.

As you are no doubt aware, there is a dearth of funding for insurance for ambulatory care other than medicaid and medicare programs. With reference to medicaid, in 1966 New York State had one of the most liberal programs in the country where a family of four with a net income of $6,000 was eligible for medicaid. We are almost 10 years later with a tremendous inflationary period and there has been in fact a reduction in those income levels. So that family of four now has to have a net income of $5,000 to be eligible for medicaid.

This is a tremendous problem in the city of New York in all ambulatory care programs run by the voluntary programs and the municipal hospitals under the corporation. Without the implementation of a comprehensive national health insurance plan the corporation recommends there be no cutbacks in current funding of health care.

Thank you.

Mr. FLOOD. Thank you very much.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

WITNESS

DENNIS LINDSAY, ESQ., LINDSAY, NAHSTOLL, HART, DAFOE & KRAUSE, PORTLAND, OREG.

Mr. FLOOD. Mr. Lindsay, Portland, Oreg., on Longshoremen's and Harbor Workers' Compensation Act.

Mr. LINDSAY. I am Dennis Lindsay, a lawyer from Portland, Oreg. I practiced with Bob Duncan years ago. I made the trip out here to speak about the Department of Labor whereby they seek to put the administrative costs of the act on the longshore employers. The people I am speaking about represent all the longshore firms on the west coast, about 30 of them employing 18,000 to 20,000 men.

They have a direct payroll of about $200 million. There is a long statement which I hope can be incorporated in the record. It is so long I put an index on it, some 22 or 23 pages. I will make three or four points very briefly.

[The statement follows:]

PREPARED STATEMENT OF DENNIS LINDSAY, COUNSEL FOR THE MASTER CONTRACTING STEVEDORE ASSOCIATION OF THE PACIFIC COAST, INC.

My name is Dennis Lindsay. I am a practicing attorney in the law firm of Lindsay, Nahstoll, Hart, Defoe & Krause, of Portland, Oreg. Our firm specializes in admiralty and maritime law and has had long experience with matters arising under the Longshoremen's and Harbor Workers' Compensation Act. I appear before you as counsel for the Master Contracting Stevedore Association of the Pacific Coast, Inc.

THE STEVEDORE ASSOCIATION

The association is composed of some 30 firms engaged in the stevedore business in various cities on the west coast. They render stevedoring services at San Francisco, Los Angeles, Seattle, Portland, and almost all other ports in the Pacific Coast States, California, Washington, and Alaska.

The member stevedore firms are the business organizations which perform the actual work of loading and discharging vessels and related terminal and warehouse activities. The association members were responsible for the payment of the large majority of the $190 million direct labor payroll for longshoremen, clerks, and other maritime shoreside and offshore workers in California, Oregon, and Washington during 1974.

The members of the association include companies immediately and directly affected by changes to the Longshoremen's and Harbor Workers' Compensation Act, and particularly, by increases in the costs of administering that act.

INTRODUCTION TO STATEMENT

The balance of this statement outlines the reasons for the association's vigorous opposition to the administration's proposal to fund its costs of regulating the Longshoremen's and Harbor Workers' Compensation Act through assessments against carriers and self-insurers.

The basic reasons underlying our opposition to the Administration's "user charge" proposal include the following:

(1) the "user charge" proposal is not new. It has been previously considered and rejected by those committees charged with overseeing the act. Continuation of the appropriations funding mechanism was impliedly assured during 1972's massive amendments. A departure from earlier funding policies should not occur without full consideration by the Senate and House Subcommittees on Labor.

(2) Private industry already pays the costs of administering the Longshoremen's and Harbor Workers' Compensation Act. The Department of Labor regulates that administration. The costs of regulation should be paid from general tax revenues.

(3) The Administration's claim that title 31, United States Code, section 483a (The Independent Offices Appropriation Act of 1952), provides existing authority for its "user charge" proposal is incorrect. No such authority exists.

(4) The imposition of industrywide "user charges" would constitute a sharp break with Federal Government traditions. The administration seeks to levy a tax against the waterfront industry. Only Congress may levy taxes. A new and unprecedented Federal taxation policy should occur only after substantive congressional deliberation and action.

(5) The "user charge" proposal is grossly unfair to private waterfront employers. It seeks to impose assessments upon only a minority of those employers providing Federal compensation benefits. It seeks to tax that minority for the costs of reducing the burdens on Federal courts.

THE USER CHARGE PROPOSAL

The user charge proposal was outlined to representatives of the stevedore industry at a meeting with Under Secretary of Labor Richard F. Schubert in Dallas, Tex., on January 15, 1975. At that time, the industry expressed strong opposition to the general proposal and requested that the Department of Labor provide a fuller explanation of its intentions.

On April 15, 1975, the Department of Labor's Employment Standards Administration circulated its explanation to industry representatives.

Although vague, that explanation demonstrates that the administration seeks to impose upon waterfront employers a 5.5-percent assessment which the Department anticipates will generate sufficient funds to recover the "full cost of administering the Longshoremen's and Harbor Workers' Compensation Act." The costs which the Department intends to recover include the following:

(*a*) Direct program costs (including salaries and contingent expenses for monitoring of claims, provision of medical monitoring, and rehabilitative services).

(*b*) Legal and appellate (costs incurred by the Solicitor of Labor, Office of Administrative Law Judges, and Benefits Review Board).

(*c*) Employment Standards Administration and departmental overhead.

The administration proposes to exclude District of Columbia employers from the burdens of the user charge provisions.

Finally, the explanation provides two reasons why the user charge proposal would be "fair," and, indeed, "advantageous" to the maritime and insurance industries affected. First, the administration has explained that its proposal is "fair" because it will—

"* * * encourage healthy competition among companies to improve their safety records vis-a-vis one another. The result would be that the companies with the best safety record; that is, whose benefit payments are less than those of the industry in general, will pay a proportionately smaller amount as a user charge."

Second, the administration explained why its user charge proposal will be "advantageous" to our industry:

"The application of user charges under the Longshore Act will be advantageous to the maritime and insurance industries affected, in that the contributors to the assessment will be afforded an opportunity to provide input into the administrative and legislative functions of the program."

The balance of this statement will demonstrate that the user charge proposal is neither "fair" nor "advantageous" to those industries "served" by the Longshoremen's and Harbor Workers' Compensation Act.

The Master Contracting Stevedore Association of the Pacific Coast, Inc.,

trusts that this subcommittee will find in this statement, and in others provided by similarly burdened industries, sufficient reason to reject the user charge proposal.

The "user charge" proposal is not new. It has been previously considered and rejected by those committees charged with overseeing the act. Continuation of the appropriations funding mechanism was impliedly assured during 1972's massive amendments. A departure from earlier funding policies should not occur without full consideration by the Senate and House Subcommittees on Labor.

The traditional method of funding the regulation of the Longshoremen's and Harbor Workers' Compensation Act has been through appropriations. Sections 45 and 47 of the act created that method of financing in 1927. The appropriation method has survived—intact—earlier assessment atttempts.

The President's fiscal year 1967 budget recommendation advocated the assessment of safety and administrative user charges totaling $1,546,000.

Hearings on Senate bill 2485 were held before the Senate Subcommitttee on Labor in late 1967 and early 1968. That bill included a proposed amendment to section 45 of the Longshoremen's and Harbor Workers' Compensation Act which would assess the costs of regulation against carriers and self-insurers on the basis of insurance premiums paid.

The Senate bill and the "user charge" proposal attracted much opposition from such disparate organizations as employers, insurers, and labor. Near the close of the hearings, Senator Morse, one of the bill's sponsors, noted that these opponents had made a "very strong prima facie case" against the assessment of user charges. Senate bill 2485 was not enacted.

In 1972 the Longshoremen's and Harbor Workers' Compensation Act was fully reconsidered by the Senate and House Labor Subcommittees. Massive changes resulted. The only mention of administrative expenses throughout the 1972 legislative history appears in Representative Steiger's "Questions and Answers" printed at pages 298–302 of the Longshoremen's and Harbor Workers' Compensation Act Amendments of 1972 (GPO 1972) :

"*Question.* What are the costs?

"Answers. * * * The only other additional cost to the Government would be that incurred in administering the provisions of the bill. Since there is an existing staff structure, the increased administrative costs would be minimal. The Department of Labor has not been able to give a firm estimate of the additional administrative cost, because of the many variables involved, but indicates somewhere around $2.8 million additional will be needed. Current administrative costs are $1.4 million. Which would mean a total of $4.2 million upon enactment for administration.* * *"

The basic point of this short history should be clear: The administration's proposal is not new. When earlier suggested, the proposal was recognized as substantive and rejected by those subcommittees charged with overseeing the substantive aspects of the Longshoremen's and Harbor Workers' Compensation Act.

When, as in 1972, broad amendments were enacted, the Department of Labor did not press for user charges. All interested parties—Congress, employers, insurers, and labor—presumed that the traditional funding mechanism would continue. All interested parties knew that more funds would be required. The passage of the 1972 amendments and the grant of the enormous additional benefits to labor was, in part, based upon the assumption that more funds would be appropriated.

At the time of the 1972 amendments, the administration estimated that those amendments would require an additional $2.8 million in administrative funds. Passage of the amendments without a substantive change in the act's financing mechanism created a commitment that necessary additional funds would be provided and that those funds would be provided from general revenues.

If additional funds are required, that commitment should be honored and the funds provided. However, the funds should be provided by general tax revenues.

Private industry already pays the costs of administering the Longshoremen's and Harbor Workers' Compensation Act. The Department of Labor regulates that Administration. The costs of regulation should be paid from general tax revenues.

The Administration has estimated the costs of "administering" the Longshoremen's and Harbor Workers' Compensation Act at approximately $3.7 million. The fact is that the actual costs of administration far exceed that total.

"The administrative costs of workmen's compensation include the expenses

and profits of private insurers and State funds, the cost of administering self-insurance plans, industrial commission expenses, and other charges to the public for administering workmen's compensation laws. In essence, they [the administrative costs] cover all expenses of the program except payment for cash benefits and medical and rehabilitation services. * * *" (Compendium on Workmen's Compensation, National Commission on Workmen's Compensation Laws, 1973, at p. 267.)

If the Administration is correct in assuming that a 5.5 percent assessment will generate $3.7 million, then over $65 million will be paid out in compensation and medical benefits during fiscal year 1976. From figures developed by the National Commission on State Workmen's Compensation Laws, that compensation and medical benefit payout necessitates $25 to $30 million of "administrative costs"—all of which are paid by employers either directly or through insurance premiums.

Thus, over 90 percent of the total costs of the Federal compensation program are already being paid by employers. The $3.7 million which the Administration anticipates it will expend is, in fact, not a true "administration" expense. Rather, it is an expense created by Congress' instruction that the private insurers and self-insuring employers be regulated.

Viewed in this context, it is clear that "user charges" will not "* * * encourage healthy competition among companies to improve their safety record. * * *" That competition is already intense. It will not be encouraged by $3.7 million in additional costs.

The costs of Federal regulation should be paid by general revenues.

The Administration's claim that 31 U.S.C. 483a (the Independent Offices Appropriation Act of 1952) provides existing authority for its "user charge" proposal is incorrect. No such authority exists.

Whole industries may not be assessed pursuant to 31 U.S.C. 483a.

The Administration has expressed the "joint opinion of the Department of Labor and OMB" that title 31 U.S.C. § 483a and OMB Circular No. A–25 authorize the proposed assessment of user charges.

The statutory provision relied upon by the administration—the Independent Offices Appropriation Act of 1952—provides, in part, as follows:

"It is the sense of the Congress that any work, service * * * benefit * * * license * * * or similar thing of value or utility performed, furnished, provided, granted * * * by any Federal agency * * * to or for any person (including * * * corporations) * * * shall be self-sustaining to the full extent possible, and the head of each Federal agency is authorized by regulation * * * to prescribe therefor * * * such fee, charge, or price, if any, as he shall determine * * * to be fair and equitable taking into consideration direct and indirect cost to the Government, value to the recipient, public policy or interest served, and other pertinent facts. * * *"

In two relatively recent decisions,[1] the Supreme Court has construed the 1952 act to authorize assessments or user charges only for "specific charges for specific services to specific individuals or companies." The Supreme Court expressly held that "* * * whole industries are not in the category of those which may be assessed." (415 U.S. at 349)

The act benefits the public and all claimants; it does not "serve" only industry.

Despite the Supreme Court's clear rejection of practices similar to the administration's user charge proposal, the administration seeks to avoid that rejection by theorizing:

"* * * that the general taxpayer should not bear the burden of administering programs which do not affect the public at large, and that such costs should be borne by the industries served."

First, it is clear that the Longshoremen's and Harbor Workers' Act—as do all workmen's compensation programs—beneficially affects the public at large. According to the National Commission on State Workmen's Compensation Laws, the success of workmen's compensation programs—

"* * * can be evaluated by the extent to which they satisfy the following commonly accepted objectives:

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[1] *National Cable Television* v. *United States*, 415 U.S. 336, 39 L. Ed. 2d 370, 94 S. Ct. 1146 (1974); *Federal Power Commission* v. *New England Power Co.*, 415 U.S. 345, 39 L. Ed. 2d 383, 94 S. Ct. 1151 (1974).

"(1) Income replacement;
"(2) Restoration of earning capacity and return to productive employment;
"(3) Industrial accident prevention and reduction;
"(4) Proper allocation of costs; and
"(5) Achievement of the other four objectives in the most efficient manner possible.

"Not all of these objectives are equally important or accepted. The first two generally are considered most important. These objectives sometimes conflict with one another but in most ways they are linked by the design of the program." (Compendium on workmen's compensation, p. 24.)

It is absolutely clear that the achievement of these objectives primarily benefits claimants and the entire society. The costs of regulating a broad social service program should be borne by the public.

The imposition of industrywide "user charges" would constitute a sharp break with Federal Government traditions. The administration seeks to levy a tax against the waterfront industry. Only Congress may levy taxes. A new and unprecedented Federal taxation policy should occur only after substantive congressional deliberation and action.

There is no Federal precedent for this type of assessment.

At page 2 of its April 15 "explanation," the Employment Standards Administration stated:

"The concept of assessing user charges against industries affected by governmental services is well established. Congress, over the years has enacted a number of laws authorizing user charges, and it is an established method of financing services performed by governments."

True—but greatly misleading. Congress has enacted a "number of laws authorizing user charges." Those laws, however, were enacted after full deliberation by congressional committees charged with substantive legislative responsibility. Those laws did not result from a backdoor appropriations proposal.

The fact is that the administration's attempt to assess charges against the waterfront industry is, to our knowledge, unique. Moreover, if successful, that attempt will work a sharp break with our governmental taxation traditions.

In 1974, the Solicitor General advised the Supreme Court that only four Federal agencies assess "annual industrywide fees" pursuant to title 31, section 483a. Those agencies were the Federal Power Commission, the Federal Communications Commission, the Atomic Energy Commission, and the Securities and Exchange Commission. Not one of the fees assessed by those agencies—except those ruled unlawful by the Supreme Court—is analogous to those sought here.

The fact is that there is no Federal precedent for assessing user charges against industries "affected by" governmental services. There is good reason for that fact.

The administration is seeking to "tax." That is Congress responsibility.

Almost all Government "services"—defense, health, welfare, etc.—"affect" almost all industries.

"It would be such a sharp break with our traditions to conclude that Congress had bestowed upon a Federal agency the taxing power that we read 31 U.S.C. 493a narrowly as authorizing not a 'tax' but a 'fee'" (*National Cable Television* v. *United States*, 415 U.S. 336, at 341).

In its budget, the administration seeks to impose a tax on the waterfront industry. No Federal precedent for such an administrative tax exists.

Although no current precedent exists, the user charge proposal is apparently only one example of a broad administrative policy which will supplant Congress as our Nation's taxing authority.

For example, we understand that the administration seeks to recover all costs of the Commerce Department's export expansion programs through assessments against exporting firms. Even the Commerce Department itself has been less than enthusiastic about the proposal.

These recent assessment attempts may broaden. If workmen's compensation and exports, both of clear broad social benefit, are to be paid for by only a few private industries, why not try the same approach with some big ticket items like occupational safety and health, Federal employees' compensation, Federal aid to education, or any of the other major Federal programs which have their immediate effect on identifiable groups?

Why not? Because administrative taxes are not part of our governmental tra-

dition. That tradition should not be changed by an effort to hold general revenue spending to a politically feasible level. If the programs are needed by the Nation, they should be paid from the Nation's funds. If the programs only benefit a few, perhaps they should be reconsidered.

The power to tax remains the power to destroy. Congress—not the administration—should hold that power.

The administration has not been candid.

Our traditional taxing policy is not the only tradition which the administration's proposal will affect. A fundamental premise of our system of government is that all citizens—including maritime and insurance industries—have, through Congress, full opportunity to provide input regarding programs of interest.

The administration, however, states that its user charge will be advantageous to waterfront industries because "* * * contributors to the assessment will be afforded an opportunity to provide input into the administrative and legislative functions of the program."

We now possess an acceptable opportunity to provide input into the legislative functions of the program. What is it that the administration assures us that our contributions will purchase? Will we have opportunity to name administrators, administrative law judges, and Benefits Review Board members who will favor industry? Will the act be regulated without regard to the interests of the maritime industry if no contributions are forthcoming? We trust that the answer to both questions is "No."

The fact is that our contributions will purchase nothing which the industry does not now possess. And, that is the way it should be. The administration is simply being less than candid when it claims its proposals will be advantageous to industry. The rationale for the user charge was candidly explained by Assistant Secretary of Labor Esther Peterson in the 1967 hearings on this same issue conducted by the Senate Subcommittee on Labor of the Committee on Labor and Public Welfare. In her prepared testimony, Mrs. Peterson stated:

"The purpose of these assessments is to relieve the Federal Government of costs which must be borne out of general tax revenues—approximately $3.4 million annually."

Mrs. Peterson's user charge rationale remains current. The argument that assessments will provide better input is a red herring. The administration is simply attempting to refinance a program which has traditionally been and should properly be paid out of general tax revenues.

That attempt—and the precedent it could establish—should be rejected by this subcommittee.

State use of assessments does not justify Federal use. The conditions are markedly different.

In support of its user charge proposal, the administration cites as precedent the fact that about 21 State workmen's compensation programs operate on the basis of administrative assessments. The administration particularly commends Oregon's program as especially comparable to the Longshoremen's and Harbor Workers' Compensation Act.

Oregon does utilize assessments to fund administrative costs. For fiscal year 1976, the assessments allocable to administrative costs amounts to 2.5 percent of the premiums paid. According to figures developed by the National Commission on State Workmen's Compensation Laws, Oregon's assessment approximates 3.8 percent of compensation and medical benefit payments.

Oregon established its assessment practice when our legislature decided to end the previous State monopoly on the underwriting of workmen's compensation insurance. With that decision, the need for State regulatory machinery was created. The erection of that machinery meant that, unless another funding vehicle were developed, a new agency would have to be funded out of very limited and, in the main, committed State moneys. The diversion of money from the State budget to the new Workmen's Compensation Board was politically impossible.

Faced with that problem, Oregon enacted, as part of the entire substantive workmen's compensation legislation, an assessment system. The passage of the assessment program occurred only after considerable opposition similar to that being expressed in these hearings. The assessment program was enacted only because opponents and proponents agreed that assessments, although inequitable in theory, were tolerable where the State was small, the operation centralized, and communication among interested parties good.

These factors which make assessments tolerable within a State do not exist

on the Federal level. The national physical area is too large, the communication—even with the opportunity for informal input—too difficult, the operation too decentralized, the interested parties too diverse.

The main point is this: What is inequitable may be tolerable. An inequitable assessment program is not tolerable when a vast, decentralized Federal regulatory bureau is involved.

Congressional purse-string budgetary control must be retained.

Finally, this subcommittee should note that the Council of State Governments has not approved the policy of assessments. As noted by the administration, the Council of State Governments has suggested assessments because "* * * it is considered to be a more predictable method of financing than is appropriations."

The National Commission of State Workmen's Compensation Laws phrases the issue slightly differently:

"The assessment method of financing is the one recommended by the Council of State Governments. Most administrators prefer to have workmen's compensation costs financed through assessments rather than legislative appropriations. Such a method of financing provides funds on a relatively regular and predictable basis with less need to compete with other agencies for public funds." (Compendium on workmen's compensation laws, p. 275.)

The administration's desire to be free from the budget scrutiny afforded by this subcommittee and its parallel in the Senate is understandable. We expect that nearly all Federal agencies would prefer to establish and fund their own budgets without congressional scrutiny. However, we strongly believe that continued congressional budgetary scrutiny and purse-string control is essential.

The "user charge" proposal is grossly unfair to private waterfront employers. It seeks to impose assessments upon only a minority of those employers providing Federal compensation benefits. It seeks to tax that minority for the costs of reducing the burdens on Federal courts.

Why not assess the employers in the District of Columbia? Are the costs of regulating the District's claims being assessed against maritime employers?

In 1972, Senator Eagleton advised the President that the Longshoremen's and Harbor Worker's Compensation Act covered more than 800,000 workers. That figure included 200,000 longshoremen and ship repairmen, 300,000 employees of private employers within the District of Columbia, and 200,000 workers in defense bases, in nonappropriated fund Federal agencies, and engaged in work on the Outer Continental Shelf. [Congressional Record, Senate, October 18, 1972.]

The administration's explanation of the user charge proposal is vague. At one point, it anticipates that the cost of administering the Longshoremen's and Harbor Worker's Compensation Act and its extensions will be $2,892,000, allegedly excluding the cost of administering the D.C. Workmen's Compensation Act. In addition, the administration anticipates a need for $844,000 to fund 30 legal support positions, including the Benefits Review Board. The total of those two figures is $3,736,000, a figure which—at another point—the administration states is the "current actual total for administrative costs." We note that this figure is quite close to the $4.2 million figure which was, in 1972, thought necessary for all administration—including that for the District of Columbia.

One must at least suspect that the administration intends to assess the costs of funding the D.C. workmen's compensation program against waterfront employers.

Even if this suspicion is not correct—even if the administration has somehow deducted the costs of the District's program from its assessment proposal—one point is absolutely clear. The employers of the District of Columbia will not be subject to user charges. Instead, the District's program will either be funded by waterfront assessments or by general appropriations.

Past proposals—such as Senate bill 2485—at least did not favor the District of Columbia. Assessments were sought against its employers also. Past proposals were defeated. This more discriminatory proposal should also be rejected.

It is extremely unfair to charge private industry for the costs of alleviating the burdens on Federal courts.

The 1972 amendments created the Benefits Review Board as a substitute for the U.S. District Courts. One of the primary reasons for the creation of the Benefits Review Board was expressed by Secretary of Labor Hodgson in his testimony before the Senate Subcommittee on Labor, Committee on Labor and Public Welfare:

"Lawsuits by injured longshoremen, who may understandably be lured by the

possibility of large recoveries in seaworthiness actions against the shipowner, have become commonplace. The bill for this unnecessary litigation, which clogs the courts and runs up millions of dollars worth of legal fees and court costs, is eventually passed on to the consumer in the form of higher prices for goods shipped by water. * * * The Philadelphia four-judge panel observed that:

" 'Many of the courts which now have the longest median time interval for termination of trials are the courts which have a high percentage of longshoremen cases.'

"The court then put extra emphasis on the next paragraph:

" 'There is complete unanimity among the judges of our court that we would welcome an inquiry by Congress for a revaluation of the issue as to whether the Longshoremen's and Harbor Workers' Act should be amended so that the latter would be the exclusive remedy and thus bar actions between the longshoremen and shipowners and if there can be no relief for this historical anachronism * * * *then there must be additional judges and facilities for those "longshoremen Federal courts" which are struggling to diminish the delays in civil trials.*' " (Emphasis added.)

The creation of the Benefits Review Board alleviated the need for additional judges and facilities. The alleviation of that need presumably lessened the demands upon Federal tax revenues. The costs of obtaining that saving to the Federal Government should not be imposed upon private industry.

CONCLUSION

At this point it should be clear that the primary beneficiaries of the amendments of 1972 were the workmen themselves. Perhaps the Independent Offices Appropriations Act of 1952 could be stretched to permit the assessment of administrative charges against those workmen. Such an assessment would be inappropriate. An assessment against the workmen would impose an additional hardship upon persons already suffering the very real problems of industrial injury.

It is equally inappropriate to impose additional charges upon the employers of those persons. The welfare of the injured worker and his family is not and should not be the exclusive concern of that worker's employers. The entire national economy and society is adversely affected whenever members of its production team are injured. The cost of maintaining and administering programs which support the general productive effort is a proper responsibility of the country as a whole.

In addition, it would be a highly questionable precedent to grant to any administrative agency budgetary carte blanche. Congressional budgetary purse-string controls should continue. If additional funds are required, they should be paid from general revenues.

Finally, we have not made a special study of the need for additional funds. Our focus here has been on the funding method proposed by the administration. However, it is obvious to all parties concerned with the administration of the act that additional funds are badly needed at the Deputy Commissioner level.

We greatly doubt the need for additional lawyers at the Benefit Review Board level or in the Solicitor of Labor's office.

The amendments of 1972 have increased the number of claims. More support personnel and claims examiners are undoubtedly needed. This need was anticipated in 1972; it should come as no surprise.

Mr. LINDSAY. I think the thing that sticks in our craw more than anything else is the suggestion of trying to pass these costs on to us which is sort of a back door way of doing what was not done before. I have been with this whole problem of the amendments to the Longshore Act, finally culminating in the 1972 amendments, since about 1961. That is about 11 years for the whole process, the disputes and compromises that had to be developed between the Department of Labor, AFL–CIO, and then industry, both the stevedore employers and the ship repair people.

As Bob Duncan mentioned to you earlier, ultimately it was a whole succession of compromises. Early in the game the Department of Labor

came up with proposals and there were bills introduced by the administration on which there were hearings where they put in the substantive legislation this very approach—that the costs of administering would be shouldered by industry through the assessment method. That was thoroughly blasted by the labor people and the industry people. In fact, the people hearing it, Senators Moss, Yarborough, and later Eagleton, all said they could not quite see that approach. So ultimately the bills in 1971 and 1972 ended up being the 1972 amendments to the act and they did not include that proposal.

All of us thought the method of funding had been laid to rest. All of a sudden we received by mail information that they now proposed the costs be put back on the industry. I guess our most direct answer to that is if that is what they want, they should do it through the legislative panels which should be the committees on Labor in the House and Senate rather than coming in through the back door of appropriations. Coming in through that back door, it seems to me is illegal under a couple of decisions of the Supreme Court. The thing that is overlooked constantly when they talk about having us pay the cost of administration is that, in fact as I look at it, we are probably paying now about 90 percent of the cost.

As you know, employers handle the costs of compensation either by getting insurance or doing it on a self-insurance basis. According to figures developed by the organization called the National Commission on State Workmens' Compensation Laws it appears to us, as it is set forth in the statement, that at the moment the employers are perhaps paying by what they do to make the compensation act itself work, the forms they fill out and all the administration they do themselves is—around $25 to $30 million.

The administration's or the Office of Management and Budget's proposals seem to add about another $4 or $5 million on that.

It appears to us we are already paying approximately 80 or 90 percent of the administrative costs.

We are at a loss to understand why this extra load should be dumped on us.

Finally, you will have perhaps noticed in the Department's proposal they suggest that these user taxes be assessed only against the stevedore firms that have longshoremen or against the ship repair firms, leaving out the District of Columbia. For the life of me I cannot understand why you would make the distinction between the two.

The Longshore Act covers approximately 900,000 workers, about 200,000 on the waterfront and 300,000 in the District of Columbia, and about 400,000 under the various defense bases acts and all the instrumentalities where people can get injured outside the territorial jurisdiction of the United States. We are really at a loss to understand why this particular group, the longshore employers and the ship repair people should be picked up to pay for the burden of this act.

Lastly, we are not really against the Department receiving some money to fund itself in order to make this act work. In fact, we are all for that. There is a really critical shortage of help. They really are short of help at all the deputy commissioner levels.

Claims are not being processed as fast as they should be. They do

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need help in their examiners and deputy commissioners. I think Tom Wilcox was getting at the point where they don't need help, in the Solicitor's Office and at the legal end of this business. By and large, and I have been at it 35 or 36 years, in the contested cases you have rather experienced counsel on both sides, ILW, ILA and industries or the carriers who hire people who specialize in this business who between them they arrive at a result. What has happened to us and where the Department proposes now to put in almost $1 million, is that they keep wanting to intrude, as it were, by beefing up the Solicitor's Office of the Department of Labor to what end I am not quite sure. It has been my impression, and it would be the impression of the plaintiff's bar, that they are adequately representing the injured people insofar as there has been a dispute, and industry is looking after itself.

If there are to be any funds appropriated, we certainly hope it will be put in the right direction of getting more people so that this compromise worked out in the 1972 amendments to the act will really work.

I thank you for your attention.

Mr. FLOOD. Thank you.

TUESDAY, MAY 20, 1975.

ADMINISTRATION EMPLOYMENT SERVICE BUDGET

WITNESS

GERALD MILLER, VICE PRESIDENT, PERSONNEL LABOR AND PUBLIC RELATIONS, SHARON STEEL CORP., SHARON, PA.

Mr. FLOOD. Mr. Gerald Miller, personnel labor and public relations, Sharon Steel Corp.

Mr. MILLER. Mr. Chairman, I previously sent a copy of a statement we gave to the Pennsylvania delegation.

The only change in that now is that we have contacted similar groups from other States and they have telephoned me or wired me that they would be happy to associate themselves with the statement and give me the authorization to speak on their behalf from the other States. So that statement which I will paraphrase today is the statement of a group of 85 committees representing 1,500 employers in 27 States of the country.

As a little background, in 1972 and 1973 the Manpower Administration retained Arthur Greenley Associates to look into how the employer services from the employment service could be expanded and improved. Therefore, this program of 25 advisory councils in the first 11 States were formed and they drew up joint plans of action and the cooperation started.

Late last year at a meeting requested by Assistant Secretary Kolberg, the original 25 chairmen came to Washington and met with Secretary Kolberg and his staff. They presented to him how important we felt the employment service improvement program was and how important we felt a viable employment service was. He was gratified to find that employers were standing up saying: "We want effective employment service." Since that time we have expanded into 85

advisory committees in 27 States representing 1,500 employers, many of whom are in the top 1,000 of the Fortune 500.

In Pennsylvania alone we have seven committees and a State committee. We became very concerned with the administration's proposed budget for the employment service that would in effect result in an employment service cut nationally of 12 percent at the time when the employers of this country feel an employment service has never been more necessary.

We also want to point out that a cut in the service at this time is going to affect the handicapped, minorities, unemployed, welfare recipients and other income maintenance people who have no place to turn to get a job, be counseled, and tested, and subjected to job testing, and make them income producers in this country rather than tax drainers. These people would have no place to go without an effective employment service.

We are requesting that your committee help to place $68.5 million nationally. That is the figure that would be necessary to restore the employment service to the staff level which fiscal year 1975 would have assured. The funds appropriated in 1975, we are saying that is a fine staff level and it will take $68.5 million to keep that level that would have been assured by 1975 appropriations. We recognize that you are under tremendous pressure for fiscal restraint. On the other hand, we feel our request is efficient with fiscal restraints. Only through this employment service can they be placed in income-producing jobs for their families and keep the using costs under control. Only through an effective employment service can other income maintenance people be exposed to jobs which have been developed for them by the employment service people. They are the only agency that can do that. I mean finding their qualifications, working with them, and testing them.

Without the employment service there is nothing and no place for these people to go.

It is cost effective. A public service job costs about $7,000 each. Hopefully that is only temporary. On-the-job-training program it costs $1,500 each. Institutional training is $3,000 each. When all that is over these people still have to be placed in the private sector of the economy by somebody. That somebody has to be the employment service since there is no other agency to do that for them.

The placement is a little under $200 per man. But they have to be placed in the private sector and the public service jobs may be necessary and the others may be necessary but there still has to be a permanent job for them when it is all over.

By cutting the employment service staff at this time—at any time, but especially at this time—the unemployed are going to be suffering. The underemployed will be the victims. What profession can you now go into? We have to work with the employers and introduce the backgrounds of the people that are not evident on the résumé we see everyday. Keep in mind an effective placement is not luck. It is easy to place a person on a job but it may last 1 or 2 days.

Misplacement discourages the man. Effective counseling takes time and guidance and job developing. That is what we are designed for. We want to continue that way. We are having tremendous success with it. The relationship has never been better. We hate to see after all this

time and trouble that the whole thing dies on the vine. We now know how valuable an effective employment service is.

With the cooperation of all the groups, people are being served in a way they have never been served before. That is by the employer, person, the community, labor, there is a joint effort on this.

Take Philadelphia, for example, in the first 7 months of fiscal 1975 job placements through the employment service were up 21 percent at the time Philadelphia jobwise was going down the drain. This is how this program can work.

The employee services program can work if you get the employers together with the BES.

In Pennsylvania we may have 9 percent unemployed but we also have 91 percent employed. Among them are many attritions, turnovers, quits and what have you. We have a right to have these unemployed men tested and have them exposed quickly to jobs.

The longer it goes the less chance they will have of accepting jobs. That is why this program we feel is cost effective.

Mr. FLOOD. You indicated in the statement that the employer service improvement program has been very successful in Pennsylvania and some other places as well.

Mr. MILLER. Yes, sir.

Mr. FLOOD. Under those circumstances do you think the program should be extended to the rest of the country as well?

Is there anyplace it has not been set up so far?

Mr. MILLER. This program which Pennsylvania took over on its own after a while, it should be extended to every city where there is a local BES office. It should be extended to every State to make sure the employment service and people who benefit from it can have it.

Mr. FLOOD. What can the Department of Labor do to extend it?

Mr. MILLER. I think they can continue to work closely with the State offices of the BES. In Pennsylvania we were pleased with having a State council and a very dedicated State office. The local committees are pulled together on projects but the Labor Department can support it.

They like to decentralize and that is right. They can work with the State people and encourage them to form State committees and local committees through some catalyst if they feel that is necessary.

These people have to be pulled together. The employers have to realize that the employment service image of 10 years ago really was not deserved and they can do the job and they have proved they can do the job.

The unemployed, underemployed, handicapped, income maintenance people have been the beneficiaries of this and employers have been beneficiaries. I am thinking without this there is no place for these people to turn. There has to be an effective employment service.

Mr. FLOOD. Thank you.

The committee is recessed until 2 o'clock tomorrow.

HIGHLIGHTS OF PRESENTATION TO PENNSYLVANIA CONGRESSIONAL DELEGATION BY PENNSYLVANIA EMPLOYER ADVISORY COUNCIL

PURPOSE OF MEETING

Pennsylvania employers want to express their concern over the administration's employment service budget. Such budget would result in an employment

service staff reduction of 12 percent at a time when an effective employment service has never been more necessary to serve the unemployed and the community at large. We, as employers, are seeking your understanding and are requesting your help in assuring that the necessary funds are appropriated and released to provide an employment service staff at least equal to the level which the fiscal year 1975 appropriations which Congress authorized would have provided.

BASIS FOR EMPLOYER CONCERN

The State and 14 local employer advisory councils were established in 1973–74 for the purpose of working closely with the employment service on both the local and State level to establish a close working relationship to aid the employers, the unemployed and the communities at large. These efforts have been successful; job placements are up substantially, badly needed employment and personnel services are being provided and the employer-employment service relationship has never been better. Approximately 300 employers have representatives on the State employer advisory committees.

We have learned that the effect of the administration's fiscal year 1976 budget request will be a cut in the number of employment service positions authorized by Congress for fiscal year 1975 by about 12 percent. We realize that this is a difficult time for the Congress because of the mounting size of the Federal deficit and the multitude of demands for funds from all sources. Yet we regard the cuts in the employment service as being against the best interests of employers and the unemployed. The cost to the taxpayer of an employment service placement in a private sector is well under $200 as compared to the $7,000 annual cost of a public service job which is, at best, temporary; a $3,000 annual cost for an institutional training position; and, a $1,500 annual cost of an OJT position. And, most importantly, there has never been a time when an effective employment service is needed more.

By cutting employment service positions, job development and placements in the private sector from among the unemployed, veterans, the handicapped and minority groups will suffer. A public service jom program, properly administered, is probably needed. Yet, such a program touches so very few of the total number of the unemployed. An effective employment services touches all unemployed and can result in the permanent placement of many through job development and counseling.

Counseling, testing, job matching, et cetera are the services so necessary to assure an effective placement. These services have suffered because of past cuts in the employment service staff. For example, since 1972 the Pennsylvania Employment Service has lost over 500 man-years through a 28 percent cut in funded positions because of this. Counseling man-years had to be reduced by nearly 41 percent and the testing volume by almost 30 percent. A continuation of this trend will further adversely affect the quality of service employers need, want and pay for. The presently unemployed will be substantially ignored and left to do the best they can on their own.

EMPLOYER REQUEST

The Pennsylvania Employer Advisory Council is asking the Pennsylvania congressional delegation to support an adequate appropriation for the employment service because we believe that the positive results it has achieved can be expanded and improved even in a period of recession. We have endorsed, and are sponsoring, a "hire now" campaign in Pennsylvania which is designed to identify those firms which have substantial hiring activity and to work with these employers to develop a comprhensive plan of placement services.

The council's request is not just an attempt to maintain the status quo. It is based on the belief that the Bureau of Employment Security serves a vital and important function in reducing the length of unemployment for those laid off. As a consequence, the costs of unemployment insurance, welfare and other income maintenance programs are reduced. In almost every one of the 14 cities where councils are operating, there has been a very marked improvement in employment service placement performance. If the basic staff is cut, there is no way to sustain, much less improve upon, the present level of effectiveness.

CETA

The council believes CETA offers a promising approach to the delivery of manpower services. Yet the council wishes to emphasize that the ultimate success of

CETA will depend upon the degree to which CETA results in job placements in the competitive private sector of the economy.

The State advisory council has studied the operations of CETA in those Pennsibility of making the disadvantaged, unemployed and underemployed "job ready." conclusions are as follows:

There is substantial duplication of services where prime sponsors are not fully utilizing existing BES services. This duplication which is prohibited by the act itself, can be substantially reduced if CETA prime sponsors were to be considered as training coordinators and if prime sponsors were charged with the responsibility of making the disadvantaged, unemployd and underemployed "job ready." Such matters as certification, testing, referral, job development, counseling and placement should be the responsibility of the Bureau of Employment Security and those other manpower agencies which have particular expertise for particular segments of the program. With the Bureau of Employment Security a partner, job matching, job placement and followup will be performed with known expertise and with assurance that placements are job matched and free from bias. With the duplicate job development efforts now existing, all are confused and employers are beginning to reject the efforts of both the Bureau of Employment Security and CETA. This, of course, works to the detriment of the Bureau of Employment Security for non-CETA job placements and to the detriment of both the Bureau of Employment Security and CETA for CETA positions.

Many CETA training programs are being developed without input. To be responsive to employer needs, program development should be a joint CETA, Bureau of Employment Security, employer, labor and community project. Without this, people will be trained for jobs which do not exist.

If the investment Congress has made in CETA is to be a success, the individuals served by CETA prime sponsors must end up in jobs. It will not happen if duplication of placement effort and misdirections of training continue. The CETA prime sponsors need—and need to use—an effective employment service.

ALPHABETICAL LIST OF ADVISORY COUNCIL EMPLOYERS

A. Rifkin Co.
AC Machine & Manufacturing Co.
Adams Manor Convalescent Residence
AllState Insurance Cos.
Almarts
Amatex Corp.
American Bank
American Can Co.
American Printing & Publishing Co.
Anvil Products, Inc.
Apollo Metal Works
Armstrong Cork Co.
Arro Forge
Automatic Timing & Controls, Inc.
Avco-Lycoming Corp.
Bachman Foods, Inc.
Bucyrus-Erie
Bailey Meter Co.
Baldwin Hardware Manufacturing Corp.
Bell Telephone Co. (3)
Boyer Brothers, Inc.
Bethlehem Fabricators, Inc.
Bethlehem Hotel
Bethlehem Steel Corp. (2)
Birdsboro Corp.
Blue Cross of Northeastern Pennsylvania
Boeing Vertol Division
Boiler Engineering & Supply Co., Inc.
Bonded Maintenance Corp.
Boston Store
Boyer Brothers, Inc.
Britts Department Store
Bro-Dart Industries, Inc.
Budd-Polychem Division Co.
Burnham Corp.
Burron Medical Products
Carbidie Incorporated Division
Carpenter Technology Corp.
Carter Dinino Studios, Inc.
Certain-Teed Products Corp. (2)
Chambersburg Community Improvement Association
Chambersburg Engineering Co.
Chambersburg Laundry
Channellock, Inc.
Chicago Bridge & Iron
City of Bethlehem
City of Reading
Clover Stores
Clyde Fox Motors
CNA Insurance
Color Process, Inc.
Commonwealth Telephone Co.
Computer Peripherals, Inc.
Consolidated Casket Co.
Consolidated Molded Products
Container Corporation of America
Continental Can Co.
Continental Cigars
Cooper-Bessemer Co.
Cooper Mirror & Glass Co.
Cox's Department Store
Cutler-Hammer
Dad's Dog Food, Inc.
Dart Container Corp.
DeWalt Division of Black & Decker

ALPHABETICAL LIST OF ADVISORY COUNCIL EMPLOYERS—continued

Dick Brothers, Inc.
Durkee Famous Foods
Eberhard Faber, Inc.
Educators Mutual Life Insurance Co.
Eltra Corp.
Erie Bolt Corp.
Erie Tool Works
Extra Corporeal Medical Specialties, Inc.
F. W. Allen Co.
Faith Shoe Co.
Ferrous Casting Specialists, Inc.
First Eastern Bank
First National Bank
First Valley Bank
Fisher Body
Flexsteel Industries
Fort Pitt Steel Casting
Foster-Wheeler Corp.
Franklin County Horticultural Society
Frick Co.
Fulton Industries
G. C. Murphy Co. Variety Stores (2)
Gables Department Store
Gardner Cryogenics
Gee Bee Department Store
General Battery Corp.
General Electric Corp. (3)
General Hospital
General Telephone Co. of Pennsylvania
Genuardi Super Markets, Inc.
Gilbert Association
Girard Bank
Glassco Apparel Co., Inc.
Glyco Chemical Corp.
Golden Dawn Foods, Inc.
Greater Chambersburg Chamber of Commerce
Greater Scranton Chamber of Commerce
Grit Publishing Co.
Grove Manufacturing Co.
GTE Sylvania, Inc. (2)
H. J. Heinz Co.
Hamot Medical Center
Harte & Company, Inc.
Hellertown Manufacturing Co.
High Steel Structures, Inc.
HMW Industries, Inc.
Holiday Inn
Home Health Service of Northeastern Pennsylvania
Host Enterprises, Inc.
Hubley Division (Gabriel Industries Inc.
Hughson Chemical Co.
IBM Corp.
Insurance Co. of North America
International Salt Co.
ITT Grinnell Corp.
J. C. Penney Co. (4)
J. K. Rishel Furniture Co.
J. Roberts Manufacturing Co.
J. Schoeneman, Inc.
Jacob Haller Co.
Jaunty Fabric Corp.
Jefferson University
Jessop Steel Co.
John Wanamaker (2)
Joseph H. Cohen & Sons
KD Manufacturing Co.
Kawecki Berylco Industries, Inc.
Knouse Foods Coop., Inc.
Lee Tire & Rubber Co.
Lehigh-Litho
Lehigh University
Leslie Fay, Inc.
Lord Kinematics Corp.
Ludens, Inc.
Luzerne Products, Inc.
Lyons Transportation Lines, Inc.
Maiers Bakery
Manhattan Shirt Co.
Manpower Planning & Operations Office
Manufacturers Association of Erie
Marine National Bank
Mason's
McAnallen Brothers
McDowell National Bank
McGraw-Edison Power Systems
McKeesport Hospital
McKinney Manufacturing Co.
McNeil Laboratories, Inc.
Meadville Malleable Division
Medico Industries, Inc.
Mercy Hospital
Metropolitan Edison Co.
Mid Penn Telephone Co.
Mid-State Bank & Trust Co.
Millcraft Products, Inc.
Montgomery Ward
Morco, Inc.
Mountain Brook Orchards
Muskin Corp.
National Annealing Box Co.
National Cash Register
National Castings
National Central Bank
Nelson of Kingston, Inc.
Nesbit Memorial Hospital
Nichols Discount City
Nitterhouse Concrete Products
North America Music Industries
North American Rockwell Corp.
Northeastern Lumber Co.
Northern Central Bank & Trust Co.
Northwest Rural Electric Co.
Ohio Rubber Co.
Oppenheim's
Penco Products, Inc.
Penn Central Transportation Co. (2)
Penn Dixie Cement Corp.

ALPHABETICAL LIST OF ADVISORY COUNCIL EMPLOYERS—continued

Penn Dutch Corp.
Penn State University
Pennsylvania Electric Co.
Pennsylvania Optical Co.
Pennsylvania Wire Rope Corp.
Pennwalt Chemical Corp.
Personnel Association of Erie
Philadelphia Gear Corp.
Philadelphia Parts Distribution Center
Pic Electric
Plymouth Golf Ball Co.
Polymer Corp.
Pomeroys Department Store
Presbyterian-University of Pennsylvania Medical Center
Prestige Shoe Corp.
Proctor Silex, Inc.
Protected Home Mutual Life Insurance Co.
Quaker State Coca-Cola
Radio Corp. of America (3)
Reading Alloys, Inc.
Reading Tube Division
Red Barn Restaurant
Red Cheek
Reznor ITT
Richman Bros.
Rockwell International
Roney-Foley, Inc.
Rural Health Corp.
S. A. Heisey & Sons
Sagner, Inc.
Sanner Office Supply Co.
Sauquoit Fiber Co.
Sawhill Tubular Division
Sears Roebuck & Company (3)
Sharon General Hospital
Sharon Steel Corp.
Sharon Store
Sharpsville Steel Fabricators
Sierra Permaneer Furniture Co.
Singer Co.
SKF Industries (2)
Smiths G.E. Appliances, Inc.
South Manufacturing Co.
Spang Industries, Inc.
Spencer Hospital
St. Joseph's Hospital
St. Luke's Hospital
Standard Brands
Sterling Engineering & Manufacturing Co.
Strawbridge & Clothier
Stroehmann Brothers Co. (2)
Suburban General Hospital
Sun Oil Co.
Sun Shipbuilding & Dry Dock Co.
Sure Fit Products Co.
T. B. Woods Co.
Teledyne-Firth Sterling
Teledyne Landis Machine Co.
Temple University
The Budd Co. (2)
The Eastern Foundry Co.
The New Jersey Zinc Co.
The Topton Lutheran Home
Third National Bank
Travelodge Motel
Tri-State Engineering Co.
U.S. Steel Corp.
Union Bank & Trust Co.
Union Camp Corp.
United Natural Gas Co.
Univac
University of Scranton
Urick Foundry Co.
Valley Vending Co.
Veeder-Root, Inc.
Verplex Corp.
Vienna Baking Co.
Vo-Tech
Warnaco Men's Sportswear, Inc.
Warner & Swasey Co.
Washington Hospital
Welding Engineers, Inc.
West Brothers Tire Store
Western Electric Co.
Western Pennsylvania National Ban...
Westinghouse Electric Corp.
Westwaco C. A. Reed Division
Williamsport Hospital
Williamsport National Bank
Wilson Products Division
Yellow Cab Co.
Young Windows, Inc.
Yourga Trucking, Inc.
Youth Center

PRESENTATION TO PENNSYLVANIA CONGRESSIONAL DELEGATION BY PENNSYLVANIA EMPLOYER ADVISORY COUNCIL

PURPOSE OF MEETING

1. To express deep employer concern over the Administration's Employment Service budget which will result in another Employment Service staff reduction at a time when all effective Employment Service has never been more necessary to serve the unemployed and the community at large.

2. To point out that aside from the problems the unemployed will experience without an effective Employment Service, we, as employers, will cease receiving services we need, want, and expect.

EVENTS GIVING RISE TO EMPLOYER CONCERN

1. Local and State Employer Advisory Councils were established in 1973–74 for the purpose of working closely with the Employment Service on the local and

State level to establish a close relationship which would aid the employers, the unemployed and the communities at large. These efforts have been successful. Job placements are up substantially, badly needed employment and personnel services are being provided, and the Employer-Employment Service relationship has never been better.

2. Then, last fall, as this momentum was continuing to grow and as the economic downturn became recognized as a recession, we employers learned that adequate funds would not be furnished for the staff necessary to assure that the unemployed would be exposed quickly to available jobs and employers who were hiring would be effectively serviced by local Employment Service offices. The State Employer Advisory Council sent each of you a letter expressing its concern. We were gratified with your response to the situation through the passage of an appropriations bill which seemed to provide adequate funding to maintain a sufficient Employment Service staff in our State. However, we once again became greatly concerned when $18.5 million which Congress appropriated was not released by the Department of Labor to the States for the Employment Service.

3. Now we have learned that the effect of the administration's fiscal year 1976 budget request will be a cut of about 12 percent in the number of Employment Service positions authorized by Congress for fiscal year 1975.

4. We as employers are extremely concerned about this budget proposal. We urge you to assure that the necessary funds (approximately $65 million nationally over the administration's budget proposal) are appropriated, and released, to provide an Employment Service staff at least equal to the level which the fiscal year 1975 appropriations bills which Congress authorized would have provided. We recognize the need for fiscal restraint. We feel our request is consistent with such restraint since only through an effective Employment Service can many of those receiving unemployment insurance payments be placed in available jobs for which they are qualified and thus keep unemployment insurance costs under control.

5. We realize that this is a difficult time for the Congress because of the mounting Federal deficit and the multitude of demands for funds from all sources. But, we regard the cuts in the Employment Service as being "pennywise and pound foolish," particularly when the cost to the taxpayer of an Employment Service placement in a private sector job is well under $200 as compared to the costs of other manpower strategies. For example:

(*a*) A public service job costs an average of $7,000 a year and it is, at best, temporary.

(*b*) Institutional training costs an average of $3,000 a year per trainee.

(*c*) An OJT position costs an average of $1,500 a year.

Yet, at the end of each of these programs the enrollee must still be placed in a job in the competitive market. Obviously, the investment in placements in the private sector is far less expensive than these other alternatives. It is also more cost effective because tax dollar consumers on the rolls of unemployment insurance, welfare, food stamps, etc., are converted into tax producers.

6. We, as employers, recognize a need for a properly administered public service job program. Yet, we want to remind all concerned that hopefully this program is temporary. Job placements in the private sector by the Employment Service are mostly permanent. By cutting Employment Service positions, job development and placements in the private sector from among the unemployed, veterans, the handicapped, and minority groups will suffer.

SPECIFIC ASPECTS OF CUT IN EMPLOYMENT SERVICE STAFF

1. Our experience with the Employer Advisory Councils has demonstrated to us how effective the Employment Service can be and how valuable it is in both the short and long run in making effective and lasting job placements. Without adequate funding, the Employment Service cannot fulfill its short and long range roles to the community at large and to the employers. The Employer-Employment Service relationship will once again be one of discouragement; the unemployed and underemployed will be the victims.

2. In almost every one of the 14 cities where employer councils are operating, there has been a marked improvement in Employment Service placement performance. For example, in Philadelphia, despite rising unemployment, Employment Service placement have increased 21 percent over the first 7 months of this fiscal year as compared to a year ago. We are convinced that this kind of

economic and socially vital performance can be achieved everywhere. However, if the basic staff is cut, there is no way to sustain, much less improve upon, the present level of effectiveness.

3. The Pennsylvania Employer Advisory Council is asking the Pennsylvania congressional delegation to support an adequate appropriation for the Employment Service because we believe that the positive results it has achieved can be expanded and improved even in a period of recession. We have endorsed, and are sponsoring, a "Hire Now" campaign in Pennsylvania which is designed to increase the placement effectiveness of the Pennsylvania Bureau of Employment Security. Despite the fact that approximately 9 percent of the work force is unemployed, 91 percent are still employed. Even if some firms have layoffs, many are hiring to replace turnover and attrition. The "Hire Now" campaign is designed to identify those firms which have substantial hiring activity and to work with the employed in meeting his hiring needs through the development of a comprehensive plan of placement services. Bureau of Employment Security staffs have been trained to work with employers to insure that those among the unemployed who can meet hiring needs, are occupationally classified, tested, counseled, and referred for placement as quickly as possible.

The "Hire Now" campaign is an imaginative and positive response to an urgent problem. It points to the fact that an effective Employment Service is needed more now than ever.

4. Our request to you is not just another attempt to maintain the status quo. Rather, it is based on our belief that the Bureau of Employment Security can serve a vital and important function in reducing the length of unemployment for those laid off and, as a consequence, reduce the costs of unemployment insurance, welfare and other income maintenance programs.

5. People do not receive permanent jobs at random or by accident. Counseling, testing, job matching, et cetera, are services necessary to assure an effective placement. These services have already suffered from past cuts in the Employment Service staff. Since 1972, the Pennsylvania Employment Service alone has lost over 500 man-years through a 28-percent cut in funded positions. Counseling man-years had to be reduced by nearly 41 percent and the testing volume by almost 30 percent. In short, it has been impossible for the Bureau of Employment Security to meet employer demands for these very important job placement services. A continuation of this trend will further adversely affect the quality of service employers need, want and pay for. The presently unemployed will be substantially ignored and left to do the best they can on their own. On the other hand, an effective Employment Service can explore and professionally communicate their qualifications to employers who might otherwise dismiss their applications for employment.

6. According to the U.S. Department of Labor's Manpower Administration, the Employment Service is mandated to provide registration, counseling, testing and placement services to a host of special groups under 21 different laws, 17 Executive orders and 14 special agreements with other Federal agencies. In addition, several major court orders require "equity of access" to special groups including the disadvantaged, veterans and migrants and seasonal farmworkers. Many of these mandates adversely affect the efficient operation of the Employment Service in carrying out its primary function—placement of people in jobs. Even with existing resources, including those appropriated by the Congress in fiscal year 1975, the Employment Service would be hard pressed to fulfill all these mandates effectively. Besieged with mandates and court-ordered priorities, the Employment Service, faced with staff cuts, will be forced to further curtail services to employers and to those among the unemployed who are qualified and available for work.

EMPLOYERS CONCERNED

1. Employers need the services of the Employment Service. The advisory councils can help the total effectiveness of the Employment Service because employer needs are communicated and the Employment Service responds, people get jobs and employer needs are met. We can assure you that in Pennsylvania, we will continue to help the Employment Service become even more effective. Advisory councils in 22 other States are serving similar roles.

2. It is important to point out that employers have a right to an effective Employment Service. We pay payroll taxes which are supposed to fund an effective Employment Service. We also have a right to expect that unemployment insur-

ance claimants, welfare and food stamps recipients will be exposed to placement opportunities. Only in this way can we expect any substantial reduction in the estimated $1 billion of unemployment insurance claims in Pennsylvania this year. Finally, we have a right to expect quality job development and placement services to meet our employment needs.

CETA

CETA may offer a promising approach to the delivery of manpower services. Yet, we wish to emphasize that the ultimate success of CETA will depend upon the degree to which CETA results in job placements in the competitive private sector of the economy.

The State Advisory Council has studied the operations of CETA in those Pennsylvania cities (and areas) where we have local advisory councils. Our major conclusions are as follows:

There is substantial duplication of services which is specifically prohibited by CETA itself. The root cause of this duplication is the failure of CETA to fully utilize existing Bureau of Employment Security services. This duplication can be substantially reduced if CETA prime sponsors act as training coordinators charged with the responsibility of making the disadvantaged, unemployed, and underemployed job ready. Such matters as certification, testing, referral, job development, counseling, and placement should be the responsibility of the Bureau of Employment Security and those other agencies which have particular expertise for particular segments of the program (e.g., urban league for OJT). Only in this way can the Bureau of Employment Security-employer-community relationships be developed and maintained on a permanent basis. Further, job matching, job placement and followup would be performed with known expertise and with assurance that placements are job matched and free from bias. With the duplicate job development efforts now existing, all are confused. Employers are beginning to reject the efforts of both the Bureau of Employment Security and CETA. This, of course, works to the detriment of the Bureau of Employment Security for non-CETA activities and to the detriment of both the Bureau of Employment Security and CETA for CETA-type positions.

Many training programs are being developed without the necessary employer input. Program development should be a joint CETA, Bureau of Employment Security, employer, labor, and community project. Only through such joint effort can the programs be responsive to employer needs.

If the investment Congress has made in CETA is to be a success, the individuals served by CETA prime sponsors must end up in jobs. It will not happen if duplication of placement effort and misdirections of training continue. The CETA prime sponsors need—and need to use—an effective Employment Service.

WEDNESDAY, MAY 21, 1975.

JOB CORPS

WITNESS

HON. AUGUSTUS F. HAWKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. PATTEN. The committee will come to order.

We are pleased to have with us our favored colleague, the gentleman from California, Mr. Augustus Hawkins.

Mr. HAWKINS. Mr. Chairman, I would like to file my statement with the committee.

I would like to make two or three remarks.

I am appearing in behalf of the status of the Job Corps. This at one time fell within the jurisdiction of my Subcommittee on Equal Opportunity, a subcommittee of the House Education and Labor Committee.

It is now transferred because of the Comprehensive Employment and Training Act, to Mr. Daniel's committee. However, we did take much testimony on the Job Corps and on other acts that relate to juveniles.

As you well recall, we did pass last year the Juvenile Justice and Delinquency Prevention Act and the Law Enforcement Assistance Administration is administering this act. The idea of that act was to keep young people out of the conventional justice system that in a sense had been committing injustice against them, that is incarcerating them in detention and correctional facilities. We thought we should have alternatives to that. This act, however, has not really been funded. Yesterday I appeared before another subcommittee of the Appropriations Committee seeking money for that act.

The Office of Management and Budget has completely turned down any money this year for that act.

Mr. PATTEN. What committee did you appear before?

Mr. HAWKINS. Mr. Slack's subcommittee.

Mr. PATTEN. Where would that come in?

Mr. HAWKINS. That is because I am making the point——

Mr. PATTEN. That is under the Justice Department.

Mr. HAWKINS. In the case of the Job Corps and in all the various programs that affect juveniles and have as their intent the purpose of trying to prevent serious problems, crime and juvenile delinquency, we are in effect not funding them or funding them at a very low level. So it is with the Job Corps which is certainly an alternative. Between 1960 and 1973 it may be of interest to note that almost 45 percent of those arrested for serious crimes were juveniles. These are 18 and under. If we add those between 18 and 21, it is almost two-thirds of the serious crimes.

It seems to me the Job Corps is one of the alternatives to consider. Yet we have been cutting back on this program year after year. The enrollees have almost been decreased 50 percent. In 1973 we mandated that women should be given equal consideration in the program which means 50 percent. If we are to really comply with that mandate it simply means we have to have more slots.

In spite of all of this and in spite of the fact of serious crime being committed largely by persons for whom the Job Corps would be one alternative perhaps to keeping them out of trouble we seem to be going in the opposite direction to the facts and findings of subcommittees and committees of the Congress and turning our back on the facts that we accumulate.

It seems to me that this just doesn't make sense. I would like to file with the committee my complete statement and simply indicate that we believe that this is one program that should not be further reduced but should be expanded. I think the parameters of that expansion are definitely included in my statement. I appreciate the opportunity, Mr. Patten.

Mr. PATTEN. Fine.

Your statement will be made a part of the record.

Mr. Chairman, I appreciate the opportunity to appear before you to express my concern about the status of the Job Corps. At a time when unemployment continues to climb, I believe that every program designed to reduce the unemployment rolls should be at maximum strength.

For the past 10 years the need for Job Corps training for out-of-school and out-of-work youth has been acknowledged. Even so, as the unemployment rate for youth rose from 12.9 percent in 1967 to 20.6 percent in March 1975, the Job Corps size was reduced from 43,159 in 1967 to a projected 20,496 in 1975. The size of the Job Corps is, of course, controlled by the budget.

From a high of $303 million in 1966, the budget was reduced to $171 million in 1975. The number of spaces in the Jobs Corps was further reduced by inflation during the past few years. Today we place emphasis on the development of employment opportunities. Perhaps there has been too little emphasis on providing training and education to meet the needs of young people who require encouragement to build up their skills. With an opportunity to learn and work, they can become responsible citizens.

As directed by the Comprehensive Employment and Training Act, steps should be taken to achieve an enrollment ratio of 50 percent enrollees in training in the Job Corps consistent with efficiency and economy.

I strongly endorse an increase in the size of the Job Corps for fiscal year 1976. This Congress should appropriate the funds to provide an expansion of this creative program for our young people.

Thank you, Mr. Chairman.

Mr. PATTEN. One of the largest Job Corps centers was a couple of miles from my house at Camp Kilmer. I used to watch this with great interest. You have one adherent. I don't know where we are going.

Mr. HAWKINS. It is nice to have an adherent whose voice is as articulate as yours.

Thank you.

Mr. PATTEN. Thank you.

WEDNESDAY, MAY 21, 1975.

STATE-FEDERAL VOCATIONAL REHABILITATION PROGRAM

WITNESS

THOROLD S. FUNK, DIRECTOR OF THE DIVISION OF VOCATIONAL REHABILITATION IN THE STATE OF WEST VIRGINIA, REPRESENTING THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Mr. FUNK. Mr. Chairman and members of the committee, I am Thorold S. Funk, representing the council of State administrators of vocational rehabilitation in my capacity as president of that organization. I am also director of the division of vocational rehabilitation in the State of West Virginia. Both the council and I are grateful for this opportunity to appear before you to express our concerns with respect to the funding for the State-Federal vocational rehabilitation program in fiscal year 1976.

The council of State administrators of vocational rehabilitation is composed of the chief administrators of the State agencies serving vocationally handicapped, disabled Americans in each of the States, the District of Columbia, and the U.S. territories. These agencies constitute the State partners in the State-Federal program of vocational rehabilitation services provided under the Rehabiiltation Act of 1973 (P.L. 93–112), as amended by the Rehabilitation Act amendments of 1974 (P.L. 93–516). This 55-year-old program is the major resource in this Nation for vocational rehabilitation services for the disabled,

and our organization has been an active force in strengthening the effectiveness of the program. Founded in 1940 to provide State input into the State-Federal program, the council has since enjoyed a quasi-official status as adviser to the Federal administrators in the formulation of policy and program decisions at the Federal level.

Mr. Chairman, your committee is in an excellent position to assure the disabled citizens of this country that there is an effective implementation of the stated intent of the act that the handicapped be given the training, skills, and opportunity to engage in gainful employment. Our members are deeply concerned about the ability of their programs to meet the congressional mandate for vocational rehabilitation of the severely handicapped in their States.

Surely there is no need to emphasize to this seelct group the devastating effects of the inflationary cost spiral of the past 4 years on our capacity to maintain a stable level of service functioning. This has severely limited purchasing power, not only for overall services, but particularly for services relating to the mandates of the Rehabilitation Act of 1973 and the amendments of 1974.

BASIC STATE GRANTS

We strongly urge that your Committee provide appropriations for basic State grants under section 100(b)(1) of the act in the full amount authorized, $720 million, for fiscal year 1976.

It is difficult for us, in these times of inflation and pervasive economic uncertainty, to come to you seeking more money; but the realities of our mandate—that priority be given to the rehabilitation of the severely handicapped—compels us to do so. The costs of serving this group are great, many times greater than the cost of rehabilitating the less severely disabled, but certainly it is indisputable that these dollars are well spent. The loss which we try to rehabilitate or redress is not compensable in dollars, for dollars cannot approximate value here. But certainly it can be said that the funds you have given us in the past have been used to build, not only in the sense that handicapped persons have become self-sufficient and have been able to more than repay in tax dollars the funds spent to rehabilitate them; but also, even more important, these funds have been used to prevent an incalculable waste of human potential.

Under the most optimum conditions and support thus far, the number of disabled individuals being reached by the vocational rehabilitation program has been but a small portion of the total population of individuals who might benefit from vocational rehabilitation services. During the recent period of restricted appropriations and rising costs, many State agencies have found it necessary to slow down or defer service programs, especially to new applicants. This is also an inevitable result of the increased emphasis on rehabilitation of the severely disabled, a group for whom vocational rehabilitation requires greater time, greater effort, and more money.

The recent amendments to the Rehabilitation Act of 1973 mandate costly administrative requirements for the review of each ineligibility determination "not later than 12 months after each such determination" (section 111(c)). While this will undoubtedly result in some

eligibility determinations following the previous year's ineligibility decision, it will nevertheless require a substantial increase in man-hours and will siphon off funds previously used for direct services to clients.

Section 103(a) (2) and (3) of the Rehabilitation Act of 1973 mandate new services, such as "followup, follow-along, and other post-employment services necessary to assist such individuals" and "services to the families of such individuals as are necessary to the adjustment or rehabilitation of such individuals." These services will be costly, in serving all our people, and particularly the more severely disabled.

Section 101(a)(5)(A) clearly mandates expanded and improved services to handicapped individuals with the most severe handicaps. In addition, this same section provides that "in the event that vocational rehabilitation services cannot be provided to all eligible handicapped individuals who apply for such services" that an "order to be followed in selecting individuals to whom vocational rehabilitation services will be provided" be established.

Mr. Chairman, this conflicts with congressional committee reports accompanying Public Law 93–112, the Rehabilitation Act of 1973, which cleary state that services now being provided in any program should not be reduced or eliminated. We submit that, at the present funding level of $680 million, which the Administration recommends be maintained in fiscal year 1976 for section 110 moneys, an order of selection will rule out any but the most severely handicapped, and that we will not be able to continue even our present level of services to that group because of the cost spiral and the new mandates of the amendments.

Each of the State vocational rehabilitation agencies has been polled by our organization within the past month to determine the latest State funds available for matching Federal moneys appropriated under section 110 in fiscal year 1976. These figures, provided to you in the attached charts, show that the States have sufficient funds available to match not only the full $720 million authorized, but an additional $175,242,552 as well.

Mr. Chairman, we can assure you that every dollar appropriated to the States under section 110 will be used to the benefit of the handicapped citizens we serve. We submit that full funding under section 110, in the amount of $720 million, is vital merely to allow us to maintain our present level of services to the most severely handicapped; even this, we are sad to say, will not allow us to properly fulfull the mandates of the Act and the amendments.

I am pleased to say that the States represented by your committee in almost every case except one have far more capability to invite this service for your people than is presently contemplated under the Administration request proposal.

INNOVATION AND EXPANSION GRANTS

Moneys under section 120, for innovation and expansion, are vitally important, in that they allow for experimentation by State agencies which does not cut into what we believe to be irreducible minimums in the basic formula grants. Innovation and expansion grants provide an

opportunity to engage in, for lack of a better expression, "risk projects" in rehabilitation services.

Risk projects, made possible through innovation and expansion grants, allow greater experimentation with new techniques and methods of rehabilitation which would be impossible were it not for the advantageous Federal-State matching differential of 90–10 percent. Because of the facility with which successful innovation and expansion projects can be incorporated into the basic State program, the importance of having sufficient section 120 funds available cannot be overstated.

Mr. Chairman, the Council's recommendation that the full authorization of $42 million be appropriated under section 120 stands in marked contradistinction to that of the administration, which has again recommended no funds whatsoever.

We recognize that there are other service project provisions of this act which could be used for special target disability populations. These special projects, however, are projects which are usually not incorporated directly into the State program machinery. The project authority most closely allied to the regular State program is found in section 110, innovation and expansion, which is considered a part of the regular caseload of the State vocational rehabilitation agencies. Vital projects dealing with persons with spinal cord injuries, with epilepsy, elderly blind persons, deaf persons, and those who are renally disabled demand continued and adequate funding, lest the progress already made in these areas cease.

We find that this permits us to build in those services best suited to the needs of the people.

As the chairman and committee members are aware, the administration deferred and asked the Congress to rescind some $23 million appropriated by the Congress in fiscal year 1975 for innovation and expansion grants to the States. We were very pleased when the Congress failed to grant its approval to this rescission request.

The moneys appropriated under section 120 in fiscal year 1975 have now been released to the States, where they are being used for the benefit of the severely handicapped. The Council of State Administrators urges the Congress to again express its faith in this section of the law and appropriate moneys for this invaluable program. We hope, also, that the administration will not delay in allocating all moneys appropriated under section 120 to the States, where it is so sorely needed to develop and continue innovative programs for the rehabilitation of the severely handicapped.

We hope Congress will continue its diligence to be sure that the States continue to receive this money for such worthwhile purposes.

SPECIAL PROJECTS

Similarly important are the special projects for the severely disabled under section 304(b)(1) of the act, which has an authorization level of $20 million for fiscal year 1976.

For section 304(b) the administration has requested a mere $2.7 million, which would be sufficient to fund but a few projects.

It is our hope that you will see fit to appropriate the full $20 million authorized, in order that important projects for groups such as the

underachieving deaf, the aging blind, those with endstage renal disease, and those with spinal cord injuries not be neglected.

Our experience in past years under the innovation and expansion grant authority, as well as the special project provisions, has enabled us to bring into the mainstream of the program handicapped people who otherwise have been considered too great a risk to be included in the regular vocational rehabilitation program.

TRAINING GRANTS

This is a time when we should be strengthening our staff competencies to deal with the increased numbers of severely disabled we are serving. The specialized rehabilitation professions in the areas of counseling, work evaluation, rehabilitation medicine, and rehabilitation facility administration do not have long histories of broad support and, in fact, have been the creations of the training programs under the Vocational Rehabilitation Act. We strongly believe that these programs should continue to receive vocational rehabilitation support, so that we may continue to upgrade the quality of services to the handicapped.

The President would like to see training funds maintained at the fiscal year 1975 level of $22.2 million. Not only would this deny attention to many handicapped persons; it would likewise deny a productive and meaningful source of education and employment to able persons. The Council of State Administrators feels that an appropriation of any less than $27.7 million in newly appropriated moneys would serve neither the interests of the handicapped nor those of the able, and we recommend this amount as a minimum appropriation for funds under section 203 of the act.

FACILITIES

There is a great need to assure quality services within the community, especially in the case of the severely disabled. These services are available in rehabilitation facilities, but sorely inadequate numbers of such facilities exist in reasonably available sites in most communities. The lack of funding for construction and improvements of facilities has slowed down and greatly limited the ability of the State agencies to serve additional applicants, especially those with severe handicaps.

In the face of a well known and critical need for facility expansion, the administration's failure to request any funding whatsoever for sections 301, 302, and 303 of the act comes as a slap in the face to those seriously concerned with implementing the act's dictate that the severely handicapped be given top priority. Facilities and services cannot be developed overnight and, therefore, the almost total lack of funds in recent years is now reflecting itself in a reduced capacity for serving increased numbers of the severely disabled in facilities. It is most important, therefore, that the Congress provide immediate support in a substantial amount for construction and initial staffing of rehabilitation facilities, as provided in section 301 of the act.

Because of the immediacy of this need, the CSAVR must press for your committee's support for an appropriation of $25 million for

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section 301 for fiscal year 1976. This would allow the prompt initiation of construction; $20 million and staffing; $5 million of additional service facilities to a degree that could have an impact on increased services for the severely disabled in the reasonably near future.

We also ask that you allow adequate funding for section 302, to provide training services and rehabilitation facility improvement projects; and for section 303, which provides for mortgage insurance to encourage development of needed facilities. For section 302, we recommend a minimum appropriation of $23 million; and for section 303, we urge an appropriation of $5 million, which we believe will permit a realistic implementation of this program.

RESEARCH

Before closing, Mr. Chairman, we wish to comment briefly on the subject of research, since others will deal with this area more completely than we. Suffice it to say that, while ours is a more practical world, one of applying methods and procedures developed elsewhere, we are mindful of the extent to which we are all dependent upon our colleagues in research for the great strides that have been made in rehabilitation. For the research program to have a measurable impact, we feel that an appropriation of $30 million for section 202 is an irreducible minimum.

Mr. Chairman, we have tried to present the views of the Council of State Administrators of Vocational Rehabilitation with respect to the need for adequate funding of vocational rehabilitation programs, in order that we might better serve the handicapped through programs of quality and substance.

We are aware of the budgetary restraints under which you operate, and in these days of tight and erratic economic conditions, we would be the first to insist upon a full dollar's return for each tax dollar expended in State and Federal programs. Mr. Chairman, we can give that quality of service in our programs if we are given funding adequate to the task. If we are able to serve the disabled well, they will return to the Government through their State and Federal tax dollars much more than the amounts expended to rehabilitate them.

We want to serve, and we sincerely ask that all appropriate consideration be given to our requests for the minimum amounts we feel are necessary to allow us to provide to America's handicapped citizens the type and quality of service they deserve, and that the Congress intends for them to have.

STATE	AVAILABLE STATE FUNDS FISCAL YEAR 1976	FEDERAL DOLLAR EARNING POWER	FUNDS STATES CAN MATCH AND EFFECTIVELY USE IN ADDITION TO $720 MILLION ALLOTMENT
ALABAMA	$5,571,000	$22,284,000	$ 4,745,252
ALASKA	845,000	3,380,000	
ARIZONA	1,832,000	7,328,000	
ARKANSAS	4,765,091	19,060,364	2,000,000
CALIFORNIA	16,162,135	64,648,540	14,609,424
COLORADO	1,986,324	7,945,296	500,000
CONNECTICUT	1,685,000	6,740,000	262,809
DELAWARE	567,117	2,268,468	
DISTRICT OF COLUMBIA	2,003,274	8,013,096	
FLORIDA	6,829,052	27,316,208	
GEORGIA	7,378,822	29,515,288	11,198,432
HAWAII	729,000	2,916,000	750,000
IDAHO	1,225,865	4,903,460	1,462,549
ILLINOIS	6,568,288	26,273,152	1,726,855
INDIANA	4,258,694	17,034,776	
IOWA	2,775,000	11,100,000	1,500,000
KANSAS	2,203,742	8,814,968	
KENTUCKY	4,000,000	16,000,000	400,000
LOUISIANA	5,300,000	21,200,000	3,200,000
MAINE	1,116,000	4,464,000	
MARYLAND	3,400,000	13,600,000	3,000,000

MASSACHUSETTS	$4,370,000	$17,480,000	$ 1,257,711
MICHIGAN	6,047,852	24,191,408	854,295
MINNESOTA	4,579,215	18,316,860	3,580,000
MISSISSIPPI	4,665,683	18,662,732	1,500,000
MISSOURI	4,888,000	19,552,000	1,000,000
MONTANA	893,921	3,575,684	378,000
NEBRASKA	1,335,167	5,340,668	200,000
NEVADA	1,519,771	6,079,084	4,079,084
NEW HAMPSHIRE	851,313	3,405,252	432,791
NEW JERSEY	4,132,228	16,528,912	560,966
NEW MEXICO	1,400,000	5,600,000	800,000
NEW YORK	12,961,000	51,844,000	7,000,000
NORTH CAROLINA	8,360,951	33,443,804	4,852,170
NORTH DAKOTA	1,021,840	4,087,360	1,124,628
OHIO	8,630,283	34,521,132	569,541
OKLAHOMA	3,000,000	12,000,000	1,500,000
OREGON	3,335,047	13,340,188	4,501,443
PENNSYLVANIA	8,708,000	34,832,000	1,000,000
RHODE ISLAND	792,690	3,170,760	56,000
SOUTH CAROLINA	8,205,642	32,822,568	5,483,763
SOUTH DAKOTA	795,000	3,180,000	3,180,000

TENNESSEE	$4,148,324	$16,593,296	
TEXAS	22,133,512	88,534,048	$13,415,518
UTAH	2,006,300	8,025,200	1,000,000
VERMONT	600,000	2,400,000	400,000
VIRGINIA	4,663,240	18,652,960	1,850,000
WASHINGTON	3,075,442	12,301,768	1,462,484
WEST VIRGINIA	4,549,645	18,198,580	2,000,000
WISCONSIN	4,473,472	17,893,888	2,486,473
WYOMING	500,000	2,000,000	
GUAM	158,534	634,136	
PUERTO RICO	5,500,000	22,000,000	1,600,000
TRUST TERRITORY	200,000	800,000	
VIRGIN ISLANDS	107,162	428,648	

	AVAILABLE STATE FUNDS FISCAL YEAR 1976	FEDERAL DOLLAR EARNING POWER	FUNDS STATES CAN MATCH AND EFFECTIVELY USE IN ADDITION TO $720 MILLION ALLOTMENT
TOTALS:	$223,810,638	$895,242,552	$113,480,188

Mr. FUNK. We appreciate the opportunity, Mr. Chairman, to come before you today and to say to you and pledge to the Congress that the moneys we request, if given, will be administered by the States in a most effective way to respond to the needs of your handicapped citizens in each of the States. We want to serve and to serve well and we ask Congress as they have in the past to see to the needs of our handicapped persons.

Thank you, Mr. Chairman.

Mr. PATTEN. You would not have to be here if every citizen attended the graduation Monday, at Gallaudet College.

Mr. FUNK. That is right or others like them across the country.

Mr. PATTEN. I always said that before a person is entitled to vote they ought to visit one of our State institutions.

All right, thank you very much.

WEDNESDAY, MAY 21, 1975.

REHABILITATION ACT FOR 1976

WITNESS

JOHN HARMON, GENERAL COUNSEL, GOODWILL INDUSTRIES OF AMERICA, ON BEHALF OF DEAN PHILLIPS, PRESIDENT, GOODWILL INDUSTRIES OF AMERICA, INC.

Mr. PATTEN. Dean Phillips of the Goodwill Industries of America.

Mr. HARMON. Mr. Chairman, my name is John Harmon, general counsel for Goodwill. Mr. Phillips was detained on the west coast so I am appearing in his place. When you consider everything all taken together we had a very good year last year. We served a few less people, spent more wages and salaries than the year before. I hope this is a kind of trend that will not continue this year because it is not because there are not people out there who need to be served.

I have acted as general counsel for this organization now about 18 years. So I have witnessed a great expansion that has happened with the help of this rehabilitation legislation and with the kind of support which the Congress has given to it.

I must say that at this point I am very much concerned as we point out in the very last part of the statement, that I am really not sure what the administration, where they are trying to go in terms of this program. We have 156 Goodwills, of which there are probably 50, at least, that should have the advantage of these seed money grants in order to stimulate activity in the local community.

As you well know, we get most of our support in the local community. In fact, a great deal of it is through the activity of those people that we provide evaluation, training services, and work adjustment to. So that we hope that you will not be swayed by the pleadings of the administration. We recognize that money is scarce. Therefore, it becomes a matter of priorities; where do you get the most for the spare dollars which we have. We think in rehabilitation the experience has proven this to be one of the greatest places, not only money-

wise, but in many other ways. Now I would add that not only should we go to the institutions, but I have always felt that the only way to understand the Goodwill Industries program is to go into the workshop and see these people as they learn to be independent and to continue their progress.

Thank you, sir.

Mr. PATTEN. I knew a labor leader who had a brother who was blind and 35 years old. I took him to see some of your people and they put him on. You don't know how happy you made him.

My father was blind as a result of his work, for 30 years. I just wish some others could get the feel of this. This is the greatest of all afflictions.

Mr. HARMON. Absolutely.

Mr. PATTEN. Thank you very much.

STATEMENT OF DEAN PHILLIPS, PRESIDENT, GOODWILL INDUSTRIES OF AMERICA, INC.

Mr. Chairman and members of the committee, we appreciate the opportunity to appear here today to testify on behalf of the 156 member Goodwill Industries located in every section of the United States. We trust our testimony will be helpful to the committee in the very difficult task of determining priorities for appropriations under the Rehabilitation Act for fiscal 1976.

We wish to again express our appreciation for your personal leadership as chairman of this subcommittee. We are well aware of the long hours of work members of this committee and staff spend in reviewing the recommendations of the President so that the will of Congress may be expressed in an area of vital domestic importance.

Out of the total budget for the many programs under the jurisdiction of the Department of Health, Education, and Welfare, we appreciate the difficulty in pulling out two or three line items that apply to appropriations under the Rehabilitation Act.

The President's request of $735,600,000 for rehabilitation services includes $680 million for the "basic State grant program" and $56 million for "service projects, research and training." Secretary Weinberger was at least frank in stating that this recommendation was based on a "slowdown" in the growth of the Department of Health, Education, and Welfare. Mr. Weinberger stated: "Many deserving people and programs will have to scale down their expectations." A comparison of the total of $734 million appropriated for fiscal 1974 with the request of $735,600,000 represents much more than a slowdown in growth of the State-Federal rehabilitation program. We are well aware of the attempt to rescind $23 million of the 1975 appropriations for innovation and expansion grants [sec. 100(b)(2)]. Fortunately, the Congress refused to approve this action. We hope the administration will make it available to the States in sufficient time for proper planning. We are also aware that witnesses have already testified before the House and Senate subcommittees that the position of the Department—HEW—is that this particular program authorized in the Rehabilitation Act should be culminated by amendment to the present appropriations bill now before this committee.

We understand that $56 million recommended by the President includes only a little over $6 million for special vocational training services and workshop improvement [sec. 302]. This is about half of what the Congress appropriated in 1972. It is a substantial cut from the $8 million appropriated for 1975.

We appreciate the problem in understanding the term training. There are several sources of funding for different kinds of training authorized in the Rehabilitation Act. They are:

1. Training services which a State may provide for handicapped clients in its regular program under the authority of title I. State vocational rehabilitation agencies, in fact, use local Goodwill Industries for such services.
2. Training for rehabilitation personnel under the authority of title II.
3. Vocational training services for handicapped individuals under the authority of title III [sec. 302].
4. Projects in industry training services under sec. 304(d) of title III.

Within the limits of the time available, we would like to direct the committee's attention to the vocational training project needs under sec. 302 of the act. We recommend that the appropriations approved by this committee include, and be earmarked for such purposes, the sum of $15 million for fiscal year 1976. The training projects here authorized are different from other training programs in the act because they constitute special demonstrations to develop new types of skill training. There is a very special need now for training of the more severely disabled in keeping with the general mandate of the Rehabilitation Act of 1973 and the amendments of 1974. The funds here also include training allowances up to $70 per week for each trainee. The use of such training allowance has shown by experience to bring individuals into a training program for specific job skills who would not otherwise be reached in the State-Federal rehabilitation program. More money, not less, is needed for 1976.

Sec. 302 also authorizes funds to be used for grants to rehabilitation facilities, such as Goodwill Industries, to increase professional services and management effectiveness. These funds may be used to improve the operations that provide employment services. There is a very urgent need for more, not less, money for this purpose to improve safety conditions in workshop facilities.

The record of Goodwill Industries since 1966 in the use of funds under sec. 302 has been spectacular. It has been the seed money required to stimulate local voluntary effort. It has led to the greater use of local Goodwill Industries by the State vocational rehabilitation agencies. We most emphatically disagree with the HEW that funding ought to be phased out for this type of program.

We asked members of local Goodwill Industries to tell us what the effect would be if no new projects can be funded under this 302 section-training services and workshop improvement in 1976. We are advised that over 4,000 handicapped individuals needing rehabilitation services would not receive them in 41 local Goodwill Industries located in various sections of the country. A list is attached to this testimony.

We therefore again urge the sum of $15 million be included for the authority under sec. 302.

We would like to make a few comments about the projects with industry program, authorized under sec. 304(d), and its importance in the employment of the handicapped. Since its inception, projects with industry has been one of the most effective programs for training and placing the handicapped in jobs. One important reason for this program's success is that business and industry have been directly involved in the process of planning the training program, preparing the client for employment, and establishing specific jobs in their organizations for PWI trainees. This cooperative effort between the vocational rehabilitation workshop and industry has led to an extremely successful rate of placement and retention of handicapped individuals in worthwhile, well-paying jobs, one of the major goals of the Rehabilitation Act.

Projects with industry also has an important implication for the affirmative action provisions of the Rehabilitation Act, section 503. There is considerable concern among business and industrial leaders regarding the proper method for implementing this requirement of the law. The PWI program provides industry with a proven approach for employing handicapped persons in compliance with the affirmative action requirements. A coordinated projects with industry program not only benefits the handicapped client by placing him in employment, but it offers an effective method for industry to comply with the law.

Despite the demonstrated effectiveness of projects with industry, this valuable program has not received adequate funding. For example, in fiscal year 1975, only $1 million was appropriated, barely enough to maintain the ongoing PWI projects and at this low level of funding, no new PWI projects were initiated in fiscal year 1975. In fiscal year 1976, only $500,000 has been requested for the program, an amount that will seriously restrict the number of current PWI projects and guarantee that no new projects will be initiated during the upcoming fiscal year.

In our opinion, the PWI program is of such importance that we have submitted a proposal to the Department of Health, Education, and Welfare for the establishement of a project with industry office at the Goodwill national headquarters. The purpose of this office will be to assist our affiliate members in initiating PWI programs, and to maintain contact with business and industrial leaders in seeking their cooperation to provide employment opportunities for the handicapped.

In light of the ever-increasing demands on rehabilitation workshops to place

the handicapped in employment, and in light of the legal requirements on industry to establish and implement affirmative action programs, we request that the committee appropriate $2 million for projects with industry. This level of funding will assure that new PWI projects will be initiated and current projects will have adequate resources available to them to continue this important program.

Another program which has provided much needed services to local Goodwill Industries is technical assistance under section 304(e). We recommend the sum of $500,000 by appropriations for use in fiscal year 1976. This program has been most useful in providing the service of safety engineers to make surveys of needs necessary to comply with the Federal Safety Act.

We realize opinion exists that the construction authority of section 301 is no longer needed. We can in no way agree wth this position. We are well aware that the Department (HEW) has recommended that no appropriations be made under this section for several years. Fortunately, the Congress has seen fit to appropriate enough for two or three projects. It needs to be much more.

We must recommend the sum of $30 million for fiscal year 1976 for new constructional use of rehabilitation facilities.

It is a poor answer to tell an organization like a local Goodwill Industries they should raise or borrow the money locally to house workstations for the handicapped. The experience of the past 15 years in Goodwill Industries is an outstanding demonstration of the fact that if at least a minimum sum of seed money is available, the community will more than match the amount in local funds. On the other hand, we can point to the severe difficulties a local Goodwill Industries can have where it had to borrow money for a building.

We recognize there is authority under the act to obtain funds for new construction under title I out of Federal funds the State receives under sec. 100. It is a fact however, that the various States are forced to use all the available funds for other needs. This means that year by year the authority under sec. 301 of title III becomes more necessary if there is to be any available money for this much needed purpose.

We therefore recommend that the sum of $30 million be appropriated under sec. 301 for fiscal year 1976.

We would also strongly urge the committee to set the amount under title I for the basic State program at the full authorization of $720 million for fiscal year 1976. The expanded use local Goodwill Industries by the State vocational rehabilitation agencies has not yet reached the level necessary to meet the demand for rehabilitation services in the local community.

We just don't think there are many other places where the taxpayer can get more bang for his buck than a tax dollar which goes to a local Goodwill Industries program. At the present time, Goodwill Industries is able, through the work activities of the handicapped in its local programs, to generate over 70 percent of its annual budget.

Nearly 15 percent of the average Goodwill Industries budget has been coming from funds provided through the Federal Rehabilitation Act.

If the recommendations of the President for appropriations under the Rehabilitation Act are accepted, the 156 local Goodwill Industries will be forced to seriously curtail their services to the handicapped and disabled. The cuts will, of necessity, come in those functions which provide the evaluation, work adjustment, and training services which enable the handicapped to produce. This will come at a time when job opportunities in regular employment outside Goodwill Industries are seriously limited. This means Goodwill Industries must find ways of keeping its graduates in the holding pattern of extended sheltered employment.

This will come at a time when Congress has, through the 1973 Rehabilitation Act and the amendments of 1974, said more, not less, severely handicapped individuals must be served.

This will come at a time when Congress has expressed concern about the level of wages paid handicapped workers in workshops.

This will come at a time when Congress has, by the Occupational Safety and Health Act, mandated safer working conditions.

We believe the situation facing this committee to be so grave that it challenges the very existence of the State-Federal rehabilitation program.

We trust this committee and Congress will respond as it has before to the challenge.

Thank you.

GOODWILL INDUSTRIES OF AMERICA, INC.

Information - Effect of Presidents FY Budget 1976
Rehabilitation Facilities Projects

Section 301-302, Rehabilitation Act

Goodwill City	What new projects/persons who cannot be served during FY 1976	Needed Improvements including those to meet safety and accreditation standards
Albuquerque, N. Mex.	48	$1,000,000
Colorado Springs, Col.	50	150,000
Columbus, Ohio	0	0
Dallas, Texas	200	50,000
Des Moines, Iowa	40-60	55,000
DuBois, Pennsylvania	250	250,000
El Paso, Texas	100	25,000
Evansville, Indiana	47	119,531
Flagstaff, Arizona	15-20	45,000
Menasha, Wisconsin	75	2,500
Houston, Texas	50	300,000
Jacksonville, Florida	50	50,000
Kalamazoo, Michigan	75	60,000
Kansas City, Missouri	250	25,000
Lawton, Oklahoma	300	800,000
Lincoln, Nebraska	30	86,000
Long Beach, California	50	25,000
Lowell, Massachusetts	40	50,000
Lubbock, Texas	60	50,000
Madison, Wisconsin	50-65	80,000
Manasota Branch (St. Petersburg)	36-48	25,000
Memphis, Tennessee	20	8,000
Minneapolis, Minnesota	55	145,000
Muskegon, Michigan	200	300,000
New Orleans, Louisiana	50	160,000
Oakland, California	100	150,000
Omaha, Nebraska	134	44,000
Philadelphia, Penn.	225	2,000,000
Pittsburgh, Penn.	100	350,000
Port Huron, Michigan	42	45,000
Portland, Oregon	0	500,000
Pueblo, Colorado	125	1,350,000
Reading, Pennsylvania	83	125,540
Richmond, Virginia	30-120	500,000
San Jose, California	500-600	2,000,000
Sandusky, Ohio	0	0
Santa Cruz, California	119	250,000
Savannah, Georgia	60	200,000
Seneca, Pennsylvania	225	0
St. Petersburg, Fla.	155	125,000
Shreveport, Louisiana	0	250,000
Springfield, Mass.	100	200,000
Tacoma, Washington	90	85,000
Wichita, Kansas	0	0
Winston-Salem, N.C.	250	500,000
Cheyenne, Wyoming	150	25,000

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5/15/75

WEDNESDAY, MAY 21, 1975.

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

WITNESS

DR. LORIN E. KERR, DIRECTOR, DEPARTMENT OF OCCUPATIONAL HEALTH, UNITED MINE WORKERS OF AMERICA

Mr. PATTEN. Dr. Lorin E. Kerr, director, department of occupational health, United Mine Workers.

Dr. KERR. Mr. Chairman, I am Dr. Lorin E. Kerr, director, department of occupational health, United Mine Workers of America.

Before proceeding with my testimony I want to refer specifically to the Walter Reuther Memorial Lecture entitled, "The Wages of Neglect: Death and Disease in the American Workplace." This eloquent address was delivered by Arnold Miller, president, United Mine Workers of America at the 102d Annual Forum of the National Conference on Social Welfare, San Francisco, Calif., May 15, 1975. A copy of this address is attached to my statement and I respectfully request that it be added to the record of these hearings.

While the UMWA decries the annual budgetary proscriptions limiting the effectiveness of the Department of Health, Education, and Welfare, we are continually dismayed by the cavalier attitude toward job-related disease and disability manifest in the picayune budgets for the National Institute for Occupational Safety and Health. Since 1914 when the Institute's precedent was initiated, the Federal occupational health program with the exception of the two world wars has suffered the vagaries of many administrations. The only thing that changed during both conflicts was the unswerving national commitment to maximum productivity which demanded the appropriation of funds sufficient to reduce job-related disease and disability. Immediately following both wars the budget for the U.S. Public Health Service's occupational health program was drastically curtailed. In fact, the 1945 appropriation of more than $4.5 million was reduced so rapidly that by 1955 a mere $544,000 was being spent to maintain a meager national program. A macabre joke circulating in some Washington circles at that time opined that one director of the USPHS Division of Occupational Health was charged with digging the Division's grave and his successor with reciting the interment services.

Fortunately, these foreordained events were circumvented by the timely intervention of interested parties including organized labor. In the succeeding years the Division was slowly resuscitated and by 1969 the appropriation amounted to $7,463,000. However, this was only eleven cents per annum per employed worker for the detection, prevention, and control of occupational diseases.

The enactment of the historic Federal Coal Mine Health and Safety Act of 1969 and the Occupational Safety and Health Act of 1970 marked the beginning of a new era. Occupational health became a legal entity with the formation of NIOSH in accordance with the related specifications in OSHA. There have been modest budgetary increases since 1971 but the figures for the last seven budgets have bounced like a yo-yo between $25 and $32 million. Apparently there is little ap-

preciation of the mounting neglect of occupational health which has now become a national scandal. More than 25 years ago W. C. Hueper, M.D., the renowned expert on occupational cancer stated "Environmental carcinogenisis is the newest and one of the most ominous of the end products of our industrial environment." His warning to rapidly seek the facts which would enable us to combat the causes of job-related cancer at the source before "the dread disease spreads to more and more of our people" was rarely heard outside of professional meetings and journals—and even there efforts were made to mute his cry for action.

Today the nation is confronted with a virtual pandemic of occupational cancer. However, the amount of money budgeted by NIOSH to prevent and control this devastation has been reduced to $1.8 million and its expenditure is to be limited to three industries. What three industries are to be selected and what about the thousands of workers exposed to carcinogens in other industries? Eight million dollars expended in the ten industries with the highest morbidity and mortality rates due to occupational cancer will begin to indicate that our nation will no longer tolerate job-related death and disability as the reward for working for a living.

Reduction of occupational diseases demands the skill and knowledge of those trained and experienced in the design and maintenance of a healthful work environment. At the present time there is a critical shortage of all such personnel. It is estimated that three-fourths of the nation's 75 million workers are employed in establishments with less than 500 employees. These comprise 99 percent of all the 4.7 million workplaces in the country. Almost without exception there is no organized preventive health program at these sites. The remaining 25 percent of the work force are employed in the 11,500 plants with more than 500 workers. It is assumed that all these large establishments have some form of occupational health program, ranging from those services provided by one or more nurses and part-time physicians to the extensive program provided by a full-staff of physicians, nurses, industrial hygienists and other allied health personnel. Most of the specialists in industrial medicine are concentrated in less than half these plants. While industry spends an estimated $360 million annually to provide in-plant preventive health services, the limited distribution of these services bears evidence that the concept of conservation of human resources has not yet been fully incorporated into industrial management policy.

Based on an earlier report by the American Medical Association it is estimated that currently services for industry or employer groups are being provided by 10,000 physicians—about 2,000 are employed full time. Slightly more than one-third of the total are classified as specialists who maintain membership in the American Occupational Medicine Association and 500 more are diplomates of the American Board of Preventive Medicine. Board certification beginning in 1955 was the culmination of a long struggle to achieve recognition of expertise, training and competency. While some have questioned a maldistribution of qualified occupational health physicians, there is in reality a marked shortage, and the prospects for training more are slim. There are presently only eight educational institutions qualified to offer two

academic years for residency training in occupational medicine and many of their 58 positions are unfilled. In addition only 13 plants offer the third year of residency training. Sixteen more such positions are offered by 11 Federal and State agencies. The AMA reported that for the period 1960–68, 38 physicians completed 3 years of training. It is my understanding that only eight medical schools include occupational health in their curriculum.

These figures do not include industrial hygienists who are essential for the identification and control of health hazards at the worksite. Their capabilities are necessary for the development of standards and their application at the national, State and local levels. The growing demands of management, labor, insurance companies and consultants are increasing the competition for the currently limited numbers of industrial hygienists. Moreover, the shortage of occupational nurses is alarming. There is also a great need for technicians and para-professional personnel capable of conducting adequate monitoring and surveillance programs.

The $4 million designated in the NIOSH budget for manpower training should be at the very least doubled. In fact a more realistic figure would be $10 million. Closely related is the need to constantly retrain all health personnel. This updating of their skills in accordance with rapidly advancing technology will require a minimum of $5 million rather than the penurious $1.2 million allocated in the NIOSH budget.

Constant surveillance and monitoring of worksites is another essential element of an adequate national occupational health program. About 3 years ago the U.S. Public Health Service estimated that each year we can expect 100,000 deaths and approximately 400,000 new cases from occupational diseases alone. Even then these figures did not reflect all job-related illnesses since many occupational diseases are not recognized as such. As a nation we have no knowledge of the numbers of workers with silicosis, byssinosis or asbestosis, just to mention a few of the more highly publicized man-made diseases. The same is true of all other job-related illnesses such as impaired hearing; cancer of the lung, liver, and bladder; and lead poisoning. In addition, we are confronted with the impact of highly mechanized jobs on the total health of the worker.

Just as eternal vigilance is essential for the maintenance of liberty so is eternal surveillance essential for freeing workers from the thrall of job-related illness. This requires that the workers be informed of the dangers and their role in helping to control them. Management efforts to achieve compliance with standards requires monitoring. The enormity of these and related tasks requires improvement and expansion of the evaluation of health hazards. In many instances this can best be achieved by strengthening the capabilities of State health departments which unfortunately have been permitted to languish almost to the point of nonexistence. This is a violent contrast to the period of 1942–46 when one or more USPHS occupational health experts was "loaned" to nearly every State health department. I can personally attest to the merit of this procedure which helped immeasurably in eliminating lead poisoning occurring among imported and domestic agriculture workers in the Northwest.

The miserly NIOSH appropriation of $4 million for surveillance will barely initiate a limited program. The need warrants a minimum of $12 million with substantial yearly increases.

Concerning research in the field of occupational health I would commend to you the preliminary findings of a survey recently released by Representative Dominick Daniels, chairman of the House Labor Subcommittee on Manpower, Compensation, and Health and Safety. While the purpose of the survey was to develop occupational disease surveillance methodology and to find appropriate medical methods for determining the occupationally related diseases among the Nation's work force the implication for research are outstanding. Representative Daniels said: "The startling finding is that at least one out of every four workers in small businesses has an occupationally derived disease, and 89 percent of these diseases are going unreported." In addition, only 41 percent of employers of 8 to 150 workers provided medical services, 17 percent industrial hygiene services. Moreover, noise controls were inadequate with 203 of 1,556 workers exposed to excessive noise.

It is tantilizing to extrapolate these figures and suggest similar conditions prevail among all workers. While this would be an unsound procedure the mere thought of such action is a reflection of our abyssmal ignorance. This is just one of many areas in which research is long overdue. The NIOSH budget is limited to $2 million for center grants, that is for teaching centers with adequate research capabilities. A more realistic figure would be $10 million. Additional research listed at about $8 million in the current budget request must be expanded to $20 million.

There is also an additional need for research conducted in NIOSH facilities such as the Cincinnati Center. However, that center is crowded to the point that equipment and personnel are operating in hallways and a great deal of necessary research is not being conducted. Briefly there is no research facility nor any planning to relocate or build a new facility. The $6 million proposed for planning was cut out of the budget and relocation in Cincinnati would cost at least $5 million. It has been estimated that a safe and adequate research facility would cost about $44 million. A more realistic figure is $60 million. Such an item must be included in the NIOSH budget.

There are even people working in broom closets.

Mr. PATTEN. Is this under Public Health?

Dr. KERR. Yes. They wanted to plan for a new location in Cincinnati. They cut out the $6 million planning they needed. If they want to relocate them in Cincinnati they need at least $5 million to do this.

Looking ahead to the future, because I think this question of occupational disease, Congressman Patten, if I may say so, this is a real disaster area.

Mr. PATTEN. Do you know how many empty administration buildings we have in this country with the hundreds of camps we vacated?

Do you have any idea?

Dr. KERR. There are quite a few.

Mr. PATTEN. You don't know how many. We got a report on the condition of that building here only recently from some of the Federal employees.

We have plenty of facilities. We don't have to put them over there.

Dr. KERR. Well, anyplace we could get this. They really need to have safe, adequate facilities to conduct in-house research which isn't being done at the present time.

Mr. PATTEN. We have 4,000 chemical workers in New Jersey. I was in personnel in the local plant after I got out of high school. I saw a fellow who could not move. He was constipated for I don't know how many days. I made out a report and put down lead poisoning. I almost got fired. They said he had a cold.

I told the nurse he had lead poisoning. They told me, "Do you know what would happen to our rating in the plant if you said he got lead poisoning here?" That actually happened. But I did not say the man had a cold.

Dr. KERR. Good for you. I can tell you about the workers who worked with lead arsenic spray. The only way we got help on that was through the lend lease officer in State health. Everybody said it was not so.

Mr. PATTEN. Our chairman is the general specialist on Black Lung and coal workers, Congressman Dan Flood.

Dr. KERR. I know that. The only thing we are doing here is to say that the Federal Coal Mine Act made provisions and authorized $10 million a year for 3 years for research in this field and $10 million a year for research or for the treatment of this disease. The first time that there was anything done on this was in 1973, the Senate added $10 million to the appropriation bill in September. Then it got cut to $5 million in the committee and then OMB cut it to $3.5 million. So we ended up with nothing.

Mr. PATTEN. You know, we are up and down the road of winning and losing by one or two votes on the floor. The people never wanted OSHA. You know it was never easy. You know the history of the legislation.

Dr. KERR. Our economic productivity is threatened by industrial disability which results in losses of 250 million working days, 10 times more than from strikes, costing $1.9 billion in lost wages and an annual loss to the gross national product of $9 billion. Resources that could be available for productive uses are siphoned off to pay worker's compensation costs. Until recently the annual Government pronouncement that only 2 million workers are injured on the job and of those 14,000 are killed or die later has been unquestioningly accepted by the public. A 1969 report paid for by the Department of Labor indicated that a more accurate annual accounting will probably reveal nearly 20 million job-related injuries and over 20,000 deaths.

These figures make it quite apparent that NIOSH should have the capability to establish a national clearinghouse for accidents and health; $4 million should be budgeted for this item. In addition the $1.2 million requested for safety research should be increased to a minimum of $18 million. The safety research would be concerned with such items as descriptive epidemiology of accidents, motivational studies and ergonomics.

I must now turn to the special concerns of the coal miners. With the enactment of the Federal Coal Mine Health and Safety Act of 1969 Congress for the first time mandated the eradication of an occupational

disease in a major industry. The act also provided partial remuneration for the victims of black lung. Today there are nearly 240,000 totally disabled miners and 155,000 widows receiving Federal black lung benefits totalling somewhat more than $1 billion annually. Moreover, about 16 percent of the working coal miners have roentgenographic evidence of coal workers' pneumoconiosis. Thus there is good reason to believe that another 20,000 to 25,000 men still working in the mines may well be eligible for black lung benefits in the next few years. Each year the death of more than 4,000 miners can be directly attributed to black lung. This is the first time figures providing an accurate national accounting of an occupational disease has become available. Parenthetically, much of this illness could have been avoided by devoting about $2 million to the application of known preventive measures each year for the last 25 years. The value of adequate ventilation and the use of water was well known in 1949.

Today about 20 percent of the current NIOSH expenditure is devoted to implementing programs mandated by Public Law 91-173 such as the X-ray program of active miners. To date there has been no appropriation of specific funds for coal research as authorized by the act. The Black Lung amendments of 1972 authorized the appropriation of $10 million per year for each of 3 years for the treatment of black lung. In 1975 the Senate appropriated the first $10 million which was cut to $5 million by the joint conference committee. This was further reduced to $3.5 million by an OMB directive. This limited sum is now being used to develop and expand treatment centers for those hundreds of thousands of totally disabled miners receiving Federal black lung benefits and many thousand more who although severely disabled are denied benefits. The United Mine Workers of America strongly urges you to provide $10 million for research on the chronic pulmonary diseases and other job-related diseases occurring among coal miners. There is also an additional need for $10 million for the treatment of black lung.

The enormity of the total figures for all job-related disease and disability clearly indicates that the health of the worker on the job and the effect of the job on the worker's health and well-being is a major problem confronting the Nation. With the enactment of the two occupational health and safety acts Congress has mandated that this needless waste of the Nation's prime resource must be stopped. There is just now a dawning realization that in some instances the pollution of the workplace has a deleterious impact on the surrounding community causing nonworker death and disability—witness the effects of asbestos, arsenic and sulphur derivatives. The ecologists and others are slowly becoming aware of what has long been known to the worker—the 8 hours on the job can be the most dangerous daily threat to his life and health.

The prevention of this frightening toll of dead and disabled workers will yield more startling results than can be attributed to the virtual elimination of the communicable diseases. It would also contribute enormously to the containment of medical care costs. The success of this program demands the development of a personal health delivery system in which the prevention, the diagnosis, treatment, and rehabilitation of occupational illness and injury will be coordinated and inte-

grated with all of the health services provided for the worker and his family. No longer can we rely solely on programs which fragment and isolate the worker and his health needs.

The United Mine Workers of America is of the opinion that it is impossible for NIOSH to comply with the congressional mandates of Public Law 91–173 as amended and Public Law 91–596 with the proposed miserly budget of $36.2 million. At that figure NIOSH is barely viable. We strongly urge you to raise the minimum to at least $100 million and more appropriately the $167 million delineated in this statement.

In our news letters NIOSH estimates that 1 million workers are potentially exposed to inorganic arsenic which we just began to realize is a very potent cause of cancer.

But we cannot move people on this.

Mr. Patten, if we could prevent these occupational diseases this will do more for reducing illness and deaths in this country than the virtual elimination of the communicable diseases did. We have practically wiped them out, not completely, but this will do even more, but there is another very important point. It is going to provide the means by which we are going to be able to contain these rising medical care costs because so many of these illnesses are going undiagnosed, untreated. They are being paid for by the funds that come out of the contract agreements. But if we could prevent them, this would be tremendous.

Dr. KERR. Thank you very much, sir.

Mr. PATTEN. Keep up the good work.

Dr. KERR. We will try. I hope I can come here next year and we won't have to ask for the same things.

Mr. PATTEN. I just wish we had a bigger audience for you.

Dr. KERR. So do I.

THE WAGES OF NEGLECT: DEATH AND DISEASE IN THE AMERICAN WORKPLACE

(By Arnold Miller, President, United Mine Workers of America)

I want to thank you for this honor of addressing the 102d forum of the National Conference on Social Welfare. And I would particularly like to express my appreciation to the United Auto Workers of America for inviting me to deliver the Walter Reuther memorial lecture. The opportunity to speak in memory of a labor giant like Walter Reuther is a rare privilege, indeed. I am especially pleased that this conference has chosen such a timely and important theme as "Health As A Right–The Political and Human Dimensions."

I'm not a health professional. I'm president of a union of coal miners. And for most of my working life I was a coal miner, too. So I'd like to talk with you a little today about health problems from a miner's point of view because I think they're similar to the problems millions of other American workers face every day in factories, farms, mills, and foundaries across the Nation.

I worked for a total of 24 years in the coal mines of my native State of West Virginia until 1970 when I was forced to quit because of my health. I was just 47 years old at the time, and I couldn't qualify for a pension for another 8 years. But I had no choice. My lungs were filled with coal dust. And my bones were stiff and numb from arthritis brought on by years of work in knee-deep water and the cool, damp mine air.

My experience was not unique. If a roof fall or an explosion didn't get them first, coal miners in my day could count on having their health destroyed as a price for working in the mines. It was the miners' lot, and nobody really thought that anything could be done about it.

It wasn't that miners lacked the will or the courage to try to change their

condition. Hundreds of miners had endured long and bitter strikes and many had died organizing our union. What we lacked was an understanding of what was destroying our health.

During my years in the mines, the bosses always told me that coal dust wasn't harmful. Company doctors said the same thing. In fact, several claimed that coal dust was good for us. And they always threw in some four-syllable scientific mumbo-jumbo to support their claims.

Silicosis was the only lung disease miners suffered, we were instructed and it was mainly found among hard coal miners in the anthracite region of eastern Pennsylvania and a few hard rock drillers. All we soft coal miners needed was a good chew of tobacco, the doctors said, and we didn't have a thing in the world to fear from coal dust.

Miners who complained of shortness of breath were regularly diagnosed as having "anxiety" problems or psychological disorders. Or they were accused of trying to get out of working by winning a disability award. The companies mockingly called it "compensationitis."

We didn't know at the time we were being fed this medical snake oil that 3,000 miles away in Britain the National Coal Board had identified black lung as a major occupational disease. We didn't know that in the early forties the British had set up a program of compensation awards for black lung victims and rigid dust standards in the mines.

But we did know that something was badly wrong in the coalfields.

Silently, without warning, miners would begin to feel the first faint signs of shortness of breath. A lifelong hunter could no longer carry his rifle. A walk up a hill became an ordeal. Young men with only 10 or 15 years in the mines would wake from their sleep to spit up clumps of black material. In every coal camp and hollow in Appalachia one could find coal miners hacking and coughing, unable to catch their breath, unable to work and unable to quit working lest they descend into poverty.

Coal dust was good for you, they told us, and everywhere you looked in the coalfields you saw dying men.

In late 1968, three West Virginia doctors became alarmed at the staggering number of coal miners who were disabled by breathing difficulties. Coal miners were dying from respiratory disorders at five times the rate of the general population. And autopsies of miners revealed their lungs to be little more than masses of dead, coal-encrusted tissue.

Coal dust was the killer, the doctors concluded, and they set out to let the miners know.

With the help of some interested miners, Vista Volunteers, and poverty agency lawyers, the three doctors toured the coalfields meeting in schools and local union halls with groups of working and disabled miners, their wives and widows. The county medical associations passed resolutions condemning the doctors and threatened them with disciplinary action. But the doctors were unmoved and the crowds grew. Black lung is killing you, the doctors preached, and the message spread throughout the coalfields like lightning.

In early 1969, a number of miners organized the West Virginia Black Lung Organization and asked a sympathetic legislator to introduce a bill which would recognize black lung as a compensable, occupational disease under State workmen's compensation. As the bill ran into opposition from the coal-dominated legislature, miners spontaneously walked off their jobs throughout the State until every mine was shut down. In all, 40,000 miners joined the strike, and a good number of them marched on the State capital in Charleston demanding passage of the black lung bill. In the end, with miners packing the galleries of the legislature and refusing to work, the legislature relented. The miners then made sure the Governor signed the black lung bill into law. Only then, did they go back to work.

The 3-week black lung strike in West Virginia was probably the largest strike over occupational health issues by American workers, and its effects were far-reaching. Congress passed a Federal black lung benefits program covering disabled miners and their widows as part of the 1969 Coal Mine Health and Safety Act. And it established maximum permissible dust levels for the first time in American coal mines.

Since then, there has been a good deal of study and research on black lung and we know much more about it. What we have learned is truly frightening.

Black lung is one of the most widespread and deadly occupational diseases in

the country. It kills more than 5,000 miners each year. Thousands more die when their hearts collapse from the strain of pumping blood through coal-ravaged lungs. At least 200,000 former coal miners are totally disabled by black lung disease today. And it is estimated that as many as one out of every five working miners is also a victim.

Black lung cripples and kills coal miners in this Nation in epidemic proportions. But what is more frightening is that black lung represents only the tip of the iceberg of occupational diseases that are crippling and killing American workers throughout the Nation.

No accurate statistics exist that truly portray the dimensions of the problem because we have never thought enough about workers' health problems to require national recordkeeping. But the studies which have been done show the American workplace to be a chamber of horrors and the 8 hours a worker spends on the job to be the most dangerous 8 hours of his life.

He may be exposed to cancer-causing radiation or breathe air polluted with deadly carbon monoxide. Toxic chemicals like mercury or lead seep into his bloodstream. His lung tissues are gradually eaten away by exposure to cotton dust or asbestos dust or dust from rock or glass or stone. He works surrounded by deadly machinery which can tear off an arm or leg in an instant. The crash and roar deadens his hearing. The heat of a coke oven or a blast furnace blisters and peels his skin.

Lest you think I am exaggerating listen to these findings:

—A survey of 1 million workers in Chicago found that nearly half of them are exposed to urgent and serious health hazards on the job.

—Another study revealed that half of the 1,115 asbestos workers tested suffered from asbestiosis, a killer-lung disease for which there is no cure.

—100 out of 145 workers in a lead plant were found to have lead contamination in their bloodstreams.

—Steelworkers who work around coke ovens contract cancer at three times the rate of other steelworkers. Workers employed in refining nickel die from cancer at five times the rate of the general population. Workers in the chromate-producing industry die from cancer at 25 times the rate of the general population.

—The average sample of air from 691 workplaces was found to contain four times the level of sulfur dioxide as the highest level recorded in the killer smog in London which claimed 4,000 lives in 1952.

—20 million workers are exposed to noise levels higher than 80 decibels, the level at which hearing loss occurs.

Just the other day, a study of 908 farm and factory workers in Oregon and Washington State found that at least 31 percent of the medical disorders which they suffered—from cancer and lung disorders to skin disease and high blood pressure—were job related.

More disturbing was the finding that 90 percent of the job-related health disorders had never been recorded by the government. Up to now, the best Federal estimate has been that 400,000 workers contract occupational diseases every year. This study suggests that the number is at least 4 million. Over 25,000 workers are killed on the job every year. Another 2½ million are disabled.

One would think that the slaughter and slow poisoning of millions of American workers every year would be considered a major social crisis and the government would long ago have mobilized to fight it. But it has not happened.

The average State budget allocates 40 cents per worker per year for occupational health. That's less than 1 penny a week. A survey of 25 States showed that they employed 1½ times as many fish and game wardens as health and safety inspectors. And what few inspectors there were were mostly assigned to elevators and boilers. Of the 8,000 chemicals commonly used in the industrial workplace, so-called safety levels for worker exposure have been set for only 450 of them. Less than one-third of the fines levied against coal companies for violations of the Federal Coal Mine Health and Safety Act have been collected. And up until last month the Internal Revenue Service routiney allowed the companies to write off as tax deductions what few fines they paid.

The system of workmen's compensation as administered by the States is a miserable failure. The average payment for full disability is less than Federal poverty standards. And many occupational diseases are not even recognized by the States and, therefore, aren't compensable.

What's worse is that a worker covered by workmen's compensation loses his

legal right to sue his employer for negligence. So the system, in effect, protects the employer more than the worker. Clearly, we need a Federal system of workmen's compensation with uniform payments that adequately compensate a victim. And if that system is to act as a deterrent, a worker must be given the right to sue his employer for additional damages in cases of negligence or outright violations of the law.

Our Constitution says there is equal justice under the law. But in the area of job health and safety, one has to wonder if it's so. If a factory worker drives his car recklessly and cripples a factory owner, the worker loses his license to drive, receives a heavy fine, and could spend some time in jail. But if a factory owner runs his business recklessly and cripples 500 workers with mercury poisoning, he rarely loses his license to do business and he never goes to jail. He may not even have to pay a fine.

Frankly, I don't understand why. If a few factory owners or coal mine operators received stiff jail sentences when their workers are killed and maimed because of unsafe conditions, one would be amazed at how fast working conditions at other mines and factories would be improved.

We are faced with a paradox. Occupational diseases infect this Nation like a plague. Yet there is no sense of public urgency about the problem.

There are a number of reasons for this. First, I think the dimensions of the problem are hard to grasp.

If an asbestos plant explodes and 500 workers are killed, it is instant news. But when 500 former asbestos workers die a cruel and hopeless death in 500 separate hospital rooms and nursing homes, the grief is private. It is rarely the stuff of headlines. No TV cameras record the scene.

I think that the organized medical profession also bears some responsibility for this lack of urgency. Company doctors all too often act as apologists for industry rather than physicians concerned about the health of their patients. The AMA helped lead the fight against the 1970 Occupational Health and Safety Act. And only 12 medical schools in the country teach occupational health and safety.

The so-called industrial hygienists, who should be leading the fight, are usually too busy denying that any problem exists. One industrial hygienist was quoted in Business Week a few years ago as saying that occupational diseases don't produce a wiggle in the general death rate any more. The same year he made that statement 1,700 coal miners died from black lung in the State of Pennsylvania, alone.

If we ever hope to eliminate the terrible health hazards workers face on the job, there has to be a fundamental change in public attitudes about the problem of occupational health. Changing public attitudes is never easy. But I think we can take heart from the success of the environmental movement.

Only a few years ago, the only people talking about saving the environment were a handful of conservationists. Then more citizens became involved, students took up the cause, and the media began to document the pollution of our lakes and streams, our air, and water. Today, as every politician knows, the environmental movement represents an idea whose time has come.

Surely, if the Nation can become aroused at the pollution of our natural environment, we can become equally aroused at the pollution of our work environment. For they are really one and the same issue. There is no more precious natural resource than people. And if there was ever an endangered species, it is the American worker today.

You, as workers in the social welfare field—particularly those of you who work in health-related areas—can play a crucial role in this effort. Extensive health studies and medical research need to be performed on workers and on the work environment and their findings brought to wide public attention. Those of you who work in public health can insist that job health become a major ingredient of every public health program, and that workers and their unions be involved to the maximum.

As citizens and members of organizations in the social welfare field, you can join forces with those who are fighting for enactment and strict enforcement of health and safety legislation. And you can demand that every candidate for public office who asks for your support take a stand on the issue of job safety.

You can call the Governor and write your congressman. You can picket an unsafe factory alongside workers or you can protest company practices at a

shareholders meeting. You can make speeches and write letter to the editor. But don't expect miracles.

I think all of us know that the goal of a safe and healthy work place will not be won overnight. We're talking abou a long and difficult fight. But what is essential is that we begin now—because time is not on our side.

There is a common misconception that the more we modernize and automate the workplace, the healthier it becomes. But the opposite is often the case. The high-speed labor saving machinery now used in coal mining, for example, produces much greater quantities of coal dust in the air than when mining was done by manual labor alone. The same is true in textile factories, glass manufacturing, stone cutting, and many other industries.

Every 20 minutes, we introduce a new chemical substance into the workplace. We have little idea of its effects as it seeps into the bloodstreams of thousands of workers and fouls their lungs. We cannot even guess what its genetric effects might be on future generations. We dare not wait to find out.

The job of cleaning up the work environment will be costly and difficult. But what it comes down to in the end is not a question of cost, but a question of priorities. If this society can devote millions of dollars and thousands of trained workers to the goal of landing a man on the moon, surely we can devote equal resources to making it safe for a man or woman to earn a living here on earth. What we need is the will to make it happen.

The task we face is great, but I am not discouraged. For when I look out on this great body of dedicated workers in the social welfare field, I am confident that the will we need is there.

Thank you.

WEDNESDAY, MAY 21, 1975

SCHOOLS OF PUBLIC HEALTH

WITNESS

DR. HERSCHEL GRIFFIN, DEAN, GRADUATE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF PITTSBURGH

Mr. PATTEN. Dr. Griffin, Dean, Graduate School of Public Health, University of Pittsburgh.

Dr. GRIFFIN. Thank you, sir. First, I would like to associate myself with the views just expressed. One of the other many distinctions of Dr. Kerr is that he has been a president of the American Public Health Association which is the only national professional society which takes care of all the professionals who are in the field of public health.

He has been a strong right arm. I am also selfishly interested because mine is one of those schools that cannot maintain an occupational medicine program to give residencies for occupational health physicians because there are no funds for even supporting the students while they are there. But that is another story.

Mr. Chairman and distinguished members of the committee, the Association of Schools of Public Health greatly appreciates this opportunity to submit it views on the funding programs for schools of public health, their faculties, and their students for fiscal year 1976. For the record, my name is Dr. Herschel E. Griffin and I am dean of the graduate school and public health at the University of Pittsburgh and a former president of the Association of Schools of Public Health.

Mr. PATTEN. You tell me that you are so limited and you don't teach any occupational diseases up in Pittsburgh?

Dr. GRIFFIN. That is correct.

Mr. PATTEN. What do you teach then?

Dr. GRIFFIN. Most of the physicians you are referring to are taking care of people already sick or injured. They are practicing clinical medicine. I am talking about occupational medicine.

Mr. PATTEN. They are all working?

Dr. GRIFFIN. Yes, they are working but what the physicians do in the main is caring for sickness and injury.

Mr. PATTEN. Yes, they give aspirin.

Dr. GRIFFIN. That is why they go to medical schools but we want to teach them how to protect the plantworkers from getting sick in the first place.

Mr. PATTEN. I think you minimize this. You are saying this is the only national organization of the American public health people.

Dr. GRIFFIN. It is the only association which comprises all the specialties of all the people who work in public health. It has 25,000 members.

The Association of Schools of Public Health (ASPH) counts among its membership the 19 accredited public health schools in the United States. In addition, the Association of Teachers of Preventive Medicine, most of whose members are located in medical schools, is an affiliate member of ASPH. For your information, we have attached a list of our member schools.

We are extremely pleased to state that our views, in general, are supported by the American Public Health Association, the major national professional society which encompasses all the fields of public health. We are proud to be associated on a professional basis with this fine professional organization. In addition, the APHA may be submitting their own complete written statement for the record.

Mr. Chairman, we submit this statement today to offer our advice regarding what this committee can do to help support, foster and improve professional public health education in this country. We know, Mr. Chairman, from your public statements over the years that you are a friend and supporter of professional public health education. Furthermore, we are cognizant of the support that schools of public health enjoy from other members of this committee as they themselves have expressed during several prior hearings and in committee votes.

Education to recognize and solve the health problems which occur in group and community environments require schools whose faculties comprise professionals skilled in various disciplines, including social and natural sciences, interpersonal relationships, and administrative management working together in an interdisciplinary setting. As far back as 1958 the U.S. Congress realized that the breadth of resources necessary to develop a quality school of public health would make it difficult and inefficient for each State in the Union to have its own school. In fact the 19 schools which have been established, constitute a national resource serving all 50 States, the Commonwealth of Puerto Rico, the overseas territories, and our international commitments.

The 1958 congressional action was taken, in part, because financial constraints were making it extremely difficult for the then 11 accredited schools to meet the needs for graduates or to accept more than a reduced

percentage of qualified applicants. Funds derived from tuition payments and from State appropriations or endowment funds were quite inadequate to meet the educational needs at that time. Then, as now, the situation was aggravated by the increasing number of applicants stimulated by Federal and State programs designed to expand governmental health programs.

The Federal support program that began in fiscal year 1959 was designed to help the schools of public health accept more of the steadily increasing number of applicants, chiefly by supplying the extra funds needed for teaching faculty and teaching support. Existing schools responded promptly to the Federal request by expanding student bodies. In addition, new schools were opened.

In 1958, there were 1,230 students enrolled and 772 graduates—11 schools—while in 1975–76 there will be approximately 3,271 graduates—19 schools [table I]—more than 4 times the number 18 years earlier. Since 1969, as personnel needs of local, State, and Federal agencies have mounted, the enrollment has increased even more sharply. Indeed, HEW itself projects that there will be almost 7,000 full-time equivalent students enrolled in the Nation's 19 schools of public health during fiscal year 1976

In the fall term of 1969, in the then 16 schools—the University of Washington began admitting students in 1970 and Illinois in 1972—the enrollment was 3,438. In contrast, the fall term enrollment in 1974 was 6,177, an increase of almost 100 percent in 5 years [table I]. In my own school, the olny accredited school of public health in Pennsylvania—as well as in the neighboring States of Ohio, West Virginia, and New Jersey—the enrollment has increased from 77 to 454 since 1958. As I recently indicated to you Mr. Chairman, in another context, this would not have been possible—nor will this level of accomplishment be maintained—without continued Institutional support such as that now provided under the Public Health Service Act, as amended.

These increases, at a time when many other university graduate schools were remaining level or had decreasing numbers of applicants, were clearly related to expanding public interest in health care, and expanding demand for the graduates of our schools.

During the 17 years this program of Federal support for schools of public health has been in effect, the schools have changed substantially to keep pace with demands for new and different kinds of personnel. With the mounting problems of aging, for example, more attention has been given to noninfectious and chronic diseases. With the growing complexity of industrial processes and occupational disease, greater emphasis has been placed on environmental and occupational health. With lower death rates in infancy and childhood, more work has been done in family and population planning, although there is yet much to be done!

At the same time long-standing public health programs, such as control of communicable diseases, protection of food and water supplies and protection of maternal and child health, are still vitally important in the community. One has only to read of instances like the recent recurrence of typhoid fever in Florida and diphtheria in Texas and Seattle, the detection of dangerous foci and poliomyelitis in

inner city areas, the disturbingly high rates of venereal diseases, the reports of food poisoning outbreaks and the failure to apply uniformly advances in knowledge of maternal and child health, to realize that neglect of traditional public health programs presage as severe dangers to the public as neglect of fire protection might.

In more recent years, there have been great changes in still other directions. Passage of major health legislation expanding personal health services, health planning, the program of bloc grants as well as project grants to State health agencies and the development of neighborhood health centers, has required much larger numbers of administrators, managers and new types of support personnel who understand that health promotion and restoration cannot be approached purely as a market phenomenon. The need will be further increased by any advances in the national health insurance area, by the growing numbers of HMO's, by PSRO, and by the tremendous research efforts in cancer and heart disease.

All of the schools of public health have adapted their teaching programs well beyond previously traditional areas to prepare their graduates for new and expanded responsibilities at all levels of government and private (usually nonprofit) agencies. These personnel, administrators, planners, and specialists from almost every discipline in the natural and social sciences, are prepared to work in such areas as: Comprehensive health planning; organization and delivery of health services; family and population planning; nutrition; health problems of the aging; drug abuse and alcoholism; control of quality of health facilities; and health education of the public.

Regardless of what agency of government may have responsibility for environmental protection, the very fact that popular attention has shifted to nonhealth aspects of our natural resources—air, water, land—make it vital that the human health aspects of the environment not be neglected.

Moreover, passage of the Occupational Safety and Health Act has imposed an even greater government responsibility for worker health. Schools of public health will need to meet expanded demand for industrial hygienist, industrial nurses, air pollution control experts and administrators of occupational health programs.

Much of the greatest current public concern in regard to health has been over the high costs of medical and hospital care. Thus, schools of public health have given priority to preparing personnel capable of attacking these problems. Certainly by primary attention to better methods of prevention and by better planning and organization of curative and rehabilitative services high costs can be contained.

A national health, insurance approach which is purely an indemnity-insurance solution may succeed in spreading costs but will not succeed in taking advantage—for society—of available knowledge which can lower health costs by helping prevent people from getting in the first place.

CURRENT NEED FOR PERSONNEL

In former years, information could be readily obtained from the Public Health Service on vacant budgeted positions in health departments as one measure of personnel need. The last full scale study on this, carried out for the Third National Conference on Public

Health Training 1967, indicated that vacant budgeted positions just in State and local official health agencies (not even including nonprofit community agencies) for which the post description required 1 year of graduate training in public health, far exceeded available or anticipated supply. With growing population and expansion of programs like medicare and medicaid, and the introduction of new ones like PSRO, the ratio of unfilled positions to available graduates is probably even higher today.

Since the 1967 study, there have been no national scientific studies to establish accurately the precise shortages. Nevertheless, studies carried out in a number of States, such as that carried out by a legislative study commission in North Carolina have shown that the need for such personnel far exceeds the number of graduates available.

As part of a study of where graduates of schools of public health are now working and of a series of facts relating to their training, a table has been prepared of the place of employment of the 1956–72 graduates. (table II). This table was constructed by coding addresses of graduates from which the employment category could be deduced. The data may, of course, need to be corrected as soon as questionnaires are fully analyzed; but even this rough tabulaton gives an idea of the order of magnitude of the various categories.

What is most striking is the wide variety of employment these graduates have in government, universities, and other forms of public service throughout the health care system.

In addition to tabulated data available, another practical measure of need is the number of requests that come to educational institutions for graduates in a particular field. At the University of Michigan, for example, the largest school of public health in the country, every program of study reports more job inquiries and more requests for graduates than are available. As one example, last year there were 50 urgent requests for masters of public health who had specialized in industrial hygiene, yet there were only 5 graduates in that field that year. I can cite similar examples from my own school, as can each of the other deans.

Decentralization of services to State and local levels will require that these units of government directly engage the services of many new people skilled at planning, developing, implementing and evaluating health service programs. Guidelines and supervision previously provided at the national level must now be prepared and implemented at every local level of government. This emphasis hase been recommended by the administration in several of their budget messages. It is an endeavor which will not conserve public health manpower; it will require vastly increased numbers. In the long run this increase in personnel and their increased emphasis at the local level, may bring enormous benefits to the people served by health agencies and programs. But the personnel to implement this concept are simply not now available.

LEGISLATIVE SITUATION

In 1972, when testifying on a Senate bill to extend sections 306 and 309 (now renumbered as sections 312 and 313) of the Public Health Service Act, Assistant Secretary DuVal, speaking for the administration, raised no questions about the validity of Federal support for

professional education in public health. He did ask that the legislation be extended for 1 year to allow these sections to be considered in conjunction with other expiring legislation. Furthermore, the President indicated concretely his enthusiasm for the programs by proposing, in his original 1972–73 budget, increases in levels of support—almost 7 percent for sectin 309 (now section 312), student support, and almost 7 percent for section 306 (now section 312), student support, and support. On the basis of hearings and testimony, the Congress further increased these levels, indicating that both the executive and legislative branches were aware of increasing need for trained health personnel.

The 1973–74 budget, submitted on January 29, 1973, proposed a complete reversal of previous policy, calling for no extension of the legislation and for complete termination of all assistance under sections 306 (312) and 309 (313) as of June 20, 1973. In its wisdom, the Congress did indeed extend these sections for one year. Funds were appropriated by the Congress and included by the Congress in HEW fiscal year 1974 budget. Since July 1, 1974, sections 306 and 309 (sections 312 and 313) have been extended by repeated continuing resolutions. Unfortunately, the administration is again requesting the elimination of support programs for schools of public health, their faculties, and their students.

Table III shows the amounts authorized compared to the amounts appropriated for public health training. We believe it is important to note that the amounts appropriated for fiscal year 1972, 1973, and 1974 have been approximately the same for each of the program areas in public health training. Actually, there was a 5 percent drop from fiscal year 1973 to fiscal year 1974. As for the funds that may be available for appropriations in fiscal year 1975 we must await the outcome of the aforementioned proposed rescission, an action which we deeply U.S. Senate. The House of Representatives has already rejected most of the aforemntioned proposed rescission, an action which we deeply appreicate.

Currently, both the House and Senate Health Committees are preparing legislation to increase Federal support for all of the schools of health professions, including schools fopublic health. Becaseu of different legislative calendars, and for other reasons, the substantive legislative committee may not be finished with their work by the start of fiscal year 1976.

We would urge therefore, that this committee continue appropriations for sections 312 and 313 of the Public Health Service Act. Moreover, in light of the eroding effect of inflation, the tremendous increase in number of students in schools of public health (please see table I) and the actual dollar reduction that has occurred over the last 4 fiscal years in these programs, we would recommend an increase for fiscal year 1976 of approximately 40 percent above the appropriated levels for fiscal year 1974. We believe that such an increase would rectify the inequities that have crept into the appropriations for these programs over the years. In addition, such an increase will permit the schools of public health to meet the increasing demands that are being made upon them by applicants, governments at all levels, and the private sector.

To summarize our appropriations recommendations under sections

312 and 313 of the Public Health Service Act, we would submit the following figures:

Fiscal year 1976 recommended appropriation

Sections:	
312 (public health traineeships)	[1] $11,768,000
313(a) (project grants for public health training)	[1] 7,980,000
313(c) (institutional grants to schools of public health)	7,908,000

[1] Much of these funds go to institutions other than schools of public health.

HEW STAFF SUPPORT

Over the years, the total number of HEW personnel located here in the central office charged with administering the above-mentioned programs has dwindled to such a low level that the Department's ability to manage these funds responsibly has been substantially diminished. It is our understanding that the total number of central office staff has gone from 74 in fiscal year 1972 to 39 in fiscal year 1975. These 39 individuals will re responsible for administering programs in optometry, podiatry, pharmacy, veterinary medicine, allied health, and public health. We do not see how this vast array of programs can be adequately administered by 39 people. From our point of view alone, we do not see how the public health training programs can be adequately understood and administered by such a small complement of personnel.

Therefore, we would urge this committee to consider carefully the possibility of instructing HEW to increase the number of positions allocated for these important health manpower programs to a level that is adequate to run them properly.

CONCLUSION

Mr. Chairman and members of the committee, our institutions exist to serve the public welfare. In that respect our goals coincide with the goals of the members of this important committee. Our students and our faculty members have chosen to devote their lives to improving public health both here in the United States and throughout the world.

Through our association and through other mechanisms, the schools of public health constantly reexamine what they are doing in light of how they perceive the needs of this country. We make no claim that all wisdom resides in the schools of public health. Indeed, we welcome the suggestions of all interested parties to help us adjust our activities to better serve the public good. We look forward to in-depth interaction with the Congress of the United States and the executive branch.

We are deeply grateful for this opportunity to offer our views to the members of this distinguished committee regarding the funding of programs that produce the men and women who are so desperately needed if this country is to maintain and enhance the health of its citizens.

Thank you.

TABLE I.—ENROLLMENT AND GRADUATES, U.S. SCHOOLS OF PUBLIC HEALTH, 1958–72

Fiscal year ending	Students enrolled	Degrees granted
1958	1,230	772
1963	1,848	798
1968	3,363	1,337
1969	3,525	1,548
1970	3,483	1,735
1971	4,131	1,782
1972	4,802	2,159
1973	5,363	2,647
1974	6,177	[1] 2,903
1975	[2] 6,566	[1] 3,085
1976	[3] 6,960	[1] 3,271

[1] Estimates based upon ASPH projections.
[2] Estimate, including students at the University of Massachusetts (accredited April 1975).
[3] Estimate based upon HEW projections.

TABLE II.—SCHOOL OF PUBLIC HEALTH GRADUATES FROM 1956 TO 1972 [1]

TYPE OF ORGANIZATION IN, WHICH EMPLOYED [2] AT 2 TIME POINTS IN CAREER

Type of organization	Just after degree	At time of survey
Total, Government	56.4	50.4
Federal	18.0	17.3
State	19.2	18.0
Local	17.9	14.2
Foreign	.4	.2
Unspecified	.9	.7
University	17.4	18.9
Nonprofit organization	16.0	16.9
Industry	2.9	4.7
Other types of organizations	2.0	2.8
Self-employed	1.0	2.7
Student	2.5	1.2
Type of organization unknown	1.8	2.5
Total	100.0	100.1

[1] "A Survey of 1956–72 Graduates of American Schools of Public Health." Department of Behavorial Sciences, School of Hygiene and Public Health, The Johns Hopkins University, December 1974. The work upon which this report is based was performed pursuant to Contract NIH 71–4159 with the Division of Allied Health Manpower, Bureau of Health, Education, Public Health Service, Department of Health, Education, and Welfare.
[2] Includes only those employed and students.

TABLE III.—PUBLIC HEALTH TRAINING—AUTHORIZATION VERSUS APPROPRIATION

Sections	1972	1973 [1]	1974 [2]	1975
Sec. 312—Public health traineeships: [3]				
Authorization	$16,000,000	$18,000,000	$10,300,000	----------
Appropriation	8,400,000	9,600,000	9,600,000 (9,120,000)	----------
Sec. 313(a)—Project grants for graduate public health training: [3]				
Authorization	15,000,000	16,000,000	6,500,000	----------
Appropriation	4,517,000	6,000,000	6,000,000 (5,700,000)	----------
Sec. 313(c)—Grants to schools of public health:				
Authorization	12,000,000	15,000,000	6,500,000	----------
Appropriation	5,554,000	6,000,000	6,000,000 (5,700,000)	----------

[1] An appropriation was not enacted in fiscal year 1973. The amounts shown for that year are based on the budget apporved by the 1st House allowance.
[2] Amounts in parentheses reflect those amounts available for actual program obligation pursuant to the Appropriation Act Public Law 93–192, which authorized a reduction up to 5 percent of the bill amount for each program.
[3] Much of these funds go to institutions other than schools of public health.

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Below is a listing of the names, deans, addresses and phone numbers of the Schools of Public Health in the United States and Puerto Rico.

University of California at Berkeley; Dean Warren Winkelstein, Jr., Dean and Professor of Epidemiology, 19 Earl Warren Hall, School of Public Health, Berkeley, Calif. 94720, 415/642–2523.

University of California at Los Angeles; Dean Lester Breslow, School of Public Health, Center for the Health Sciences, Los Angeles, Calif. 90024, 213/825–6381.

Columbia University; Dr. John Bryant, Director, School of Public Health, 600 West 168th Street, New York, N.Y. 10032, 212/579–3929.

Harvard University; Dean Howard Hiatt, School of Public Health, 677 Huntington Avenue, Boston, Mass. 02115, 617/734–3300 (Ext. 501/502).

University of Hawaii; Dean Jerrold Michael, School of Public Health, 1940 East-West Road, Honolulu, Hawaii 96822, 808/948–8491.

University of Illinois; Dean Paul Q. Peterson, School of Public Health at the Medical Center, P.O. Box Number 6998, Chicago, Ill. 60680, 312/996–6620.

The Johns Hopkins University; Dean John C. Hume, School of Hygiene and Public Health, 615 North Wolfe Street, Baltimore, Md. 21205, 301/955–3540.

University of Loma Linda; Dean Mervyn G. Hardinge, School of Public Health, Loma Linda, Calif. 92354, 714/796–7311 (Ext. 3711).

University of Massachusetts; Dean William A. Darity, School of Health Sciences, Amherst, Mass. 01002, 413/545–0460.

University of Michigan; Dean Richard Remington, School of Public Health, Ann Arbor, Mich. 48104, 313/763–5454.

University of Minnesota; Dean Lee D. Stauffer, School of Public Health, 1325 Mayo Memorial Building, Minneapolis, Minn. 55455, 612/373–8065.

University of North Carolina; Dean Bernard G. Greenberg, School of Public Health, Chapel Hill, N.C. 27514, 919/966–1113.

University of Oklahoma; Dean Philip E. Smith, College of Health, 624 Northeast 15th Street, Oklahoma City, Okla. 73190, 405/271–4688.

University of Pittsburgh; Dean Herschel E. Griffin, Graduate School of Public Health, 111 Parran Hall, Pittsburgh, Pa. 15261, 412/624–3000.

University of Puerto Rico; Mrs. Judith Danielsen, B.S., M.P.H.E., Acting Dean, School of Public Health, G.P.O. Box 5067, Medical Sciences Campus, San Juan, Puerto Rico 00936, 809/765–3991.

University of Texas; Dean Reuel A. Stallones, The School of Public Health, Health Science Center at Houston, P.O. Box Number 20186, Houston, Tex. 77025, 713/792–4425.

Tulane University; Acting Dean Frank Moore, School of Public Health and Tropical Medicine, 1430 Tulane Avenue, New Orleans, La. 70112, 504/588–5397.

University of Washington; Dean Robert W. Day, School of Public Health and Community Medicine, SC–30, Seattle, Wash. 98195, 206/543–1144.

Yale University; Dean Robert W. McCollum, Department of Epidemiology and Public Health, School of Medicine, 60 College Street, New Haven, Conn. 06510, 203/436–3280.

All of the above institutions are fully accredited as Schools of Public Health by the Council on Education for Public Health.

Mr. PATTEN. Do the national health insurance proposals affect you?

Dr. GRIFFIN. Absolutely, we are trying to get some legislation to help with preventive services, too.

Mr. PATTEN. Now we have Richard Dowling, director, Governmental Affairs, Amercian Speech and Hearing Asociation.

HEALTH AND EDUCATION PROGRAMS

WITNESS

RICHARD DOWLING, DIRECTOR, GOVERNMENTAL AFFAIRS, AMERICAN SPEECH AND HEARING ASSOCIATION

Mr. DOWLING. Mr. Patten, the American Speech and Hearing Association represents more than 20,000 masters and doctoral level pro-

fessionals working in hospitals, schools, rehabilitation clinics, universities, and research facilities.

Our statement, which I hope will be included in the record——

Mr. PATTEN. It is so ordered.

[The statement follows:]

The American Speech and Hearing Association (ASHA) is a national scientific and professional society made up of more than 20,000 speech pathologists and audiologists. The speech pathology and audiology profession is the primary discipline concerned with the systems, structures, and functions that make human communication possible; with the causes and effects of delay, maldevelopment, and disturbance in human communciation; and with the identification, evaluation, and habilitation of individuals with speech, language, and hearing disorders. Speech pathologists and audiologists considered "qualified providers" under Medicare and Medicaid regulations must hold a master's degree in their field of specialization and have completed a "fellowship year" of supervised clinical internship. These standards are also among those set by ASHA for the achievement, on the part of potential service providers, of the ASHA certificate of clinical competence in speech pathology or audiology. ASHA additionally requires the passing of a national examination administered by the Educational Testing Service, Princeton, N. J.

Speech pathology and audiology practitioners render their professional services in such settings as hospital speech and hearing clinics, free-standing outpatient speech pathology and audiology clinics, university outpatient clinics, outpatient rehabilitation centers—for example, Easter Seal agencies—Veterans Administration hospitals, Head Start programs, private practice, and private and public schools. Among those in the Nation's communicatively handicapped population with whom speech pathologists and audiologists work are the many thousands of Americans—including 20 to 25 percent of all persons 65 and older—who experience bilateral hearing losses of a magnitude sufficient to seriously restrict their understanding of speech. Also included are those Americans for whom cancer-caused removal of the larynx results in a total loss of voice, and those who experience a significant reduction in language function—aphasia—as a result of stroke. Clients additionally include children and adults with such identifiable disorders as receptive and/or expressive language impairment, stuttering, chronic voice disorders, and serious articulation problems affecting social, emotional, educational, and/or vocational achievement; and speech and language disorders accompanying conditions of hearing loss, cleft palate, cerebral palsy, mental retardation, emotional disturbance, multiple handicapping conditions, and other sensory and health impairments.

The most recent Federal Government data puts at 20 million the number of communicatively handicapped Americans.[1] A report on the Government's study termed a population of 236,000 deaf Americans "a conservative total."[2] The same report estimated that some 8½ million Americans have "hearing problems of one type or another which are less severe than deafness but which impair communication and hence social efficiency."[3] Americans plagued by central communication disorders—for example impairments of speech and language resulting from stroke or mental retardation—were estimated at 2.1 million, and those with speech disorders at an astonishing 10 million.[4]

In this statement, ASHA addresses the funding need of five DHEW health and education program areas with responsibilities and activities that significantly affect both the Nation's communicatively handicapped and the speech pathology and audiology professionals who serve their health and education needs. The program areas are: 1. the Rehabilitation Services Administration, Office of Human Development; 2. the National Institute of Neurological and Communicative Disorders and Stroke; 3. the Crippled Children's Service, Maternal and Child Health, Health Services Administration; 4. the Head Start program, Office of Child Development; and 5. the Bureau of Education for the Handicapped, U.S. Office of Education. Insofar as the subcommittee's principal

[1] Report of the Subcommittee on Human Communication and Its Disorders, National Advisory Neurological Diseases and Stroke Council (NIH), *Human Communication and Its Disorders—An Overview*, Bethesda, Md. (1969).

[2] *Ibid.*, p. 11.

[3] *Ibid.*, p. 13.

[4] *Ibid.*, pp. 16–17.

interest on this day of public hearings is the area of health, we shall devote the better part of our presentation here to the first three of these five program areas.

REHABILITATION SERVICE ADMINISTRATION (RSA)

The Rehabilitation Services Administration is principally charged by the Rehabilitation Act of 1973 (Pub. L. 93–112) with the responsibility of developing and implementing comprehensive and continuing State plans to insure current and future provision of vocational rehabilitation services to handicapped persons. RSA also provides such services itself—serving first those most severely handicapped—so that the handicapped can prepare for and engage in gainful employment. Among others, RSA pursues these activities:

Evalution of the rehabilitation potential of handicapped persons;

Provision of assistance in the construction and improvement of rehabilitation facilities;

Development of new and innovative methods of rehabilitation, including services delivery, research, and special and demonstration projects;

Initiation and expansion of services to heretofore underserved groups of handicapped persons; and

Increasing the number of rehabilitation personnel and increasing their skills through training.

Administration estimates, offered during congressional hearings on the Rehabilitation Act, showed that there are between 7 million and 12 million individuals in the United States who require vocational rehabilitation services. We believe that population range is a markedly conservative one; but even if the low 7 million figure is used, RSA program services (again according to administration estimates) reach only about 15 percent of those who need them. Can this low-percentage figure be attributable to RSA program inefficiency? Not generally; this and former administrations have called RSAs vocational rehabilitation program one of the most effective and humanitarian of all federally supported health efforts. Only increased funding will help RSA reach more of the handicapped, yet the administration proposes not even to grant an annual inflation increase to RSA. The $680 million provided by Congress for the current fiscal year is the same figure advanced by the administration as adequate for fiscal 1976 RSA operations. The 15-percent figure will drop if the administration's budget is endorsed, for the number of newly handicapped Americans grows at about the same rate as our population.

In past years, federally supported vocational rehabilitation efforts have been responsible for returning 300,000 persons to productive activity annually. These rehabilitants earned an estimated $770 million more a year than they did during the year before they entered the rehabilitation process. Projected as lifetime earnings, these figures exceed $9 billion in increased earnings—just for those rehabilitated in 1 year. Taxpayers obviously share substantially in these earnings through increased taxes paid by the rehabilitants and reductions in tax-supported maintenance which would be required had these individuals not received rehabilitation services.

In the research area, the administration's proposal advocates the status quo in funding support; this, in the face of clear congressional intent that the focus of RSA's research support should be expanded into such areas as spinal-cord injury and end-stage renal disease, and that its commitment to other rehabilitation-related research should be otherwise increased. The administration suggests $20 million for research and evaluation efforts. ASHA believes at least $25 million is needed to support these important endeavors.

RSA's basic State grants program is pegged at the $680 million level in the administration proposal. Yet the States have shown that they have raised sufficient resources on their own to entitle them to the full $720 million authorized for fiscal 1976, and the Congress has made clear that the full authorization should and would be appropriated if the States evidenced the ability to hold up their end of the Federal-State funding partnership designed by the 1973 authorization legislation. The full $720 million should be appropriated.

With respect to the uses to which basic State grants are put by State rehabilitation agencies, ASHA hopes that the Appropriations Committee will utilize the strongest possible report language short of earmarking to encourage State agencies to begin appropriately addressing the rehabilitation needs of communicatively handicapped adults.

A comparison of data compiled by RSA [5] with data reported in "Human Communication and Its Disorders: An Overview" [6] clearly points up the fact that the number of communicatively handicapped adults rehabilitated by State vocational rehabilitation programs is miniscule. It is estimated that State vocational rehabilitation agencies have rehabilitated only 0.25 percent of all hearing impaired adults between the ages of 17 and 65 during recent years. At such a rate, it would take State agencies 426 years to rehabilitate all severely hearing impaired adults under age 65, assuming that the absolute number of hearing handicapped individuals remains stable. The problem is exacerbated in relation to the category of speech and language impairment. Only about 0.05 percent of those adults having speech and language impairments (excluding from the total population of speech handicapped adults those over age 65 and those with problems associated with mental retardation, hearing impairment and other congenital conditions) were rehabilitated by State vocational rehabilitation agencies in each of the past few years. At this rate ,it would take the State agencies 1.984 years to rehabilitate all speech and language impaired adults—again assuming that the number of speech and language handicapped adults in the United States remained stable.

The conclusion that State agencies are apparently not meeting the rehabilitation needs of severely disabled, communicatively handicapped adults is clearly demonstrated in the category of stroke and aphasia. The National Institute of Neurological and Communicative Disorders and Stroke estimates that 500,000 American adults survive strokes each year, with 60,000 having aphasic conditions. Approximately 50 percent of stroke victims are below age 60. In addition, NINCDS reports that prevalence of stroke is less than cancer and heart disease but stroke exceeds the latter two conditions in long-term illness and dependency. Yet, it is reported that all State vocational rehabilitation agencies rehabilitated between 140 and 175 adults with stroke-caused aphasia in each of the past 5 years. In other words, State agencies are rehabilitating only about 0.50 percent of those adults under age 60 who annually suffer severely disabling strokes resulting in aphasia.

This apparent failure of the State agencies to provide for the needs of hearing, speech, and language impaired adults could be attributed to a lack of funds causing the same low degree of services provided in other categories of disabling conditions. We are aware of the funding problems experienced by the State agencies; but we are also acutely aware of the fact that State-agency cost cutting is not equitably applied. Indeed, as regards certain disabling conditions, State agencies rehabiltate a far larger percentage of those needing rehabilitation services than for the conditions of hearing impairments and speech impairments. We sincerely hope that the committee will help end this inequity.

Yet another perplexing aspect of the administration's RSA budget, so far as ASHA is concerned, is its assertion that rehabilitation professionals will increase and multiply without Federal assistance. Little short of supernatural intervention could bring this circumstance to pass at the administration's proposed rate of support for training. ASHA urges that the administration's paltry $22.2 million level of training support be raised to a level of $32 million, the full amount of the training authorization for fiscal 1976.

Section 201(b) of the Rehabilitation Act of 1973 calls for "a balanced program of assistance to meet the medical, vocational, and other personnel training needs of both public and private rehabilitation programs and institutions, and goes on to include "speech pathology and audiology" among the 15 or so rehabilitation specality areas into which training funds are to be directed. Our concern here is not so much that the manpower needs of the speech and hearing profession receive less attention and support than other of the specialty areas covered by section 201. Rather our concern relates to the radical drop speech pathology, audiology, and all other training-specialty areas have experienced over the last several years. More specifically, our concern here is not that RSA is not living up to the statutes mandate to provide "a balanced program of assistance;" rather it is with the fact that the level of "balanced * * * assistance" has fallen off so markedly as to render RSA-supported training virtually meaningless.

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[5] "Characteristics of Clients Rehabilitated in Fiscal Years 1968–72: Federal-State Vocational Rehabilitation Program," Statistical Analysis and Systems Branch, Division of Monitoring and Program Analysis, Rehabilitation Services Administration, Washington, D.C. (1974).

[6] Op. cit.

Mr. Chairman, ASHA would like to see the will of Congress prevail in the instance of RSA training. We believe the best way for assuring that it does is for the Congress to appropriate the full authorized amount. An appropriation of $32 million for RSA training is both appropriate and necessary.

As regards the total RSA appropriation: The administration has recommended $735.6 million. ASHA believes that $790.4 million should be considered the minimum acceptible appropriations figure if RSA is to meet the minimum statutory requirements of Pub. L. 93–112.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE (NINCDS)

NINCDS is charged with the mission of increasing our knowledge of the brain, the nervous system, and the mechanisms of human communication. Its work benefits the more than 40 million Americans burdened by disabling neurological disorders and difficulties of hearing, speech and language. More specifically, the two-decade-old Institute is concerned with research on epilepsy, multiple sclerosis, muscular dystrophy, injury to the brain and spinal cord, hereditary diseases of the nervous system, developmental neurological disorders, tumors of the brain and spinal cord, stroke, Parkinson's disease, otosclerosis, and many other disorders affecting hearing and speech.

As in years recently past, the administration's fiscal year 1976 budget fails to propose adequate funding for the NINCDS's important mission. The request calls for about $7 million less than was appropriated 2 years ago, and an almost unbelieveable $28 million less than the amount Congress appropriated for fiscal year 1975, a rollback of momentous proportions that in these inflationary years constitutes a slap in the faces of those afflicted by neurological problems and those whose research is essential to therapeutic progress in these areas.

The number of Americans killed or disabled by stroke rises sharply each year. For a time, so did the number of NINCDS-trained professionals in the cerebrovascular disease and stroke area: NINCDS-supported training programs were responsible for increasing the number of neurologists, in the United States from 250 in 1952 to about 5,000 today, and for substantial increases in the neurological subspecialties of neuroradiology, neurosurgery, audiology, otolaryngology, and speech pathology. But today, for example, there are about 60 vacancies in departments of otolaryngology, and clinical departments of medical neurology say they will need approximately 50 new teachers in the next 5 years. The administration's budget with its neglect of training support, if adopted, would not fill these vacancies; rather it would create more.

Institute officials have repeatedly pointed to the need for significant NINCDS-supported research in the area of speech and language disorders. But the Institute, they say, does not have the financial capacity to help train the scientists who would perform this important work. Similarly, the Institute's perinatal project, which could provide breakthrough leads on communications disorders, has seen its efforts stalled. Researchers developing prototype transmodal communication devices for those with seriously impaired hearing cannot presently look with assurance to the administration's budget for training and research assistance.

The administration's budget calls for a cut of perhaps $3 million in NINCDS's speech and hearing efforts—from $14.7 million 2 years ago to the vicinity of $10 million in fiscal year 1976. ASHA believes the amount should be closer to $20 million than half that figure—we are hopeful that the Institute's recent name change (from National Institute of Neurological Diseases and Stroke to National Institute of Neurological and Communicative Disorders and Stroke) is made to mean something more than a paper change. ASHA believes that $148 million is appreciably more responsive to the research and training that ought to be addressed by NINCDS, and recommends that at least that sum be appointed. Such an appropriation would represent a $6 million increase over the amount provided by the Congress for fiscal year 1975 operations; the increase, we feel, is more than warranted.

CRIPPLED CHILDREN

The Bureau of Maternal and Child Health Services, Health Services Administration, administers funds appropriated for programs authorized by Title V of the Social Security Act. Such funds are made available through formula grants to state maternal and child health and crippled children's agencies, and for

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projects, both national and local in scope, related to the comprehensive health care of children and youth, maternity and infant care, dental care, and training of professional personnel, and research related to he health of mothers and children.

The Bureau additionally assists community and state health agencies in planning, developing, and evaluating health-service programs for children including children with language, speech, and hearing disorders. These efforts include: (1) providing technical staff assistance; (2) initiating, conducting, and supporting efforts to improve speech and hearing services and the systems through which such services are made available; (3) issuing program guidelines and other materials relevant to the needs of professionals and parents; (4) reviewing the performance of programs and initiating studies which focus on improving service quality and extension, and the training of speech and hearing personnel.

The administration's fiscal year 1976 budget recommendation would have only $65 million going to the crippled children's operations of maternal and child health, a rather weak response to the facts that only about one-half of the 9 million handicapped children in the country receive services under this program, and that about two-thirds of the chronic handicapping conditions existing among children, including speech and hearing impairments, could be corrected or prevented if care were available.

ASHA hopes and here recommends that Congress appropriate $339.75 million for the Maternal and Child Health program (some $128 million more than requested by the administration), with $77 million of this amount earmarked for crippled children initiatives.

BUREAU OF EDUCATION FOR THE HANDICAPPED (BEH)

With respect to programs authorized by Title VI, Part C of the Elementary and Secondary Education Act (ESEA), ASHA makes these recommendations:

1. That early childhood projects be funded at the $25 million level—representing a $3 million increase over the amount called for by the Administration. The preschool and early childhood projects funded by this title have offered substantial evidence of the value of early educational intervention. Now that they have, we must begin to spread their example throughout the country.

2. That the Regional Resource Centers program be funded at the $9.75 million level recommended by the Administration—representing a $2.5 million increase over the fiscal year 1975 appropriation. The objective of this program is the development of educational strategies for handicapped children. The modest $2.5 million increase would significantly contribute to the objective's achievement by assisting State and local governments in identifying and appropriately placing handicapped children, and by supporting an initiative begun recently to establish 10 resource projects devoted to the needs of the severely handicapped.

3. That the Deaf/Blind Centers program be funded at a $20 million level—representing an $8 million increase over the fiscal 1975 appropriation and a $4 million increase over the Administration's $16 million fiscal 1976 recommendation. This program maintains centers throughout the country for children who are both deaf and blind. The recommended increase would permit the provision of needed educational services for nearly all members of this relatively limited population. With the increase, for example, full-time educational services could be provided for 3,300 children—700 more than are now benefitting from such services; the number of children currently receiving short-term and part-time services could be increased from 700 to 900; and the number of parents of deaf/blind children now receiving counseling could be increased from 3,300 to 4,000. This would represent a significant step toward assuring the placement of all deaf/blind children in appropriate education programs.

With respect to programs authorized by title VI, part D of ESEA, ASHA makes these recommendations:

1. That the personnel trainning program be funded at a $50 million level—representing a $12.3 million increase over the fiscal 1975 appropriation and a $10.25 mililon increase over the Administration's $39.75 million fiscal 1976 recommendation. A comprehensive review of personnel needs in the overall education community released recently by DHEW states flatly that although the Nation's supply of teachers is expected to outstrip the demand, there is still a shortage of qualified special education personnel and regular classroom teachers

trained to educate handicapped children.[7] According to that report, only about "40 percent of the identified handicapped children today receive special education of some type."[8] ASHA is acutely aware of the needs education programs experience throughout the country for professionals qualified to provide educational and habilitative services to speech, language, and hearing handicapped children. Today, only about 100 audiologists are employed by public school systems to serve the Nation's deaf and hard of hearing children. This number is dismally below the number of professionals needed to render such education-related services as hearing examinations, hearing aid evaluations, and auditory training and habilitation. Ten times as many audiologists working in the schools would only begin to scratch the surface of the personnel needs in this important area. Approximately 33,000 speech pathologists are required to help meet the educational needs of the Nation's speech and language handicapped children. Some 16,500 are presently providing speech pathology services to school populations, only 6,800 of whom meet the widely recognized ASHA standards of clinical competence.

2. That the recruitment and information program be funded at the $1 million level called for by the Administration. DHEW's acknowledgement that education of the handicapped is one of the very few education-community areas wherein manpower needs are significantly unmet, together with the need for employing better qualified special education professionals, argues very strongly for the modest $500,000 increase over the amount heretofore provided for recuritment and information.

With respect to programs authorized by title VI, Part E of ESEA, ASHA recommends:

That the research and demonstration programs be funded at the $13 million level—representing a $2 million increase over the Administration's fiscal 1976 recommendation and a $3.1 million increase over the appropriation for fiscal 1975.

With respect to programs authorized by title VI, Part F of ESEA, ASHA recommends:

That the media services and captioned films programs be funded at a $16 million level—representing a $3 million increase over the fiscal 1975 appropriation. The bulk of the increase, we believe, would be put to use helping BEH meet its expanded statutory responsibilities for increasing and improving educational services for the most severely handicapped children.

Regarding programs authorized by title VI, Part G, ASHA recommends:

That the specific learning disabilities program be funded at a level of $6.25 million—representing a $3 million increase over the appropriation for fiscal 1975 and a $2 million increase over the Administration's recommended fiscal 1976 funding level. The Bureau of Education for the Handicapped considers learning disabilities to be the fatest growing disabling condition in the public schools. The Administration's budget request would barely accommodate inflation-caused program increases.

With respect to programs authorized by title VI, part B, ASHA offers the following comment:

As members of this subcommittee know, Congress, several months ago, appropriated $100 million in the formula grant program to allow States to initiate, expand, and improve educational opportunities for handicapped children. This appropriation more than doubled the Federal funds available to States to carry out the new provisions of Public Law 93-380; a minimum of 100,000 more children will be served as a result of this commendable congressional initiative. We are faced with a major problem this year however, since last year's authority to increase appropraitions to as much as $660 million was a 1-year emergency authorization; the authorization for fiscal year 1976 must now revert back to the $100 million authorized by Public Law 93-380. We recognize that authorizing legislation is not within the jurisdiction of this subcommittee; still, we look to you for support in our efforts to seek additional authorizations for the State grant program for fiscal 1976. In the meantime, we hope you will appropriate the full $100 million, until such time as increased authorization can be provided. ASHA wishes to thank this subcommittee for not concurring with the Administration's proposed rescissions for fiscal year 1975 operation of the State grant pro-

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[7] "The Education Professions, 1971-72, Part III." DHEW Publication No. (OE) 73-12000, Washington, D.C. (1973).

[8] Ibid., p. 1.

gram. We know you will continue to protect the interests of handicapped children during these difficult financial times.

HEAD-START

Public Law 92-424 requires the Head Start program to assure that handicapped children comprise at least 10 percent of all children enrolled in Head Start projects throughout the country. The Administration calls for a $20 million increase over the fiscal year 1975 $414 million appropriation, with the total amount of the increase bing put toward meeting the 10-percent mandate. Heretofore, no moneys have been earmarked by the legislature for the commendable purpose it outlined two terms ago; because funds have not been so designated, Head Start programs across the country have been hard pressed, indeed, in their efforts to initiate meaningful services for handicapped children without concurrently having to cut back on basic services for nonhandicaped Head Start enrollees.

According to the Office of Child Development, the $20 million would be put to work in the following ways: (1) Improving diagnostic services for children; (2) recruiting additional qualified staff; (3) training staff in techniques of working with children with specific handicapping conditions; (4) purchasing services from other agencies when such services are not available without charge; (5) purchasing special equipment and materials; and (6) modifying physical facilities to meet the specific requirements of the children served. These are commendable goals; our concern is whether they can satisfactorily be met with but $20 million.

The Office of Child Development estimates that the average cost of necessary special services for Head Start's handicapped children (at least those in full-year programs) is $1,150 per child; this, in addition to the cost of the usual and customary Head Start Services available to all Head Start children. Applying that average to each of the 38,000 handicapped children now enrolled in Head Start programs, we find ourselves facing a $43.7 million figure.

We think it unfair of the Administration to expect to meet Congress' 10-percent mandate by spending only one-twentieth of total Head Start moneys on doing so. ASHA most certainly does not want to encourage or contribute to fiscal irresponsibility; we know things are tough all over, and that frugality must everywhere be encouraged, within and outside government. A $40 million set-aside may be too much this year, but a $20 million earmark, we feel, is too little. ASHA therefore requests that the $20 million amount called for by the Administratio nto help Head Start meet the 10-percent congressional mandate be increased by $7.5 million, to $27.5 million for fiscal 1976.

Mr. DOWLING. Our statement addresses five HEW programs, three of which relate to your concern here today—health.

All three of the programs have significant interests in the hearing and speech health of Americans, children, disabled adults, and the elderly.

Summarizing, our money requests for these three programs, we ask first that $790.4 million be appropriated for the Rehabilitation Services Administration of the Office of Human Development representing a $54.8 million increase over the administration's request.

Second, we ask that $339.75 million be appropriated for the Maternal and Child Health Service of the Health Services Administration representing a $128 million increase over the Administration's request—a deserved one, we think.

Third, and finally that $148 million be appropriated for the National Institute of Neurological and Communicative Diseases and Stroke which represents a $6 million increase over the amount provided by Congress for fiscal 1975 and a $34 million increase over the Administration request.

With that very brief summary, I will leave our rather extensive statement with you with our regards.

Thank you.

Mr. PATTEN. Well, I will tell you, Mr. Dowling, you cannot go in any group without the subject matter you bring up being brought to bear. I sat on the council in my city 47 years ago and of the five elected members, two were hard of hearing. I know fellows who lost their jobs because of this problem. I want you to know we appreciate your taking the time out to come out here.

THURSDAY, MAY 21, 1975.

BIOMEDICAL RESEARCH

WITNESSES

MARJORIE GUTHRIE, PRESIDENT, COMMITTEE TO COMBAT HUNTINGTON'S DISEASE, INC.
DR. STANLEY FAHN, CHAIRMAN, NATIONAL SCIENCE COUNCIL

Mr. PATTEN. Marjorie Guthrie, president, Committee to Combat Huntington's Disease, Inc., and Dr. Stanley Fahn, Chairman, National Science Council.

Ms GUTHRIE. Mr. Chairman, I am Marjorie Guthrie, president and founder of the Committee to Combat Huntington's Disease. With me is Richard L. Branaghan, executive director of the foundation.

We are very pleased to have the opportunity to testify before you today. It is a special pleasure, Mr. Flood, to appear before you and your committee so soon after your recent legislative victories regarding the rescissions of funds which had been proposed by the Administration for the fiscal year 1975 budget.

All of us who are deeply interested in biomedical research of all kinds are grateful to you for your work. In these very trying times for biomedical research, when there are so many cross-currents and confusions which seem to militate against good research, and when there are so many in the Administration who seem to be intent on cutting back on research and service programs in health, it is pleasant to know that you, who have for so long been a champion of biomedical research, have not lessened your efforts—indeed it seems to us who are observers that as the years pass you go from strength to strength in its support. It must give you a good deal of pleasure to know that so many of the research efforts and successes of the past years have resulted because of your legislative support and leadership.

I am sure that the upcoming battle will be no less difficult than those of the past.

THE FISCAL YEAR 1976 BUDGET

We have studied the total NIH budget, as well as the budgets of those institutes which are most concerned with Huntington's disease.

Overall, we can say that the Administration's general NIH proposed budget would set back biomedical research years. Not only would there not be the opportunity for new starts in research to exploit the research opportunities which are now before us, but there would have to be cutbacks in research already ongoing. Even more, the young persons

who might otherwise desire to enter the field will certainly turn away from such a situation as the proposed budget would create.

This last point is crucially important to us. There is now emerging in the Institutes the beginnings of concern about the implications of Huntington's disease and research on it. We believe this concern has developed because of our committee's constant effort to inform them about it. We are hopeful that the concern will increase, and that research as a consequence, will increase. (After all, research is our only real hope for the future: Research to determine the genetic causes; reto establish preventive mechanisms to prevent the effects; research to provide the means for genetic counseling; and finally, research to determine the numbers of individuals who are affected, and their identities, so that they may be helped in their difficulties.)

However. researchers who have already defined their areas of interest are likely to continue those interests over a lifetime. Huntington's disease has not been an interest in the past with them, and likely will not be significantly so in the future. However, young researchers might well become interested in a field which is opening for research opportunities, but which is not yet filled with researchers who already have an established reputation. Consequently, we are betting heavily on the emergence into the field we are concerned with of young and able scientific investigators and researchers. The President's budget would not permit that to happen.

I have reviewed the Institutes which are particularly important to us.

In regard to the National Institute of Arthritis, Metabolism, and Digestive Disease, we find that the President has recommended a cutback of $25 million less for fiscal year 1976 than for 1975. This institute has received cutbacks in funds for each of the last several years, but the proposed budget in this regard is nothing short of disastrous. It represents a 15-percent cutback from the 1975 level. That, combined with the almost level funding over the last several years, and the consequent erosion of the research dollars because of inflation, simply means that the loss due to inflation, which probably equates to 25 percent of the research dollar just over the last 3 years, plus the cutback would mean that 40 percent less research will be done by that institute than was done 3 years ago.

In regard to the Institute of Neurological and Communicative Disorders and Stroke, where a great deal of interest has been developed in Huntington's disease, the fiscal year 1975 budget of $142.5 million would be reduced by the proposed budget to $114.9 million, a loss of over $27 million, and a percentage loss of 17 percent. This cutback is even more severe than that for NIAMDD.

Currently, as to specific projects, the institute has funded a number of regular research grants, and supports several collaborative studies, have a direct bearing upon Huntington's disease. That is not all, however, because in the field of basic research related to the disease, this institute has had an extensive program of research to understand the nervous system and the disorders which interrupt its normal functioning. The program has been funded at about $14 million over the last several years. Certainly we would expect that this vital research would cut back if the President's budget were accepted.

We find that the National Institute of Child Health and Human Development fares no better. Indeed, it seems to be most hard hit of the institutes in which we have interest and concern. Their fiscal year 1975 appropriations was $141 million, and the proposed budget would decrease that to $106 million, a loss of $35 million, or more than 20 percent. This institute, along with NIAMDD, has been supporting projects in categorical clinical research centers. They would almost certainly be cut back along with all other programs.

Of course, basic and applied research which is being carried on in other institutes will have an impact upon research on Huntington's disease, and all will suffer under the proposed budget.

Therefore, Mr. Chairman, we recommend that the Congress appropriate a sum of money which would not only equal the 1975 budget, but also add in the costs of inflation—perhaps 10 percent more—and some additional percentage to make sure that new research opportunities can be exploited, and so that young researchers will understand that in fact the leadership of the Congress is determined that biomedical research will continue and will in fact prosper.

Mr. PATTON. Are you for forming the National Institute for Huntington's Disease?

Ms. GUTHRIE. We don't want an Institute. We are going to ask to make available to our people the resources that already exist. That means including us in what others are already getting.

Mr. PATTEN. Well, you are realistic.

Ms. GUTHRIE. I am trying to be very realistic. I am a layman and I have looked around and this is what I see.

Mr. PATTEN. You are the president?

Ms. GUTHRIE. That is right. If you are interested, when you have a moment, if you begin on page 5, there is a long story.

Another item that should be mentioned at this point is that there is a provision in the Health Services and Health Revenue Sharing Act of 1975, which has passed the Senate in one form, and is awaiting full committee action on the House side, which calls for the establishment of a National Commission on Huntington's disease. We are very hopeful that the law will be passed soon, and sent to the President for signature.

We need this Commission to work out a short-range plan and a long-range plan against this disease. We need to establish scientific methods for identification, early detection, and the control of Huntington's disease. And then we will need to establish a network of cooperating centers for the clinical research and proper care facilities for all who are affected. One of the responsibilities of the Commission must be to examine and establish guidelines as to what proper care should be for the HD patient and his family.

We recognize that because the bill has not become law, there is no way for this committee to support it with appropriations, and indeed that it would not be proper to outline the case for appropriations, so we will not do so now. We do promise, however, that when the time comes for hearings on a supplemental appropriation for this new law, we will be requesting your support of it.

At this point, Mr. Chairman, I would like to tell you something about Huntington's disease, and how and why I have become so deeply involved in the committee.

Huntington's disease has a long and tragic history. There is evidence that as long ago as the early 1600's families suffered with a strange disorder which was passed from one generation to another. The "victim" looked peculiar as he moved with twitching and uncontrolled jerks. There were facial grimaces and tongue movements * * * and as the deterioration continued, it was believed that these persons were "tortured souls", "possessed by the devil", and "witches"! They were ostracized * * * even burned at the stake in New England.

Who were these strange people who had lived productive lives in the community for 30 or 40 years, bore healthy children, were good church-going people and now became irritable—sometimes violent—persons? As they struggled to walk down the road, frequently they were taunted * * * "too much to drink"!; "can't keep himself together"!, "look at his clothes all falling off"! And when the frightened victim realized his physical deterioration, he perhaps remembered that this is what he saw happen to one of his parents; he ran away to hide—or even commit suicide. The families were ashamed of the victim and lived in fear that one day this could happen to other members of the family.

We know today, that these victims were suffering from Huntington's chorea, disease. One group came to the United States from England, another from Holland. oBth groups multiplied * * * spreading out across the country until today there are HD families living in every State of the Nation.

In 1872, Dr. George Huntington, who had seen these families as he travelled with his father and grandfather, both physicians, wrote:

> The hereditary chorea—is confined to certain and fortunately a few families, and has been transmitted to them, an heirloom from generations away back in the dim past. It is spoken of by those in whose brain the seeds of the disease are known to exist, with a kind of horror, and not at all alluded to except through dire necessity, when it is mentioned as "that disorder"—When either or both parties have shown manifestation of the disease—one or more of the offspring almost invariably suffer from the disease, if they live to adult age; but if by any chance these children go through life without it, the thread is broken, and the grandchildren or great grandchildren of the original shakers may rest assured that the yare free from the disease.

Today "that disorder" continues to multiply and haunt every member of an HD family. What was once called a rare disorder has now become known as the not-so-rare, rare disease of the nervous system—with full penetration. Not only is the patient suffering—but all family members are acutely aware that they are potential victims all their lives. Our committee is searching nationwide for these sufferers, and because we know now that there are also children with Huntington's disease who are often misdiagnose das epileptics or schizohprenics. And while Dr. Huntington described one kind of Huntington's we know now that there are various forms of expression, even within the same family. For example, because a 4-year-old child was diagnosed as having the illness, we were able to trace 80 additional "at-risk" members in this one family. In a family of 12 children, in upstate New York, 4 children have already been diagnosed as patients with HD.

Let me go back a bit—and tell you how I learned these facts. When I met my husband, Woody Guthrie, he had already made his first recordings and was writing the story of his life—his autobiography.

He would write by hand during the day and when I returned from my rehearsals as a member of the Martha Graham Dance Company, he would read what he had written and I would type the day's work. One day, he wrote about his mother's illness. He described the sadness that seemed to overcome her as the family suffered a series of financial losses, and the death of his sister from fire at the age of 12 as their home burned to the ground. Often his mother would disappear only to be found hiding out in the local movie house. People talked about Nora Belle Guthrie as she staggered down the street, clothes all in disarray. And when she became angry and irritable, Woody wrote that she threw the dishes across the room and overturned the furniture. Papa had threatened to take her to the insane asylum so the children would straighten up the house before Papa returned. But as she deteriorated the day came when she was committed to the Norman State Hospital of Oklahoma, where she died.

Of course, I know now that what Woody had written about his mother was what a child saw. His mother did not throw dishes—but probably was trying to drink or eat and the involuntary movement jerked the dishes out of reach. She overturned the furniture because her staggered walk could not control her body movements.

As Woody read and I typed, I began to wonder—and I asked him if he could get sick like his Mama, and did he know what was the matter with her. He told me, "Oh no, Mama had Huntington's Chorea and only females can get this kind sickness." And we went on working.

I remember going to a local library—read a few words—but felt reassured that we would not have to worry when we have our children, just as Woody had said. Years later after being hospitalized several times—after being diagnosed an alcoholic—after threatening suicide—Woody was admitted to Bellevue Hospital in New York City. He was examined and was confined for several weeks in the locked psychiatric ward for observation. I came to visit regularly and then one day he surprised me. He called on the phone and said that the doctor told him to go home. I called the doctor in charge of his ward and questioned him. I will never forget his reply. He said, "Your husband is a very sick man, and don't know what to do with him." I remember, I answered—"And what do you think I am going to do with him?" My children were then just 2, 3, and 4 years old.

After leaving Bellevue, Woody continued to deteriorate. Eventually, we came crying to Brooklyn State Hospital, begging for some determination of his illness. None came. Eventually, it was recommended that he receive shock therapy and while waiting for an available bed, a young doctor made the diagnosis of Huntington's Chorea. We were both stunned. Impossible. Only females get Huntington's. We were wrong and we know now that both men and women can have HD.

Woody was hospitalized over a period of 15 years—the usual expectancy. When he could no longer walk he was tied into his wheelchair. When he could no longer speak, we made three cards—"YES," "NO," "?," and he would answer my questions by "hitting" the card. I learned that he did not feel pain. I fed him when he was hungry or thirsty. I would wheel the chair out to the terrace when he answered that he would like to see the sky or trees again. When I was unsure of his answers because the movement became so uncontrolled, I began to use

"eye blinks"—one or two to mean "yes" or "no." When the doctor asked me if I thought my husband really understood what I was saying, I asked him to stand with me and see the expression on Woody's face as he smiled back or indicated through his eyes the reality that this was a whole man—living inside the prison of his body—and not a mental patient. A man who could think and dream and remember and feel—with special needs—but unable to tell anybody anything. This was the tragedy of Huntington's.

I had been told many times that there was nothing to be done. I heard the word "hopeless" and "helpless" over and over again. I worried about my children. What could I tell them? What was wrong with Daddy? How could I tell them that they too might suffer the way he did? And then—I woke up out of my nightmare. I told Woody, "If you could tell me in some way about what is happening to you, maybe we could tell the doctor. We could get him interested in trying to help." This was the beginning doing something.

I realized then that doing something made me feel better and there must be others who felt as I did. With help from Dr. John Whittier who had already transferred Woody to Creedmoor Hospital, I began to read the scientific literature. Dr. Whittier and I talked and he helped me to understand what was happening and just a few months before Woody died we started the Committee to Combat Huntington's Disease. We did not use the name Chorea because there was already evidence that not every patient has the Chorea like movements (children often are stiff) and the Huntington gene with its various forms needed a more encompassing name. Huntington's is a disease.

I learned that no one knows how many families are affected with HD. And to support the theory that it was more widespread than anyone believed, especially because of the uniqueness of it being hidden for so many generations—I began to travel to look for HD families. I visited patients at home, at meetings, in hospitals. I found some, but we believe that the facts are still unknown. Our committee has a mailing list today of over 10,000 names of families who have written to us for information. Half of them have identified themselves as members of an HD family. Some have requested that information be sent with no identifying return name or address. Others have asked that information be sent to my friend. With our limited resources, we believe that we have just touched the tip of the iceberg.

We keep a careful count and try to document the information that our families hesitantly share with us. For every letter that we receive about an individual, we learn that we are unearthing not just one HD patient but perhaps 5 or 20, or as in the child, where we found 80 others, who are or might be affected with HD. We know from prominent physicians that because the picture has been so devastating many doctors withhold the diagnosis of HD even though the diagnosis has been confirmed. Yes, some doctors feel that since they have nothing to offer the patient it is best to say nothing. Those of us who are aware of recent advances in medicine feel that the disease must be openly discussed in order to encourage research. Dr. George Paulson states, "The statistics would be better if we had a sure treatment and everyone had a cure to gain in exchange for reporting the disease."

One surprising statistic that is available—in a survey of all 168 VA

hospitals, we have located almost 500 known identified HD patients—costing an estimated $6 to $10 million a year for their care. Since few physicians have seen or recognized a case of HD and because of the secrecy surrounding this disorder we can be sure that even within the VA the statistics are misleading. This is one of the major unique reasons why we need a special commission on Huntington's disease. We have the task of identifying and educating not only the HD families but also supplying new information to physicians, the social workers, and all the other health professionals who might come in contact with an HD family, or a family that appears to be an HD family with no family history available.

As the disease progresses many families disintegrate. Patients have been deserted. Children are sent out for adoption because there is no one at home to care for them—sometimes with, and sometimes without the family background. The financial burdens on the family are disastrous. Suicide is not uncommon. Recently in the Los Angeles Times December 29, 1974, there appeared an article entitled "The Poignant Anatomy of a Suicide." This young man jumped to his death and left a note that said, "Gentlemen: Please contact my attorney." The article stated:

> Franklin had, or worse yet, thought he had Huntington's Disease (HD). He had watched his father die 2 years ago from HD, a genetic disorder so terrible his mother called the death "a blessing." To a man like Franklin who appeared to be in control of any situation, who more than a half dozen friends described as "calm, self-composed," such suffering would be unthinkable. The puzzler is, did he really have the disease? Or only the terror of it? The tragedy beyond his death is the possibility he may have passed the potential for HD to his daughter. Now, how will she know?

The cost in suffering cannot be measured, but the cost to society for the care of the HD patient and his family needs to be surveyed. We believe that with proper care and a better understanding of the course of the disease, more patients might live at home and become less of a burden to themselves and their families if we had better medication to control the involuntary movement. It will take research and experimentation to find these drugs.

Our families are offering tissue, blood, spinal fluid * * * themselves to investigators. There is every reason to believe that, as in many other genetic disorders, we might some day find the key to early diagnosis or intra-uterine diagnosis. CCHD had pointed the way. We have located HD families not only in every State but have organized them so that they can be available to scientific investigators. We now have 50 chapters as well as affiliates in England, Scotland, Austria, Canada and recently we started the Huntington Liga in Belgium.

Many scientists agree that the two great frontiers of research today are the study of man's brain and his genes. I quote from a recent review in "The Lancet" of the first complete text book devoted to this disorder: "One cannot escape the feeling that this disease of Huntington's chorea is a key one and its final solution will have wide implications in brain research." HD has significant relationships with the aging process, with Parkinsonism, multiple sclerosis, muscular dystrophy, myasthenia gravis, and many other similar genetic and neurological disorders.

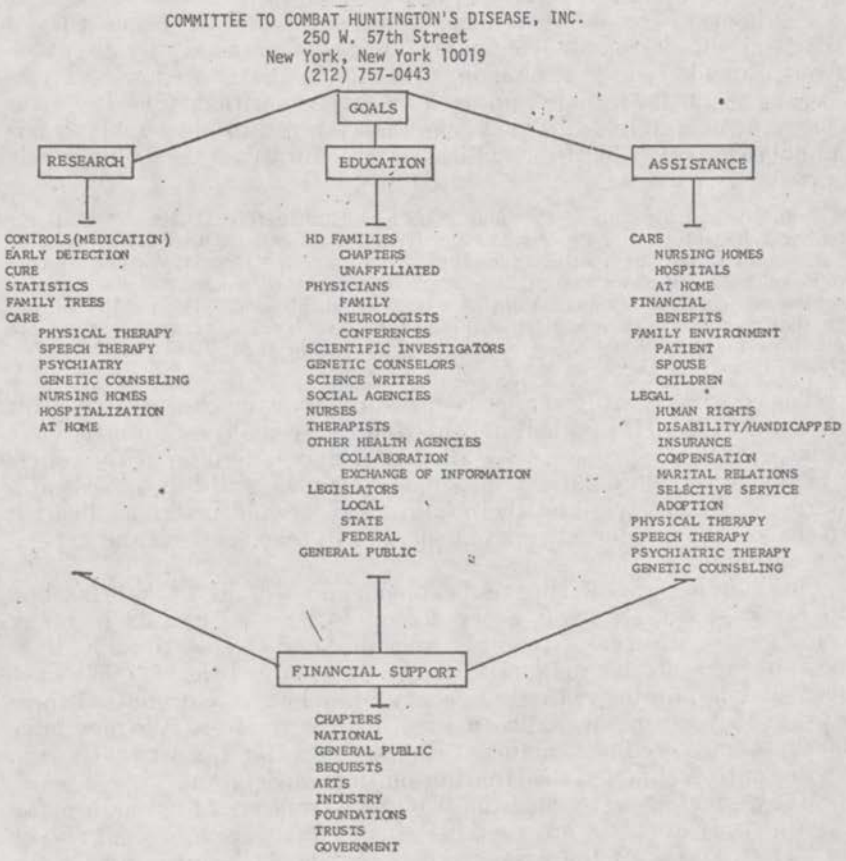
We believe sincerely that our common effort in support of basic re-

search pertaining to the human brain and the study of genes has helped to bring about a new surge of interest in an area of research hitherto almost completely neglected.

We want to continue that effort, however, we feel that we must not neglect those areas of research that could bring some measure of hope to the HD families.

I ask your permission to insert the attached chart, which explains our goals in research, education, and assistance to the victims of this disease.

So that this committee may more fully understand the nature of Huntingtons disease, I would like to include the language of an NIH report on it at this point in the record.



SPECIAL REPORT: HUNTINGTON'S DISEASE

Huntington's disease is a hereditary disorder characterized by a combination of physical and mental symptoms, either of which may appear before the other. Often, however, the physical symptoms come first, and usually between the ages of 35 and 40, by which time the individual may have passed the disorder on to several children.

Early symptoms may be confused with fidgety nervousness. The uncontrollable chorea may show itself as abnormal involuntary movements, such as jerking, twisting, and spasms of the muscles of the face, tongue, neck, trunk, arms, and legs. As symptoms become more severe, the patient may have trouble swallowing and may be unable to speak.

Huntington's disease also may begin with distressing personality changes, such as indifference, dullness, irritability, poor judgment, loss of memory, and carelessness about personal looks and habits. Outbursts of violence may occur, alternating with periods of short-lived depression. In later stages the patient may become profoundly demented.

Huntington's disease is passed on through an autosomal dominant gene, which means that each offspring of an affected person has a 50 percent risk of having the disease. Males and females and all ethnic groups may be affected.

If a person does not show symptoms by age 35, the probability of his having the disease diminishes with each succeeding year. In very rare instances, however, individuals over 70 years old have been known to develop the Huntington's disease symptoms.

PREVALENCE

Because of its hereditary nature and categorization as a "mental" disease, families have hidden its existence for centuries and it is almost impossible to assess accurately statistics regarding the prevalence of Huntington's disease in the United States.

A review of a number of studies on the prevalence of Huntington's disease in various world populations indicates a fairly uniform distribution which would mean that about 10,000 to 14,000 Americans have Huntington's disease symptoms. However, since the establishment of the Committee to Combat Huntington's Disease (CCHD), incoming letters, phone calls, and personal contacts have led the CCHD to believe that three to four times this number may have the Huntington's disease gene and either have Huntington's disease symptoms or will eventually develop symptoms.

DIAGNOSIS

There is, as yet, no means to test and identify persons with Huntington's disease before symptoms become apparent. The diagnosis of Huntington's disease is usually based on the clinical findings of dementia, and chorea, and positive family history. The insidious onset of involuntary movements is unlike most other forms of chorea and can aid in the identification of the disease.

EARLY DETECTION

Early detection of Huntington's disease may be helped by knowledge of the family history and the expected age of onset from that in older siblings. Investigators report that the mothers of some large choreic families may be able to sense which children will develop the disease, and later events prove them to be correct.

ADVANCES IN DIAGNOSIS

Preliminary findings from several Federally supported laboratories have sparked the hope that a test for the early detection of Huntington's disease is near.

In one collaborative study investigators have described a predictive test based on the observation that the drug levodopa aggravates choreiform movements in patients with Huntington's disease and might bring out undetected chorea in asymptomatic victims. When the effects of oral levodopa were compared in offsprings of choreics and controls, the children of choreics developed facial twitches and involuntary movements while controls remained unaffected. It has not yet been proved that individuals developing chorea with this test will develop the disease later, nor that those in whom the test is negative may not develop it in time. The National Institutes of Health is presently supporting research to investigate the effectiveness of such a test. If this predictive test proves reliable, it should be of considerable value in eliminating the disease. Attempts are now being made to refine the L-dopa test to find biochemical changes that occur without concomitant physical symptoms.

Other preliminary reports indicate that it may eventually be possible to detect Huntington's disease using less drastic approaches. National Institute of Neurological Diseases and Stroke (NINDS) grantee scientists in California have found that a certain type of cell (fibroblasts) taken from patients with Huntington's diease and cultured in the laboratory do not survive as long as cells from normal individuals cultured under the same conditions. This difference in cell life span may be useful in identifying Huntington's disease very early in presymptomatic victims. It is also hoped that such a test, if successfully developed, could be extended to intrauterine tests to detect Huntington's disease in the fetus.

While the development of a test to identify carriers before symptoms occurred would, of course, be of considerable value in genetic counseling, the question has been raised by a recent NINDS survey whether individuals who risk developing the disease would choose to know if they carry the defective gene. In the study 23 percent of the high-risk respondents—those under age 45 with a Huntington's disease parent—indicated that they might refuse to take a simple and safe predictive screening test if one is developed.

CAUSE

Until now the nature of Huntington's disease has been poorly understood. However, a recent report from a group of Canadian researchers may change this status. They found that the brains of patients who had died of Huntington's disease were deficient in a compound called gamma-aminobutyric acid or GABA. It is believed that GABA inhibits neural transmission in the brain and that a deficiency might produce the symptoms characteristic of Huntington's disease.

Support for this hypothesis recently came from a group of English scientists who reported a reduction in the activity of an enzyme (GAD or glutamic acid decarboxylase) in the brains of Huntington's disease victims. The reduced activity of this enzyme which is involved in the production of GABA indicates that certain GABA-containing nerve cells in the brain are malfunctioning.

TREATMENT

It is hoped that these exciting leads into the biochemical nature of Huntington's disease will pave the way for the development of a successful treatment. Until now the treatment for Huntington's disease was directed toward improving the involuntary movements of the patients. Presently a number of laboratories are directing their studies toward the evaluation of GABA as a therapeutic agent and correction of what appears to be the basic biochemical abnormality of Huntington's disease.

In one promising pilot study, two of seven Huntington's disease patients given large doses of GABA have shown striking improvement, one patient has shown moderate improvement, and the remaining four have remained unchanged.

At the National Institute of Mental Health, scientists have synthesized a compound similar to GABA, but which may pass through the blood-brain barrier and enter the brain more readily than GABA. It is hoped that this agent will help correct the GABA deficiency and improve the patients' condition.

RESEARCH

The Department is presently supporting several types of research through the National Institutes of Health and the National Institute of Mental Health of the Alcohol, Drug Abuse, and Mental Health Administration, aimed at finding the cause, cure, and treatment of Huntington's disease and at disseminating information materials relating to it.

The NINDS funds seven regular research grants, a portion of a program project and categorical clinical research centers, and two collaborative studies at $416,000.

Other research studies relating directly to Huntington's disease include six general clinic research centers, funded by the Division of Research Resources at $78,787, and a portion of two program projects and categorical clinical research centers funded by the National Institute of Arthritis, Metabolism, and Digestive Diseases, and by the National Institute of Child Health and Human Development at $35,000.

In addition to these programs relating directly to Huntington's disease, the NINDS has an extensive program of basic research funded at $13,475,000, which is important in understanding the nervous system and the disorders which interrupt its normal functioning.

The Institute works closely with the Committee to Combat Huntington's Disease (CCHD), a voluntary health organization that encourages research in Huntington's disease. The CCHD plays a vital role in disseminating information about the disease and in providing psychological support for members of families affected with Huntington's disease.

Mr. Chairman, thank you for listening to our testimony.

Mr. PATTEN. I read it, all the way from Brooklyn to Belleville.

Ms. GUTHRIE. I commend you, Mr. Patten.

I really appreciate your telling me this. I want you to know that what I am telling you I have learned from experience. I am not going to only talk about Huntington's and all the work that I am doing.

Most people don't understand. Even my own people in my own organization are not able to see the long-term goal that the real thing is going to be brain reesarch.

Mr. PATTEN. Dr. Stepto tells us in the field of genetics that we are going to accomplish more than ever in the next 10 years.

Ms. GUTHRIE. I just came from the hearings in another room and I was commenting to Mr. Brannigan, the question came up, what is a genetic disease and should we have everything come into one category called genetic disease. Nobody said what I am going to say to you today. What they did not say is that at this moment in scientific investigatory history the important thing is not the name of your disease; the important thing is that is a gene. If we know what a gene is, then some day we will be able to categorize all your different genetic diseases through knowing more about what is a normal healthy gene. Nobody gave that answer.

Instead of worrying about all the names of all the different diseases, we should be worrying about genes. I feel the same way when I speak about all the neurological disorders. If you don't know what a healthy brain is, if you don't know how the nervous system works, what is the difference what you call all the diseases that grow out of a brain that doesn't function properly. So I am testifying in behalf of all these institutes that are worried and concerned with the basic research in genetics, meaning genes, and brain meaning anything that has to do with the nervous system and the brain. That is what I wanted to say today.

I appreciate your letting me speak in my own way. I thank you very much.

Mr. PATTEN. That is a very good statement. You have lived it, my dear, and according to my religion you have to go to heaven.

Mr. GUTHRIE. Thank you. I would like to go up with a few thousand people and let them live good lives and make a contribution to society.

Mr. PATTEN. You have done a good job.

Ms. GUTHRIE. Thank you. I am pleased to have this special conversation with you. We don't often get this opportunity.

Mr. PATTEN. Mr. Frederick Mandell, Children's Hospital Center and Mrs. Anne Barr, president, Massachusetts Chapter, National Foundation for Sudden Infant Death, Inc.

WEDNESDAY, MAY 21, 1975.

SUDDEN INFANT DEATH SYNDROME

WITNESSES

DR. FREDERICK MANDELL, CHILDREN'S HOSPITAL MEDICAL CENTER

MRS. ANNE BARR, PRESIDENT, MASSACHUSETTS CHAPTER, NATIONAL FOUNDATION FOR SUDDEN INFANT DEATH, INC.

Mr. PATTEN. Mr. Conte is here today. He is involved in a conference with the Senate on the second supplemental, but he has taken the time to come over here and testify on SIDS, in which we all know he has a great interest.

Mr. Conte?

Mr. CONTE. Thank you Mr. Chairman.

Mr. Chairman, the loss of a child, for any reason, is tragic. My heart goes out with special compassion, however, to the parents of the victims of sudden infant death syndrome. For unlike many childhood diseases, this one strikes without warning and without currently apparent symptoms. Its toll annually is approximately 8,000—or about 2.5 deaths per 1,000 live births.

Research into sudden infant death syndrome has just scratched the surface. Theories are being tested, but more needs to be done, both in research and in education.

I want to emphasize that what we are talking about is a disease, but one which, so far, is not able to be diagnosed by any symptoms other than the very fact of the sudden death of an apparently healthy infant.

In reality, there is more than one victim of sudden infant death syndrome.

First, of course, the infant—usually between 1 and 6 months of age. And second, the parents of that infant.

It is my pleasure today to introduce two witnesses who have intimate knowledge of both types of victims.

Dr. Frederick Mandell is a pediatrician at Boston Children's Medical Center. He is a medical advisor and trustee of the Eastern Massachusetts Chapter of the National Foundation for Sudden Infant Death and is vice president and trustee of the National Foundation for Sudden Infant Death. He is a recognized authority on SIDS in this country.

I would also like to introduce Mrs. Anne Barr of Stow, Mass. Mrs. Barr lost a child to SIDS in 1973, and is presently the president of the Eastern Massachusetts Chapter of the National Foundation for Sudden Infant Death.

Mr. PATTEN. You people are doing great work. They testified before us that they are making progress. They have leads. They said that they expect to get results.

SUDDEN INFANT DEATH SYNDROME: THE NECCESSITY FOR FUNDING THE SUDDEN INFANT DEATH SYNDROME ACT OF 1974 (PUBLIC LAW 93-270, REGIONAL CENTERS) AND PRIMARY RESEARCH THROUGH PROPER GOVERNMENTAL HEALTH AGENCIES (THAT IS NICMH)—TESTIMONY ON BEHALF OF THE NATIONAL FOUNDATION FOR SUDDEN INFANT DEATH, INC.

Frederick Mandell, M.D., trustee and regional adviser, the National Foundation for Suddent Infant Death, Inc., Children's Hospital, 300 Longwood Avenue, Boston, Mass. 02115.

Anne W. Barr, president, eastern Massachusetts chapter, the National Foundation for Sudden Infant Death, Inc., Box 2122, Boston, Mass. 02126.

I am Dr. Frederick Mandell, pediatrician at the Childrens' Hospital Medical Center, Boston, Mass. In the United States this year, one infant in every 350 live births will die of the sudden infant death syndrome, about 8,000 well cared for babies. Sudden infant death is the most common single cause of death in the first year of life excluding the neonatal period. At present these deaths cannot be prevented and the victims cannot be predicted. This disease, the suddent unexpected loss of a healthy appearing child, is unique in the spectrum of pediatric disease. The need for proper diagnosis is essential since the perplexing nature of the death may lead to a profound and undeserved sense of guilt by those who have cared for the child. Self-condemnation may be made more poignant by an unintentional lack of sensitivity by those involved in the process of the tragedy.

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This unnecessary human suffering can be altered by training and education about SIDS at multiple levels. It is essential that the long term family consequences of SIDS, its prevalence, and its characteristics be made known to those in positions to make judgments.

Families who lose infants require an answer to their urgent first question: "Why did my baby die?" This answer should not be delayed. Families require factual information about SIDS. They need to know that SIDS is not preventable and not predictable, that they in no way were responsible for the death of the child and that this was not suffocation or aspiration. They also need to know that minor omissions, such as not checking the infant or changing the formula, was not the cause of death. These basic facts should be expressed by a knowledgeable, understanding human being as close to the time of death as possible.

Recently a father found his infant son dead in the crib. The father phoned the police for resucitative help. The police came to the house and informed the father of his rights to be silent. Another family was waiting in a small room in an emergency room. They had just learned that their infant was dead. A nurse opened the door, threw the child's clothes on the floor and said, "How could you do it?" Often, however, nonhandling has been the cause of as much damage as the above mishandling. The constant availability of educational information to grieving parents and emergency personnel would serve to avoid these harsh innuendoes or bewildering inattention.

The loss of a well cared for healthy child who is the focus of family enthusiasm is one of the most painful types of grief. Parents mentally recreate the few hours before the death of this child to search for evidence that they could have, in some way, prevented the terminal event. Mothers experience feelings of failure and guilt, and question their own ability as mothers.

Initial shock becomes grief and the internal bargaining process common to all grief begins. When a sudden death is due to a known cause, the concrete character of the event can be incorproated into the normal rationalization of mourning. When death is due to an unknown process, feelings of self-condemnation and inadequacy of mothering are reinforced. For young parents this loss may be their first experience with family death and often, poorly informed relatives and friends add further remorse with inference of parental blame. And to this the stresses of a lower socioeconomic or minority status and the overwhelming feelings of worthlessness can be consuming.

The lack of information and understanding by individuals in the array of people confronting the problem has given rise to the haphazard and unorganized effort to reach families who have lost children to SIDS. This paucity of knowledge and absence of response has sometimes produced cruel ordeals for parents who would receive support and understanding if their children had succumbed to a readily identified disease. Parents are often provided erroneous information or no information. In many lower socioeconomic groups, despair at a time of grief strips them of their remaining energies to follow through or seek help. Many families have been unduly burdened with feeling that they are somehow responsible for the death of their baby. A recognized organization with a central area for a broad population base can provide information follow through, counseling, and help. This organization could also establish a base of education for medical and paramedical personnel and the lay communities.

In July of this year, SIDS regional centers will begin to provide; (1) standardized pathological examinations, (2) education of medical and paramedical personnel, (3) notification of parents within 48 hours of the cause of death and (4) utilization of the term sudden infant death syndrome as a disease entity and cause of death on death certificates, and (5) counseling, support, and help to the families of victims.

These several regional SIDS centers will serve as a base for an excellent beginning. However, in many other inner cities, suburban towns and vast rural areas in the United States, families will believe they killed their babies, that they died of suffocation or pneumonia when in fact they died of the disease sudden infant death syndrome.

Appropriations of moneys to continue and expand the initial regional center program and to create others in needy areas, could moderate this unfortunate high frequency of unnecessary human suffering.

The cause of sudden infant death syndrome is still unknown. It remains elusive because the problem is complicated. However, to find the etiology is not

impossible. Recently there have been some very exciting elemental findings. Using this base, good researchers must have appropriations to continue. These funds will provide uninterrupted and original research to bring us closer to the delineation of that final common pathway in the etiology of the sudden infant death syndrome. These appropriated funds would then be instrumental in the medical communities' ultimate goal, to prevent sudden infant death and its suffering.

My name is Anne Barr, resident of Stow, Mass. Two years ago, my husband and I lost our daughter to SIDS. I am currently president of the Eastern Massachusetts Chapter, National Foundation for Sudden Infant Death. Through my work with this volunteer organization, I have come to realize the necessity for professional and systemized management of SIDS families. I have found that talking to a new parent whose doctor has told her that her baby died of SIDS is one thing, trying to convince a new mother that, in spite of what her pediatrician said, her child did not suffocate, is another. There is little I can do to repair the damage done to a 7-year-old boy who has seen his mother questioned by the police as to "what she did to the baby" and "why didn't she like him." I have sat up all night with an SIDS mother who threatened suicide. This woman needed professional help and there was no one I could send her to. As she said, "I went to see the people at the mental health clinic, and they didn't even know what SIDS was. I'll never go again."

It soon became apparent to me that parents who were well treated, who had autopsies, and death certificates with SIDS on them, were having a much easier time accepting the death of their babies. What appalls me is that well-treated parents are so few and far between. Our chapter contacts approximately half of the new SIDS parents in our area. Less than a third of these are well handled. I hate to think of what is happening to those parents we don't hear about. Last week, I was on a call-in radio show. A woman phoned. Twelve years ago, she had been babysitting for her nephew. The boy died of what was obviously SIDS. The doctor diagnosed the death as pneumonia and said he couldn't understand why she hadn't noticed it, why she hadn't heard the baby crying. The tragedy here is that this woman decided not to have any children of her own because she couldn't handle it; she felt she was unfit to be a mother.

Incidents such as this need not occur. It is absolutely criminal that, through ignorance, we often add to the tragedy of losing a child rather than providing assistance. Until the Sudden Infant Death Act of 1974, Public 93-270, the only work being done in this field was by volunteers—usually parents of SIDS victims themselves. This is not sufficient. The regional centers under the funding of Public Law 93-270 this past year are an excellent beginning. The regional SIDS centers are essential to the well-being and mental health of thousands of parents across the country. It is imperative that moneys are released for the continuance of this program.

I am also here to ask that, through NICH, funds be released for SIDS research. I don't feel that it is necessary to be descriptive about what it is like to discover your own child dead in her crib. It is, quite obviously, a horrifying experience. It is the one thing that all SIDS parents try to forget and can't. It haunts them in dreams, in the scream of a police siren, and in the sight of a baby sleeping. The only answer is cure for SIDS through research. As I understand it, there is some excellent research going on. I would pray that lack of funds would not impede it. A cure for this devastating disease must be found.

Dr. MANDELL. If I may, I would like to expand a little bit on your remarks, Mr. Patten, because they are very, very pertinent at this time.

As you well know, Sudden Infant Death is the biggest killer of infants in the first year of life between 1 week and 1 year of age. There is no other disease that even comes close to that. We are talking about 8,000 babies a year who die in the United States. We are talking about a disease that is different in character than any other disease in the pediatric spectrum of pathology. I think that we need to talk about two different areas. The first is in the realm of helping people who lose children. We need to help those families get information about SIDS. They need to be educated. They deserve to know that their children

died of sudden infant death syndrome and that it is a very specific disease entity. It is not parents beating or killing their children and it is not suffocation or pneumonia.

Parents need to be helped, not on a haphazard level, because the problems in the rural areas are as pronounced as the problems in the inner cities. The beginning of this program has been the regional centers. Beginning this July, there will be several regional centers which will provide education and counseling for parents, and information for medical personnel.

This is a fantastic beginning. In terms of continuing and expanding that program, the figure of $3 million will be requested. I hope that those moneys will be made available to expand that program. In terms of research, there have been some very, very exciting leads over the past several years. Using these clues as a base, I know the medical world is capable of finding an answer.

I hope that the administration's request of $4.5 million for SIDS research and its related fields will meet with your approval.

Mr. PATTEN. Are you familiar with what the head of research at NIH told us? He said you can see clues to SIDS in advance.

Dr. MANDELL. This is one of the most exciting things. We have always said that sudden infant death was something that happened quickly and we had no warning. Now the question is whether we do have some clues at the beginning and whether we can pick out these children and attempt to prevent sudden infant death. This is what is so exciting.

Mr. PATTEN. He said they want to continue. They feel they may get someplace.

Dr. MANDELL. I hope they will be able to do that.

Mr. PATTEN. He acted quite enthused. That is not his nature particularly, but when I quizzed him on it, he said, "They have good reason to continue with their work." He explained some of the theories they have come upon, not the least of which is that you can control it if you know what to look for.

Shall we hear from Mrs. Barr?

Dr. MANDELL. I would like to introduce Mrs. Barr. Anne is a parent who has lost a child to sudden infant death. At the present time she is president of the Eastern Massachusetts Chapter of the National Foundation.

Mr. PATTEN. Do you have older children?

Mrs. BARR. Yes. I have a boy who was 3 years old when my daughter died and a son who was born 18 months after she died. I would like to testify also in support of the research which the administration has requested for $4½ million for SIDS research and related projects. It is very important that this research be supported.

Obviously the only real answer to SIDS is total prevention.

The other thing that is terribly important in my role as president of the chapter is that I talk to parents who have lost children to SIDS almost on a daily basis. That is one of the things we do. We contact the parents so they will understand the child died of a disease to help them through the grief process. I have found that the parents who were treated well by professionals and had autopsies on the children and had the term SIDS on the death certificates were able to accept

it more easily than parents told by a professional or doctor or even friends that the child suffocated or died of pneumonia. It is hard for us as a volunteer organization to convince the parents that the child died of a disease in spite of what the pediatrician told them. It is apparent to me that unless these centers are funded the parents will not get the help they need and deserve. We would like to see approximately $3 million for this informational work, to be spent on the continuation and expansion of these centers.

Mr. CONTE. We were fortunate to get the amendment in last year in the subcommittee to get this program going. I was very grateful to Chairman Flood and you, Mr. Patten, and others who supported me in this.

Mr. PATTEN. Mrs. Barr, how large is your Foundation? Do you have a chapter in New Jersey?

Mrs. BARR. Yes, an excellent one.

I think the Junior League of New Jersey raised $8,000 for the local chapter for the National Foundation for SIDS.

Dr. MANDELL. I think that as I said before there is such exciting steps that have now come out, using this as a broad base. I am very much committed to not only counseling parents but also to finding an answer to that elusive sudden infant death syndrome. I got started in this about 3 years ago when I was asked to give a talk to the parents group. I recognized that this was such a widespread disease and there were very few people involved. I guess I just became committed.

Mr. PATTEN. Well, I'm glad you came down.

In Mr. Conte, and I can tell you, he is an advocate, you have great support.

Mr. CONTE. Thank you, Mr. Chairman. I hope we can provide the funds so desperately needed for research and education on SIDS.

Well, our last witness today is Mr. E. D. Vickery, Western Gulf Maritime Association.

WEDNESDAY, MAY 21, 1975.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

WITNESS

E. D. VICKERY, WEST GULF MARITIME ASSOCIATION

Mr. PATTEN. Mr. Vickery.

Mr. VICKERY. Mr. Chairman, I would like to submit the statement I supplied to the committee to be inserted in the record.

Mr. PATTEN. Your statement will be made a part of the record.

Mr. VICKERY. I hate to go to a negative note; there has been so much in the way of optimistic notes in the hearing this afternoon.

My name is E. D. Vickery and I am a senior partner in the law firm of Royston, Rayzor, Cook & Vickery of Houston, Tex. I have had extensive experience in the handling of claims under the Longshoremen's Act at all levels of the administrative and adjudicatory processes since I first started practicing law in Houston in 1948. I was also involved on behalf of the West Gulf Maritime Association and other

gulf maritime associations in connection with the 1972 Amendments to the Longshoremen's Act which the Department of Labor asserts are responsible for their need to make such a request of the Congress.

The membership of the West Gulf Martime Association is composed of steamship owners, operators, agents, and independent stevedoring companies, totaling some 50 in number. Its membership covers the geographical area from the Port of Lake Charles, La., on the east, to the Port of Brownsville, Tex., on the west. All of its members are employers of substantial numbers of employees who are covered for injuries and death by the Longshoremen's and Harbor Workers' Compensation, Act, 33 U.S.C.A. section 901ff.

In order to avoid unnecessary duplication and in an attempt to be more helpful to the committee, I will direct substantially all of my testimony to the Department of Labor's position in support of its request for user charges to finance the regulation of the Longshoremen's and Harbor Workers' Compensation Act. I do so because I have had an opportunity to review the extensive testimony given to the committee by Mr. Dennis Lindsay of Portland, Oreg., on behalf of the Master Contracting Stevedores Association of the Pacific Coast, Inc., and I can affirmatively state that the West Gulf Maritime Association which I represent fully endorses and supports the position of the Master Contracting Stevedores Association of the Pacific Coast, Inc.

Before turning to the Department of Labor's position as distributed to the industry in a paper dated April 15, 1975, entitled "Proposed Changes in Funding Administration of the Longshoremen's and Harbor Workers' Compensation Act Through User Charges of the Industry," I must call to the attention of this committee—as I have in testimony before the Senate Subcommittee on Labor in 1967 and again in 1972, and the House Select Subcommittee on Labor also in 1972—giving the Department of Labor a blank check and unlimited authorization to spend an amount of money for administration or regulation of the act would be an invitation to disaster based on its history in administering the trust fund accounts under section 44 of the act (33 U.S.C.A. § 944). Section 39(c) of the act (33 U.S.C.A. § 939(c)) authorizes the costs of administration of its vocational rehabilitation provisions to be paid out of the trust fund. The Department has not made any user charges for its administration against the trust fund since fiscal year 1968 because their user charges from fiscal year 1961 through fiscal year 1968 had amounted to nearly $2 ($1.85) for every $1 which had been paid to or for the benefit of injured employees. On July 1, 1960, the special fund had a balance of $691,717.27. Eight years later it had a balance on June 30, 1968, of only $13,436.54, although during this 8-year period it had additional receipts totaling $197,002.42. During this 8-year period a total of $812,750.68 was expended. Of this amount only $285,493.58 was paid to or for the benefit of injured employees; whereas a total of $527,257.12 was expended in salaries and expenses in the administration of thef und. In fact, if these user charges for administration were all attributable to section 39(c) expenditures for vocational rehabilitation, the only statutory authority given the Department which totaled only $51,837.67, the cost of administration would amount to $10.17 for each $1 paid to or for the benefit of injured employees.

These figures graphically demonstrate the danger in giving any such unlimited blank check authority to any Governmental department to impose user charges on an industry such as those proposed by the Department of Labor in any area.

THE ALLEGED BACKLOG

The Department of Labor's position paper of April 15, 1975, indicates its "principal area of concern is the ever-increasing backlogs" in the Office of Workers' Compensation Programs (hereafter OWCP) district offices (page 3, paragraph 5). On pages 4 and 5, the statistics which the Department uses attempt to demonstrate that the 1972 Amendments to the act have resulted in a 109.8 percent—the figures quoted of $58,000 in 1972 and $136,818 in 1974 actually produce an increase of 135.8 percent—increase in the total injuries reported, an 86.5-percent increase in lost time injuries and a 461.2-percent increase in the backlog of cases by comparing fiscal year 1972 with fiscal year 1974. The fiscal year 1972 which was picked as a comparable base is not in fact comparable but is unfair, unrealistic and misleading for several reasons.

First, fiscal year 1972 is not comparable because the longshoremen on the Pacific coast were out on strike a total of 136 days during that fiscal year, those on the Atlantic coast and in east gulf ports, through New Orleans, were out on strike a total of 57 days and those in west gulf ports—(Lake Charles, La., to Brownsville, Tex., were out on strike a total of 13 days. It is hardly fair or realistic to use this as a base year when longshoremen were on strike for a total of 206 days or 56.4 percent of the days that year.

Second, it is unfair, unrealistic and misleading to use fiscal year 1972, as its total injury figure of 57,940 is the lowest total for any fiscal year since 1962. For the 9-year period immediately prior, fiscal year 1963 through fiscal year 1971, the average number of total injuries reported each year was approximately 80,000 (79,720) with a high of 87,497 in fiscal year 1967. Using the average for this 9-year period would show only a 71-percent increase in 1974 and using the highest figure would produce only a 56.4-percent increase. While I do not have available the lost-time injury statistics on which the Department relies for its 86.5-percent increase, using the same reduction as shown in total injuries would reduce the 86.5-percent lost-time injury percentage to only 55.9 percent on the 9-year average and to only 44.5 percent on the fiscal year 1967 high. Thus, when fiscal year 1974 figures are compared on a fair and realistic basis, the Department's quoted percentage increases are shown to be very much overstated:

1. Their 109.8 percent figure is overstated by 38.8 percent, by 64.6 percent if my 135.6 percent figure is correct, on total injuries using the 9-year average and by 53.4 percent, by 79.2 percent if my figure is correct, using the fiscal year 1967 high.

2. Their lost-time injury figure of 86.5 percent is overstated by 30.6 percent using the 9-year average and 42 percent using the fiscal year 1967 high.

Third, the alleged 461.2-percent increase in the district offices' backlogs based on a "reported" total backlog of 1998 cases at the end of

fiscal year 1972 and a "reported" backlog of 11,213 cases at the end of fiscal year 1974 is even more grossly unfair, unrealistic and misleading—page 5, paragraphs 1 and 2 of Department's position paper. While admittedly I do not have access to some of the information "reported" by the District offices to the Department, these "backlog" figures are completely new to me, and I cannot imagine how the Department arrived at them. However, the Department has for many years published a summary of injuries reported under the act by fiscal years by district offices from which we can obtain a realistic comparison of the backlogs in the district offices. Attached to this statement as exhibit A is the September 1974 Summary of Injuries Reported covering the fiscal years 1970–1974.

While as previously indicated I do not know what the Department's quoted backlog figures may involve, I have always understood a backlog of cases to mean those pending in a court or in an office which are not closed at the end of a fiscal year because they are incomplete. To me at least an increase or decrease in a backlog of cases is the difference between the number pending at the end of one fiscal year compared to another. Please note page 2 of exhibit A on the extreme righthand side of the page where the "Incomplete Cases" or cases still open are shown in two categories—"Being Compensated" and "Awaiting Action." I have written in ink the total number of incomplete cases in the righthand margin for each of the years. These show that at the end of fiscal year 1972 there were a total of 16,866 incomplete or pending cases in all district offices, and at the end of fiscal year 1974 there were 27,226, an increase in the backlog of 10,360 cases. This is a percentage increase of only 61.4 percent and not the 461.2 percent increase the Department claims. The Department has overstated the real increase in the backlogs in district offices by only 399.8 percent. Using the average number of incomplete cases for the same 9-year period, the increase in fiscal year 1974 is only 46.2 percent and only 30 percent compared to the high in fiscal year 1968.

Now that the increases in reported injuries, lost-time injuries, and district office backlogs have been placed on a fair and realistic basis, what is responsible for the increase and is fiscal year 1974 truly representative of what may be anticipated in fiscal year 1976 and thereafter? As the Department's position paper indicates, substantially all of the increase is attributable to the extension of the act's jurisdiction ashore, but what the Department does not say is that it has systematically and energetically adopted policies and practices designed to extend the act's and thus the Department's jurisdiction ashore to the maximum possible extent. And this, even though both the House and Senate committee reports on the 1972 Amendments to the act clearly state that:

> The Committee does not intend to cover employees who are not engaged in loading, unloading, repairing or building a vessel, just because they are injured in an area adjoining navigable waters used for such activity.

The proposed guidelines published by the Department in the Federal Register on the shoreward extension of the act in effect said injury in an adjoining area is all that is required. Unfortunately most of the administrative law judges and the benefits review board have embraced the Department's guidelines, and the benefits review board has even

affirmed a holding by one administrative law judge that the injury does not even have to be sustained in an area adjoining navigable waters, provided he is working on his employer's premises and these premises are as close as possible to navigable waters and what he is working on may at some indefinite time in the future be used to load or unload some unidentifiable vessel still on the high seas, or indeed, possibly one which may still be under construction. Thus, the fiscal year 1974 figures are realistic only if the courts are willing to disregard the legislative history contained in the committee reports as completely as has the Department of Labor.

The Department has had its Office of Workers' Compensation Programs district offices openly solicit and encourage the filing of claims even in those instances where the employee has hired an attorney of his own selection who believes there is no Longshore Act jurisdiction and is, therefore, prosecuting his claim under a State act. In fact, it is the Department's position that the Longshoremen's Act is not an employee's exclusive remedy and he is free to prosecute his claim to a conclusion under a State act and then prosecute a claim under the Longshoremen's Act just to see which act will produce the most money. In one such case involving only 9 days lost time, for which the employee had been paid his State compensation benefits in full, upon the district office's recommendation at an informal conference the employee hired an attorney to prosecute his claim under the Longshoremen's Act. His claim was tried by an administrative law judge who came to Texas from Washington, who found Longshore Act jurisdiction but when credit was given for the compensation already paid under the State act, he had been paid $71.54 more than he was entitled to under the Longshoremen's Act. All was not lost, however, because the employee's attorney was awarded a fee of $500 to be paid by the employer and carrier. In yet another case where the employee had declined to prosecute his claim before an administrative law judge who had come to Texas from Washington, D.C., to try the case because on the advise of his own attorney he desired to proceed under the State act. Thereafter the employee on advice of his own attorney settled his claim under the State act and requested that his claim under the Longshoremen's Act be withdrawn. The OCWP district office declined and advised all parties that the employee's "claim under the Federal Act remains a viable one". How many of the so-called increases in backlog are attributable to such situations where only the Department desires to keep the claim open?

The Department has also instituted a policy which requires an injury report to be filed in every instance where any first aid treatment is sought—no matter how minor or trivial—and even though no accident is reported. Failure to do so subjects the employer to the imposition of a civil penalty up to $500. Precisely the same potential penalty may be assessed if an employer in good faith reports an injury to the State compensation authorities and the district office decides the employer should have reported it under the Longshoremen's Act. At the insistence of the General Accounting Office, the Department has issued instructions to its district offices to levy more civil penalties. Under these ridiculous and unnecessary circumstances an employer can protect himself only by filing an injury report under the Long-

shoremen's Act in all cases even those which the employer believes to be completely outside the jurisdiction of the Longshoremen's Act. I have no doubt that a substantial portion of the increase in reported injuries fall into these categories.

Obviously, until the courts have either adopted the Department's ever-expanding view on shoreside jurisdiction or have established the necessary guidelines which will permit the jurisdictional line to be drawn between the State and Federal acts, the fiscal year 1974 figures cannot be considered to be realistic. Several significant jurisdictional cases are now on appeal and hopefully by the end of this year we will have some authoritative court decisions. To seriously consider the Department's unrealistic figures as a basis for its needs for fiscal year 1976 and thereafter would be going too far, to fast, too soon. And for Congress to abandon its control over the Office of Workers' Compensation Programs' budget and give them a free hand to assess the maritime industry in unlimited amounts under these circumstances is unthinkable.

THE ALLEGED INCREASE IN DISTRICT OFFICE RESPONSIBILITIES

The Department's position paper asserts that the backlog in its district offices is attributable to the increase in the district offices' responsibilities under the 1972 amendments to the act primarily in three areas—vocational rehabilitation, medical services, and assistance to claimants, page 5, paragraph 1. For convenience we shall consider each of these three areas separately.

1. VOCATIONAL REHABILITATION

For the Department to suggest as it does that the 1972 amendments require the OWCP to do something in the field of vocational rehabilitation which was not already required of it by section 39(c) [39 U.S.C.A. § 939(c)] of the act is misleading in the extreme. The substance of section 39(c) of the act was unchanged by the 1972 amendments insofar as vocational rehabilitation is concerned and provides now as it has since its amendment in 1956 to read as follows:

> The Secretary shall direct the vocational rehabilitation of permanently disabled employees and shall arrange with the appropriate public or private agencies in States or Territories, possessions, or the District of Columbia for such rehabilitation. The Secretary may in his discretion furnish such prosthetic appliances or other apparatus made necessary by an injury upon which an award has been made under this Act to render a disabled employee fit to engage in a remunerative occupation. Where necessary rehabilitation services are not available otherwise, the Secretary of Labor may, in his discretion, use the fund provided for in section 44 in such amounts as may be necessary to procure such services, including necessary prosthetic appliances or other apparatus. This fund shall also be available in such amounts as may be authorized in annual appropriations for the Department of Labor for the costs of administering this subsection." [Note: This subsection has been renumbered to 39(c)(2)].

The only reference to vocational rehabilitation in the 1972 amendments was in the sentence immediately preceding the foregoing language which provides:

> * * * The Secretary shall also provide employees receiving compensation information on medical, manpower, and vocational rehabilitation services and assist such employees in obtaining the best such services available." Section 39(c)(1), 33 U.S.C.A. § 939(c)(1).

This sentence was obviously inserted into the act to attempt to get the Department to perform those functions already authorized under section 39(c) [33 U.S.C.A. § 939(c), now renumbered to become § 939 (c) (2)]. For the Department to suggest that user charges are needed in connection with the vocational rehabilitation requirements under the act is an attempt to conceal the Department's real purpose in this area—to have Congress remove the requirement of section 39(c) (2) that the cost of administering the subsection on vocational rehabilitation can be paid from the fund provided for in section 44 of the act only "in such amounts as may be authorized in annual appropriations for the Department." In this limited area of vocational rehabilitation alone Congress has provided for the cost of administering this program to be paid from the special fund but provided these costs are approved annually in the appropriations for the Department. Congress very wisely gave no blank check and unlimited authority to pay the costs of administering the vocational rehabilitation program to the Department from the fund. Thus, the vocational rehabilitation argument made by the Department is nothing more than a smokescreen by which the Department hopes to get Congress to remove its control over the sums paid out of the special fund in section 44 for the cost of administering the vocational rehabilitation program.

The Department's approach to vocational rehabilitation as reflected by its position paper is predicated on the absolutely false premise that employers and insurance carriers under the act have no interest in providing rehabilitation services in those cases where they are indicated. But such rehabilitation services are not needed in every case which produces as much as 6 to 8 weeks of disability all of which are required to be reported to the vocational rehabilitation offices of the Department for its consideration. In fact in my experience more often than not, when the employer or carrier suggest the advisability of vocational rehabilitation testing the Department's reaction is not that the employer-carrier have any desire to rehabilitate the man but are really only looking for a way to reduce their potential exposure for compensation benefits to him.

Those cases in which vocational rehabilitation services—that is, the retraining of a longshoreman to engage in some other remunerative occupation—in my experience in handling cases under this act since 1948, where those employees who are permanently disabled to such an extent that they are willing to or can be persuaded to change their occupation, are few and far between.

If we assume that the present rehabilitation staff of the Department in the Longshore Act area is unable to meet the responsibilities imposed on it first in 1956 and unchanged since that time, I respectfully submit it is primarily because of the Department's attempt to look at every injury which produces as much as 6 to 8 weeks of disability as one of sufficient permanent disability and severity as to require consideration by its rehabilitation services. Certainly the various district offices with their experienced deputy commissioners and their direct contact with the claimants are in the best position to know when vocational rehabilitation services may be required and to have the professional staff of rehabilitation specialists literally screen thousands of cases is completely unnecessary.

The Department states at the conclusion of its position on vocational rehabilitation that:

> The overall aim of the program is to achieve the swiftest possible restoration of the injured worker to employment with a minimum residual disability.

The Congress may rest assured that this is also the overall aim of employers and insurance carriers under the act and in fact many insurance carriers have vocational rehabilitation departments of their own for this very reason. Congress has already provided the Department with all the authority it needs in this area, and all the Department needs to do is to proceed to operate their vocational rehabilitation services on a realistic basis.

2. MEDICAL SERVICES

The manner in which the Department has approached the 1972 amendments to section 7 of the act is directly responsible for substantially all of the increased workload in their district offices insofar as the monitoring of medical services is concerned. Prior to the 1972 amendments, the employer was required by the act to name a panel of physicians, whose qualifications all had to be approved by the Deputy Commissioner in the district office of the Department, and while for the most part injured employees were treated by doctors on the panel of approved physicians, if the employee was dissatisfied he could obtain a physician of his own selection or he could be sent by the Deputy Commissioner to a physician of the Deputy Commissioner's selection. Section 7(c) of the act was amended in 1972 to read as follows:

> The Secretary may designate the physicians who are authorized to render medical care under the Act. The names of physicians so designated in the community shall be made available to employees through posting or in such other form as the Secretary may prescribe.

The Department's response to this congressional mandate that they designate physicians authorized to render medical care under the act was a regulation which designated every physician in the United States "duly qualified * * * as defined by state law." When it issued this regulation, the Department lost any chance it had without the addition of literally hundreds of additional employees to comply with the congressional mandate that the Department actively supervise the medical care rendered to employees injured under the act. Control and supervision of medical care of necessity starts first with the selection and use of a well qualified doctor and in many instances a well qualified medical specialist to undertake the treatment at the earliest possible time following an injury. The "any doctor" designation of the Department means that any doctor, qualified or unqualified, and whether capable of recognizing the needs for a medical specialist or not may, undertake the treatment. By the time the district office receives the doctor's report, even if it is filed within the 10-day period provided in the statute, it may well be too late for the active supervision of the injured employee's medical care to be of any help to him simply because the doctor he selected did not have the experience or qualifications necessary to recognize the employee's need for a particular medical specialist before his physical damages from the injury had been irretrievably set.

The physical task of obtaining medical reports from doctors who are not familiar with the reporting requirements of the act or of the Department which meets the needs and requirements of the district office in trying to actively supervise the injured employee's medical care has undoubtedly been a formidable one.

Not only the Department's task of actively supervising the medical care to injured employees but the medical care actually received by these injured employees would be substantially enhanced and improved if the Department would face up to its responsibility to designate the physicians in the community who are authorized to render medical care under the act based on their qualifications, their experience, and their willingness to timely provide medical reports which are essential to any medical care supervision program. Until such time as the Department faces up to its responsibility in this regard it will continue to experience substantial difficulties in this area almost regardless of the number of employees it may have. As the Department's position paper clearly reflects, "The medical monitoring function is essentially that of obtaining and conducting a careful and continuing review of medical reports to insure prompt and proper medical care * * *." While the 1972 amendments were intended by Congress to improve the medical care of injured employees, the Department's failure to designate only those physicians that the Department through its district offices know to be qualified to treat industrial accident victims has in many instances resulted in poorer medical care and substantially increased the workload in the district offices. I think all will agree that the Department's designation of every licensed physician in the United States has not worked nearly as well as did the pre-1972 provisions for a panel of physicians to be selected by the employer, but to be approved by the Deputy Commissioners in the Department's district offices. I believe that I am safe in saying that had I known or had those with whom I worked on the 1972 amendments to the Longshoremen's Act from the management side of the maritime industry known that this amendment would have made any change other than to have a panel of physicians designated by the Secretary rather than by the employee subject to the approval of the Deputy Commissioners, any such change would have been vigorously opposed on the grounds that it would produce precisely what it has produced—a lower standard of medical care for injured employees and a tremendous increase in the administrative burden of the Department's district offices which is insurmountable under its present policies.

3. IMPROVED ASSISTANCE TO CLAIMANTS

While for the first time in the 1972 amendments, Congress by statute required the Department to furnish assistance to injured employees or their beneficiaries in processing and handling of their claims, for the Department to assert that this has required it or its district offices to take on more administrative responsibilities than they had prior to the 1972 amendments, is to reflect an absolute and complete lack of knowledge and information on what had been going on in the Department's district offices to my knowledge since I first started handling claims under this act in 1948. A claimant has always been able to get help and assistance from the Department's district offices in the filing of his

claim, in the processing of his claim, and in obtaining medical care and attention; yes, even in obtaining an attorney to represent him in the prosecution of his claim if litigation were necessary to resolve some disputed issue with the employer-insurance carrier.

The only additional assistance which the 1972 amendments required the Department to provide was legal assistance in the prosecution of his claim at a formal evidentiary hearing before an administrative law judge. Prior to the 1972 amendments, these formal hearings were held by the Deputy Commissioners, and since 1948 in the handling of such claims under the act, I have never experienced a single instance in which an injured employee did not have legal counsel available to him either of his own selection or upon recommendation of the Deputy Commissioner in the Department's district offices. If an appeal were filed or necessary, either the Department of Labor or the Department of Justice furnished attorneys for the prosecution of the employee's appeal, or for the defense of him if an appeal were taken by the employer and carrier.

Ironically enough, even though the 1972 amendments authorized the Secretary upon request from a claimant to provide legal assistance in the processing of a claim [33 U.S.C.A. sec. 939(1)], this is one provision of the act which has not been implemented. So far as I am aware, the Department has furnished no legal representation for any person covered by the act before an administrative law judge. To what then have the 13 staff positions in the Office of the Solicitor of Labor assigned to the Longshoremen's Act devoted their time and energies? They have devoted their time and energies to interjecting themselves in almost every case before the Benefits Review Board on behalf of the Director of the Office of Workers' Compensation Programs. This the Department has done by a bootstrap regulation which purports to make the Director a party at interest in any proceeding before an administrative law judge or the Benefits Review Board or the courts of appeals, or the Supreme Court of the United States. This was a regulation that the Department did not put into the proposed regulations that were circulated in January 1973 for comments from the industry but included in its final regulations in September 1973.

If the Solicitor of Labor's Office was representing the injured employee upon his request, it would be furnishing the legal assistance contemplated by Congress in the 1972 amendments contained in section 39(c)(1). However, the Department has participated in those cases in which either Department or the Director of OCWP or the Solicitor's Office were fearful that the administrative law judges or the Benefits Review Board or the courts might make a determination which was not in keeping with the views of the Department or the Director or the Solicitor of Labor's Office with respect to the manner in which the act should be interpreted. In substantially all, if not all of the cases in which the Solicitor has injected himself into the adjudicatory process, the injured employee or his beneficiaries and the employer-insurance carrier have been represented by counsel of their own selection who were fully capable of presenting the issues to the administrative law judge or the Benefits Review Board or the courts for decision.

In one such case after counsel for the employee and for the employer

and insurance carrier had fully stipulated all of the facts relating to a jurisdictional case and the matter was fully submitted by briefs to an administrative law judge for decision, the Solicitor's Office arranged for an extension of time in which it might file a brief, although it had not been requested to assist by the injured employee or his counsel. When the Solicitor's Office contacted the employee's counsel, it was suggested that on the stipulated facts there was no way the Solicitor's Office could support jurisdiction under the Longshoremen's Act and that the employee's attorney had stipulated himself out of court. No claim was made that any of the stipulated facts were not true, but only that something would have to be done to get the stipulations either changed, amended, added to, or in some way altered in order that the Solicitor might join the employee in urging that jurisdiction for this man's injury ashore was within the jurisdiction of the Longshoremen's Act.

The injection of the Department into the matter through the Solicitor's Office resulted in approximately a 6-month delay in the submission of that case to the administrative law judge for decision. As the Solicitor's efforts to establish jurisdiction were unsuccessful before the administrative law judge, the Solicitor has now filed an appeal to the Benefits Review Board, not on behalf of or at the request of the injured employee, but on behalf of the Director of the Office of Workers' Compensation Programs. Thus, so far as we are aware or as is apparent, the 13 positions in the Office of the Solicitor have been used almost exclusively, not in representing those persons covered by the act upon request as contemplated by the Congress, but in espousing either the views of the Department or the Director or the Solicitor.

Typical of such views is the position taken by the Director through the Solicitor of Labor's Office that in the 1972 amendments Congress, through oversight or otherwise, gave to the Deputy Commissioners in the local district offices a Russian veto over any agreed settlement which might be made under section 8(i) of the act when they urged upon and obtained a Benefits Review Board ruling that an administrative law judge and inferentially the Benefits Review Board, a court of appeals, and even the Supreme Court of the United States had no authority to approve an agreed settlement under the Longshoremen's Act. This case has been argued and is awaiting decision in the Court of Appeals for the Seventh Circuit at this time. Additionally, such a position was asserted by the Director through the Solicitor of Labor's Office to the same effect in the Court of Appeals for the Fifth Circuit who, without opinion, summarily rejected the Russian veto position of the Solicitor's Office. That this is the view of the Office of Workers' Compensation Programs in Washington is clear because it is common knowledge in the industry that the Washington office believes very few cases should be settled by agreement, and indeed some of their staff believe no cases should ever be settled by agreement.

And as an example of the Department's alleged objectivity in "insuring that the rights provided all parties under the law and regulations including employers are protected" (p. 5, par. 3) presumably by presenting both sides of such a question to the Benefits Review Board and to the courts of appeal, the Solicitor's Office deliberately

concealed from the Courts of Appeal for the Fifth Circuit the section of the statute which, in my opinion at least, clearly transferred to administrative law judges and to the Board and to the courts, authority to approve agreed settlements under section 8(i) of the act. Perhaps the participation of the Department, the Director, and the Solicitor in these cases could be justified if they could be counted upon to present fairly and impartially both sides of a disputed issue and not simply their own partisan and personal views as to how such an issue should be resolved. The West Gulf Maritime Association respectfully submits that the administrative law judges, the Benefits Review Board, and the courts are fully capable of resolving disputed issues under the act, and the maintenance of a staff of 13 in the Solicitor's Office solely for the purpose of espousing the views of the Department or the Director or of the Solicitor, is wholly unnecessary.

The Department now suggests that even though the employer and insurance carrier under the 1972 amendments must pay the fees of attorneys who represent the employee over and above any compensation to which the employee is entitled, that the employer-insurance carrier should now be assessed user charges to pay for 13 positions in the Office of the Solicitor of Labor to do precisely the same things for which the employer and insurance carrier are paying the injured employee's own attorneys. We respectfully submit it is for administrative law judges and the appellate tribunals to decide the issues arising under the Longshoremen's Act, and it is hardly necessary or appropriate for either the Department or the Director or the Solicitor of Labor to inject their own views into these proceedings. And this is particularly true when the Solicitor of Labor is required by statute to represent not only the Director, but the administrative law judges and the Benefits Review Board if any legal representation is required by them.

The extent to which the Solicitor's Office has been involved can best be demonstrated by looking at the decisions of the Benefits Review Board which have been published by Matthew-Bender. There are a total of 81 decisions from the Benefits Review Board which have been published up to this time in that service. In five of those cases, no counsel are shown on the cases. Of the remaining 76 cases in which the Benefits Review Board decisions have been reported in Matthew-Bender's service, the Solicitor's Office has been involved in 70 of them or more than 92 percent of the cases. Although there is no service yet which either publishes or digests the decisions of the administrative law judges, of the decisions we have from the administrative law judges for fiscal year 1974, the Solicitor of Labor's Office has participated in approximately 25 percent of those cases at the administrative law judge level, not as attorneys for the injured employee upon his request, but as attorney for the Director to espouse either his own views or those of the Solicitor or of the Department.

Apparently approximately 300 cases were placed on the docket of the administrative law judges under the Longshoremen's Act and the extensions thereof during fiscal year 1974. Of this total we are aware of written opinions in a total of 161 of these cases. Of these 161 cases a potential jurisdictional question under the Longshoremen's Act itself (not including any of its extensions to the Outer Continental Shelf,

defense bases, etc.) was involved in 144 of them. Of this total, 57 of them involved questions of jurisdiction relating to the extension of the act's jurisdiction ashore by the 1972 amendments. Thus more than 40 percent of the total cases decided by opinion by the administrative law judges docketed in fiscal year 1974 involved jurisdictional cases. Of those arising subsequent to the 1972 amendments, 57 out of 71 or 80 percent involved jurisdictional cases. We therefore think it is safe to assume that once the authoritative decisions from the courts are available on the extent to which the act's jurisdiction has gone ashore, the docket of the administrative law judges should show a drop in the number of cases by some 30 percent to 35 percent.

Additionally, we are unable to tell whether the 13 positions referred to in the Department's position paper (page 8, last paragraph) are for administrative law judges only or whether these 13 positions also include whatever secretarial or clerical help the judges might need.

We do not mean any of our comments with respect to the number of positions involved in the office of the administrative law judges to imply in any way a criticism of what they have done in the past or will do in the future, for we frankly have no information on the size of the case load for administrative law judges in the Department of Labor and we are aware that during fiscal year 1974 a total of at least 19 different administrative law judges heard cases under the Longshoremen's Act and its extensions. What we are suggesting, however, is that if the 13 positions sought by the Department in its position paper are for administrative law judges only, that we do not believe the caseload should be anticipated to be as great as would be necessary to require 13 full-time administrative law judges under the Longshoremen's Act alone. This is particularly true when we must anticipate a reduction in the number of cases for trial by the administrative law judges once the jurisdictional line on the extension of the act ashore has been more clearly drawn by the courts.

The West Gulf Maritime Association believes that the separation of the administrative functions from the judicial functions under the act by the 1972 amendments has been a very wise decision. While the complete separation of the adjudicatory functions from the administrative functions under the act were proposed and insisted upon by the staff of the Senate Subcommittee on Labor in connection with the 1972 amendments, I believe that this separation has made a substantial improvement in the adjudication of contested claims under the act. While as the committee would undoubtedly suspect, I have disagreed with the results reached by the administrative law judges in most of the jurisdictional cases and with the result which they reached in other cases as well, on a whole I believe the administrative law judges who have adjudicated claims since the 1972 amendments to the act are to be commended for their conscientious attempts to explain in detail not only the ultimate result or conclusion which they reached, but the evidence and the reasons which have caused them to reach that particular result. While as I have previously indicated, I do not agree with many if not most of their decisions, but I must respect them for the manner in which they articulate the basis of their conclusion, no matter how wrong I may think that conclusion is.

One other thing needs to be brought to the attention of the commit-

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tee with respect to the costs of administering the Longshoremen's Act. While the OWCP's district offices have had their workload increased by the shoreward extension of the act with respect to the injuries reported, et cetera, it should be borne in mind that with the equivalent of 13 full-time employees, if not 13 full-time administrative law judges having taken over the former responsibilities of the district offices to hold formal hearings and adjudicate claims in which contested issues were involved, to this extent at least, the district offices have had additional personnel available.

CONCLUSION

I call to the committee's attention one other matter relating to the Department's claim of an alleged increased backlog for which presumably it has not had sufficient funds available to obtain the necessary staff persons to handle the new injuries coming in from the extension of jurisdiction ashore. The annual Statistical Report dated October 1974 from the Department covering operations under the Federal Employees' Compensation Act and the Longshoremen's Act and its extensions contains table 3 which deals with appropriations and expenditures under all acts for salaries and expenses for fiscal years 1970–74. Attached to this statement as exhibit B is a copy of table 3. On the bottom of the page on which the Department's table is shown, I have added in ink the total expenditures for salaries and expenses for all acts after those expenditures for salaries and expenses for the administration of the Federal Employees' Compensation Act have been deducted. As these figures show, the salaries and expenses expended in administering the Longshoremen's Act and its extensions stayed fairly uniform at approximately $2 million per year for fiscal years 1970 through 1973, but in fiscal year 1974 the expenditures for salaries and expenses in administering the Longshoremen's Act and its extensions was $6,259,327, more than three times the expenditures for salaries and expenses for administering these same acts on an average for the preceding 4 years. With three times as much money expended for salaries and expenses (approximately $4 million) it is difficult to see how such an alleged backlog of cases could develop. With an additional $4 million having been expended for salaries and expenses in fiscal year 1974 compared to any of the preceding 4 years, and even allowing 50 percent of this increase or $2 million to cover the cost of the additional legal support in the Office of the Solicitor, for the administrative law judges and the Benefits Review Board, there was still $2 million more spent in 1974 for salaries and expenses in administering the Longshoremen's Act and its extensions than in any of the previous 4 years. And in addition to that table 3 shows that there was an additional $2,396,000 in funds available for salaries and expenses which apparently were not expended or used to any extent.

The West Gulf Maritime Association therefore respectfully submits that the Department has failed to show that user charges need to be imposed on the maritime industry for the regulation and/or administration of the Longshoremen's Act. Indeed, quite the contrary exists, for even using the Department's own unrealistic figures of a 109.8 percent increase in reported injuries, and an 86.5 percent increase in

lost time injuries in fiscal year 1974 compared to fiscal year 1972, an increase of 246 percent in expenditures for salaries and expenses in fiscal year 1974 compared to fiscal year 1972, amounting to $4,450,834, should have been more than ample to handle such increases.

If such a 246 percent increase could develop when Congress was looking at their request for appropriations, and would make them account for these expenditures, we shudder to think what would happen if the Department was given the requested authority to assess user charges against the maritime industry in whatever amount the Department might deem appropriate without limitation, except that the Secretary would explain how the costs on which the user charges were assessed were computed in submitting its annual budget to the Congress, not for Congressional approval but just as a matter of information.

If the salaries and expenses for administering the Longshoremen's Act can increase by more than 200 percent from one fiscal year to the next with their budget request requiring congressional approval, it is staggering to envision what increases might be in store for the industry if the Department was given the unfettered authority which they have proposed and advocated to this committee. The West Gulf Maritime Association respectfully suggests that the Department's proposed user charges should be rejected.

Respectfully submitted.

E. D. Vickery,
Attorney for West Gulf Maritime Association.

SUMMARY OF INJURIES REPORTED
TO THE
OFFICE OF WORKERS' COMPENSATION PROGRAMS
UNDER THE
LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT
BY DISTRICT
FISCAL YEARS 1970-1974

Compiled by: Division of Management Information & Computer Systems
Office of Administrative Management
Employment Standards Administration
U. S. Department of Labor
Washington, D. C.
September 1974

Exhibit A

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

ALL DISTRICTS

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES				Total Incomplete Cases
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION		
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal	
1970	80,891	99	80,990	64,813	1,645	14,335	32	1,279	82,104	5,599	759	12,658	258	19,274
1971	68,366	98	68,464	53,789	2,244	14,022	26	1,300	71,381	6,022	751	10,836	307	17,916
1972	57,845	95	57,940	45,937	1,402	12,189	67	1,460	61,055	5,239	709	10,736	182	16,866
1973	91,113	91	91,204	73,890	1,889	11,528	88	1,879	89,274	4,750	663	13,690	239	19,342
1974	136,678	140	136,818	109,999	3,451	14,108	64	1,658	129,280	6,200	729	20,103	194	27,226

Note: Beginning with FY 1972, the data shown for incomplete cases on this and each of the following tables is based on a physical inventory count taken at the end of the fiscal year, and may not be strictly comparable with data for prior years.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 1 - BOSTON

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	11,707	12	11,719	10,557	94	676	2	108	11,437	388	26	703	20
1971	7,663	5	7,668	6,538	105	798	1	100	7,542	506	27	794	22
1972	10,488	4	10,492	9,233	28	594	5	63	9,923	567	32	1,370	15
1973	16,158	7	16,165	14,329	54	673	2	236	15,294	678	33	2,438	23
1974	32,830	5	32,835	30,626	326	982	5	374	32,313	799	50	3,445	6

DISTRICT 2 - NEW YORK

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	6,744	5	6,749	3,566	77	3,137	-	562	7,342	2,067	144	4,916	48
1971	6,123	12	6,135	3,351	72	2,497	-	113	6,033	2,109	144	5,017	62
1972	3,958	11	3,969	2,820	123	2,880	17	207	6,047	1,902*	39*	4,612*	19*
1973	5,265	8	5,273	2,863	174	3,118	29	491	6,675	865	10	3,801	66
1974	8,758	26	8,784	3,470	154	1,901	12	118	5,655	1,735	60	4,847	40

* Breakout estimated.

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 3 - PHILADELPHIA

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	3,172	5	3,177	2,619	14	538	4	51	3,226	289	30	390	25
1971	2,524	4	2,528	2,118	50	630	2	42	2,842	191	43	299	13
1972	2,042	7	2,049	1,559	30	619	2	83	2,313	184	42	171	11
1973	4,669	8	4,677	4,030	47	467	2	52	4,598	160	49	371	11
1974	5,825	3	5,828	5,093	17	408	3	48	5,569	118	43	627	13

DISTRICT 4 - BALTIMORE

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	5,958	7	5,965	5,246	56	834	-	98	6,234	463	61	158	13
1971	6,163	4	6,167	5,459	46	528	2	131	6,166	533	57	395	16
1972	3,624	-	3,624	3,203	37	635	1	317	4,193	102	57	440	20
1973	7,716	2	7,718	7,010	68	621	12	106	7,817	171	49	433	5
1974	11,270	6	11,276	10,105	62	1,121	3	101	11,392	144	46	674	4

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 5 - NORFOLK

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	5,234	7	5,241	4,510	149	683	-	11	5,353	97	40	61	5
1971	3,068	5	3,073	2,511	125	537	1	23	3,197	93	41	46	3
1972	4,811	7	4,818	4,285	109	469	-	35	4,898	94	45	40	3
1973	14,822	4	14,826	13,821	325	709	5	21	14,881	112	37	36	3
1974	18,095	8	18,103	16,727	509	811	2	15	18,064	129	38	210	3

DISTRICT 6 - JACKSONVILLE

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	3,414	7	3,421	2,238	197	1,072	-	50	3,557	161	78	217	3
1971	3,116	6	3,122	1,910	264	888	3	129	3,194	176	36	230	45
1972	2,237	5	2,242	1,534	56	754	-	110	2,454	262	54	411	7
1973	3,941	8	3,949	2,346	204	825	1	128	3,504	249	75	1,144	16
1974	7,665	12	7,677	5,150	483	1,248	-	154	7,035	431	74	2,086	28

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 7 - NEW ORLEANS

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	21,553	26	21,579	19,347	261	1,766	6	178	21,558	451	141	1,252	98
1971	19,422	22	19,444	17,719	265	1,593	4	204	19,785	393	137	1,063	101
1972	11,518	24	11,542	9,745	231	1,551	14	254	11,795	391	171	995	48
1973	14,330	11	14,341	12,366	238	1,112	7	202	13,925	564	145	1,409	57
1974	17,715	26	17,741	14,830	461	1,737	6	194	17,228	502	152	1,880	49

DISTRICT 8 - GALVESTON

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	5,308	16	5,324	3,257	240	1,726	6	61	5,290	416	54	760	16
1971	5,429	11	5,440	3,489	201	1,827	4	81	5,602	505	55	694	15
1972	6,043	9	6,052	4,146	215	1,782	6	71	6,220	397	54	687	12
1973	10,129	12	10,141	7,696	215	1,661	7	47	9,626	493	60	1,190	14
1974	15,096	17	15,113	11,482	454	2,536	11	42	14,525	665	63	1,674	14

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 9 - CLEVELAND

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	1,246	4	1,250	952	26	215	-	19	1,212	185	41	61	9
1971	1,661	11	1,672	1,337	81	232	1	27	1,678	194	53	60	7
1972	1,495	10	1,505	1,151	103	233	3	59	1,549	192	52	72	15
1973	1,645	8	1,653	1,260	113	292	9	57	1,731	154	34	79	13
1974	1,854	7	1,861	1,306	125	319	5	70	1,825	209	37	125	11

DISTRICT 10 - CHICAGO

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	834	-	834	513	7	167	-	5	692	92	28	176	12
1971	1,125	-	1,125	668	175	372	1	31	1,247	100	27	65	10
1972	1,181	-	1,181	707	129	334	6	18	1,194	151	37	81	8
1973	1,286	3	1,289	833	138	222	1	12	1,206	245	57	111	2
1974	1,501	4	1,505	1,109	69	352	2	14	1,546	79	38	236	2

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 13 - SAN FRANCISCO

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	8,800	5	8,805	6,852	225	2,090	10	114	9,291	397	47	2,689	3
1971	7,009	7	7,016	4,811	646	2,600	6	366	8,429	631	58	1,597	1
1972	6,520	5	6,525	4,673	190	1,218	7	188	6,276	445	54	1,443	9
1973	6,044	8	6,052	3,970	136	884	7	492	5,489	446	40	1,858	13
1974	8,298	13	8,311	5,082	395	1,195	7	472	7,151	619	57	2,743	4

DISTRICT 14 - SEATTLE

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	COMPENSATED		Misc.	Total No. of Cases Closed	BEING COMPENSATED		AWAITING ACTION	
						Non-fatal	Fatal			Nonfatal	Fatal	Nonfatal	Fatal
1970	6,169	5	6,174	4,536	282	1,294	4	16	6,132	552	61	1,013	5
1971	4,565	11	4,576	3,486	206	1,420	1	47	5,160	553	65	514	10
1972	3,562	10	3,572	2,601	141	1,023	5	50	3,820	512	65	350	12
1973	4,754	8	4,762	3,123	164	854	6	30	4,177	576	67	754	11
1974	7,144	12	7,156	4,599	382	1,386	8	50	6,425	730	65	1,437	14

LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

DISTRICT 15 - HONOLULU

FISCAL YEAR	CASES REPORTED			CASES CLOSED						INCOMPLETE CASES			
						COMPENSATED				BEING COMPENSATED		AWAITING ACTION	
	Non-fatal	Fatal	Total	NLT	Covered by Waiting Period	Non-fatal	Fatal	Misc.	Total No. of Cases Closed	Nonfatal	Fatal	Nonfatal	Fatal
1970	752	-	752	620	17	137	-	6	780	41	8	62	1
1971	498	-	498	392	8	100	-	6	506	38	8	62	2
1972	366	3	369	280	10	77	1	5	373	40	7	64	3
1973	354	4	358	243	13	90	-	5	351	37	7	66	5
1974	627	1	628	420	14	112	-	6	552	40	6	119	6

TABLE 3. - Appropriations and Expenditures, All Acts; Fiscal Year 1970 - 1974

Period covered	Salaries and expenses			FECA Compensation Benefits under Federal Employees' Compensation Act	
	Funds available	Expenditures			
		All Acts	Federal Employees Compensation Act	Funds available	Expenditures
Year ending June 30:					
1970.....	$ 6,411,431	$ 6,409,925	$4,186,442	$131,535,958	$131,535,958
1971.....	7,337,000	7,264,088	5,279,558	163,214,939	163,214,939
1972.....	8,253,200	8,220,424	6,411,931	190,024,782	190,024,782
1973.....	9,250,963	9,207,265	7,106,000	220,910,398	217,770,190
1974.....	16,108,767	13,712,570	7,453,243	271,157,963	270,676,113

Total All Acts
Except
Federal Employees
Compensation Act

1970 .... $2,223,483
1971 1,984,530
1972 1,808,497
1973 2,101,265
1974 6,259,327

Exhibit B

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Mr. PATTEN. You have a small port down there. It is not as big as the Port of New York. I saw the Houston Channel you got down there that the Federal Government built.

Mr. VICKERY. If you pull the plug out of that, Mr. Chairman, you probably pull the whole plug out of the Houston economy because that is where all the major refineries and chemical plants are located.

Mr. PATTEN. It is terrific.

I have done a lot of compensation work and in my harbor—for there is a lot of traffic in Perth Amboy. So it would be a pleasure to exchange with you but I have to go vote.

We have all been contacted on this. I don't know whether you have done it or somebody else has done it. Every Congressman has received some literature. Are you aware of that?

Mr. VICKERY. No, I was not aware of it.

I know the Congressmen from our areas are interested in it.

Mr. PATTEN. It came out of Houston. There were pamphlets and news releases on the point you are making. Your report will be in the record. It will be digested by the staff because we have to make a decision on this.

Mr. VICKERY. Fine; thank you, Mr. Chairman.

Mr. PATTEN. The hearing is recessed until 10 o'clock tomorrow.

THURSDAY, MAY 22, 1975.

RURAL HOUSING PROGRAM

WITNESS

HON. CARL PERKINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. FLOOD. The committee will be in order.

Our first witness will be the distinguished gentleman from Kentucky, the chairman of the House Committee on Education and Labor, Hon. Carl Perkins, who has been here before 25 or 30 times.

Mr. PERKINS. Let me thank the distinguished chairman of the subcommittee for permitting me to put in an appearance again on behalf of the rural housing program.

Mr. FLOOD. If you weren't here, we would send an armed guard to bring you over.

Mr. PERKINS. We would like to have $15 million in this program but if you can't give us the 15, give us somewhere between 10 and 15 because it is one of the greatest programs I think we have for our rural people. We are getting it started.

In communities of 25,000 or less, only 1.1 percent of the money from HUD goes into these rural areas throughout America.

Mr. Chairman, I want to thank this distinguished committee for the opportunity to appear before you and comment on the first budget request of the new Community Services Administration. The CSA, and its predecessor OEO, have had an awesome responsibility—finding the causes of, and ways to end, poverty in this great Nation. Much

remains to be done, and that is why continuation of CSA is so essential.

I want to address myself today to the problem of bad housing in rural America. With less than 30 percent of our Nation's population, rural areas suffer 44 percent of the poverty and 60 percent of the substandard housing. One house in five in rural areas is substandard while only 1 in 25 in urban areas is substandard. In other words, the incidence of bad housing is five times greater in rural areas, than it is in urban areas. In some counties of Appalachia, one out of three houses is substandard, without some or all plumbing, or is overcrowded. These are statistics drawn from the 1970 census and while they are bad, they certainly do not tell the story of human suffering borne by all too many in our country.

Mr. FLOOD. You are not restricting your comments on what we call Appalachia. You and I should know about that. This is nationwide.

Mr. PERKINS. This is nationwide.

The response of the Federal agencies has been limited at best. Even before the ill-advised moratorium on subsidized programs in January 1973, the Economic Research Service of the USDA issued a report titled "The Social and Economic Condition of Rural America in the 1970's," which showed that the total expenditures for housing, excluding public housing and rent supplements, was $91 per capita in metropolitan counties and $35 per capita in rural counties. Some of this disparity between rural areas can be traced to poor communication—people don't know housing programs exist. In addition, I have found that many rural areas don't have the expertise available to make use of the resources which are available from HUD, FmHA or State agencies.

For this reason, in 1972, I introduced Section 222(a)(11) of the Economic Opportunity Act. This section provides the technical and financial tools to groups in rural areas trying to improve housing conditions for those with very low incomes. Section 222(a)(11) permits the flexibility to engage in new construction, rehabilitation, or repair of existing structures. It also encourages the use of various job training programs, such as CETA, in these efforts. I might say, parenthetically, that there are a number of fine examples throughout this country of CAP's and nonprofit groups combining job training and employment programs to build and repair housing for low-income people. In my own district, the Eastern Kentucky Housing Development Corp. has repaired 2,500 houses using Mainstream trainees and is a model for such activity. This group is now producing new houses as well. There are a number of such examples throughout the country of nonprofit groups providing desperately needed housing services to poor people.

Such a program carries with it additional benefits related to energy conservation and rural economic development, both of which are of tremendous importance at this time. For all of the reasons I have cited I urge the committee to earmark $10 to $15 million for section 222(a)(11) so that this tremendously important work can continue.

Thank you for the opportunity to appear before you.

I would like to put in the record my full statement and some statistics and backup data. When any of the members look at this certainly they can't afford, in my opinion, to vote against an appropriation of at least $12,500,000.

Mr. FLOOD. Without objection that will be done.

[The information follows:]

While the housing problems of the American cities have been encounted by various interests in different ways for some time, the housing crisis of rural America has suffered from relative obscurity. Indeed the metropolitan areas have concentrations of poverty and substandard housing, but the nonmetropolitan areas have a disproportionate share of obth poverty and substandard housing. With only one-third of the Nation's population, nonmetropolitan areas contain nearly one-half of the Nation's poor and about two-thirds of this country's substandard housing. According to 1970 census figures, 1 home in 5 is substandard in rural areas while 1 in 25 is substandard in cities. Put another way, the rate of bad housing in rural areas is five times that in the cities.

In spite of the higher incidence of substandard housing in nonmetropolitan areas, the Federal Government's emphasis has been biased in favor of urban areas. A report by the Department of Agriculture's Economic Research Service entitled "the Social and Economic Condition of Rural America in the 1970's," shows that as of 1970 total housing expenditures (excluding public housing and rent supplements) worked out to $91 per capita in metropolitan counties and $35 per capita in most rural counties. A study by the Office of Economic Opportunity on distribution of selected Federal outlays by Federal agencies shows that the Department of Housing and Urban Development (HUD) in fiscal year 1973 spent over 91 percent of its funds in metropolitan areas compared to less than 9 percent in nonmetropolitan areas. The study appears in the "Fifth Annual Report of the President to the Congress on Government Programs in Rural Areas." (See exhibit I.) Indeed as the one Federal agency charged with the task of housing the American needy, HUD has largely ignored the rural poor.

Farmers Home Administration (FmHA) has several housing programs that can serve some of the housing needs of low-income rural Americans, but a gap between FmHA and the rural poor has prevented greater housing production activity with FmHA programs. FmHA is not an outreach agency and many people are unaware of FmHA housing programs much less how to take advantage of them. Recent cuts in FmHA staff have made the problem worse.

In 1972, I introduced an amendment to the Economic Opportunity Act, section 222(a)(11), known as Rural Housing and Rehabilitation or the Perkins Amendment. Section 222(a)(11) is in the new Community Services Administration Act. The activities permitted under the provision are very flexible and can fill the existing gap between FmHA and the rural poor. The provision authorizes funding for nonprofit organizations and cooperatives to assist families 'to construct and acquire ownership of adequate housing, to rehabilitate or repair existing substandard units . . ., and to otherwise assist families in obtaining standard housing." Organizations funded under this provision would educate and assist families with FmHA programs to make fuller use of them.

I am here today to request that a sum of $10 million to $15 million be earmarked for the amendment. (See exhibit II.)

The Office of Economic Opportunity, using research and development funds, has funded several organizations to do the work described in this amendment and the results have been very favorable. These organizations have made it possible for countless rural families to utilize FmHA and other housing programs and, consequently, to obtain decent housing.

Colorado Housing, Incorporated (CHI) is one such organization. CHI has been in existence since 1971 and with a budget of $168,000 per annum has affected approximately $36 million of home building and rehabilitation. CHI has worked with local housing authorities and nonprofit organizations and has assisted them in getting approximately 1,800 units built and repaired for rural low-income families. CHI worked out an arrangement with HUD to allow small local hous-

ing authorities to apply for housing funds as a group, thereby giving them a better chance at funding when pitted against large urban housing authorities. The grouping also simplifies the application process as well as the management chores. Families have been provided homeownership counseling assistance by CHI to help them retain their homes despite tight family budgets.

The Eastern Kentucky Housing Development Corporation is another OEO-funded organization that has given rural low-income families an opportunity to obtain decent housing. The corporation owns a factory that builds housing components and has built 50 new homes and repaired another 2,500. The corporation helps families prepare applications, identifies property for construction, and performs all the necessary functions from initial applications to complete construction of homes. The corporation assists families who do not have the financial capability to get the services of private builders. In the process of building and repairing, the corporation has also trained about 100 people to do construction work. Through flexible funding, these agencies have been able to provide these services and others to rural residents.

Since HUD is not responding adequately to the housing needs of the rural poor and since FmHA housing programs, to a large degree, have not reached them, the funding of this rural housing amendment is crucial. Organizations working with the rural poor should be strengthened and their number increased so more rural households can have an opportunity to obtain decent housing for their families.

APPALACHIA

* * * In rural Appalachia, nearly one out of every four families lives in substandard [1] homes. (HAC estimate)

* * * In Harlan, Letcher, and McDowell Counties, half the housing is substandard.[1] (Census)

* * * In Central Appalachia, more than a third of all homes lack essential plumbing. (Appalachian Regional Commission)

* * * The incidence of poverty in Central Appalachia is 36 percent. (ARC)

* * * Throughout Appalachia, unemployment is twice as high as the rest of the Nation. (ARC)

SOUTH AND RURAL BLACKS

* * * Over half of the rural units valued at less than $5,000 are in the south. (USDA)

* * * Two-thirds of all rural housing lacking complete plumbing is in the south. (USDA)

* * * Nearly half of all black-occupied housing in the rural south lacks complete plumbing (USDA)

* * * Nationwide, nearly two-thirds of all black-occupied rural housing is substandard.[1] (Census)

* * * In the south, substandard [1] rural housing is three times as prevalent among blacks than whites. (USDA)

FARMWORKERS

* * * About 300,000 migrant families lack decent housing. (Senate Subcommittee on Migratory Labor)

* * * The average migrant shack consists of two rooms. The average family size is 6.4 (United Farm Workers)

* * * Over 95 percent of all farmworker homes lack a flush toilet. (United Farm Workers)

* * * Over 90 percent of all farmworker homes lack even a sink. (United Farm Workers)

* * * The average life expectancy of a farmworker is only 49 years. (General Accounting Office)

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[1] Substandard is defined here as lacking essential plumbing and/or being overcrowded.

TABLE 4.—DISTRIBUTION OF SELECTED FEDERAL OUTLAYS, BY AGENCY, ACCRUING TO SUBSTATE PLANNING AND DEVELOPMENT DISTRICTS, FISCAL YEAR 1973

Agency	United States (millions)	Greater metropolitan (percent)	Lesser metropolitan (in percent)		Totally nonmetropolitan (in percent)		
			50 percent or more of the population in SMSA counties	Less than 50 percent of the population in SMSA counties	With 50,000 or more urban residents	With 25,000–49,999 urban residents	Less than 25,000 urban residents
Department of Agriculture	$12,621	13.1	28.9	15.0	19.3	11.9	11.9
Department of Commerce	335	20.0	33.1	17.2	14.8	7.8	7.0
Department of Defense	64,861	52.1	34.2	3.8	7.0	2.0	.9
Department of Health, Education and Welfare	73,628	46.3	30.2	7.3	9.0	3.8	3.5
Department of Housing and Urban Development	10,320	52.2	35.8	3.9	5.5	1.6	1.1
Department of the Interior	837	16.9	32.1	2.7	17.2	13.7	17.4
Department of Justice	896	35.5	47.0	7.8	7.5	.6	1.7
Department of Labor	3,942	47.2	35.0	5.8	6.9	2.2	2.9
Department of Transportation	5,347	44.5	28.2	6.8	10.1	4.2	6.3
Atomic Energy Commission	2,808	38.1	35.4	9.0	9.3	3.8	4.4
Environmental Protection Agency	1,599	53.4	31.9	2.0	9.3	2.0	1.3
National Aeronautics and Space Administration	2,952	75.2	22.7	1.0	.3	.2	.6
Office of Economic Opportunity	663	51.3	28.7	4.7	7.4	3.8	4.0
Railroad Retirement Board	2,539	38.6	34.9	7.9	10.6	4.1	3.8
Small Business Administration	3,476	28.0	39.9	15.2	9.0	4.1	3.8
Veterans' Administration	15,418	50.8	33.4	4.9	6.5	2.3	2.0
ACTION	64	53.4	26.0	7.7	7.0	2.7	3.2
Department of the Treasury	6,636	32.3	44.4	9.1	8.3	2.8	3.2
Civil Service Commission	6,223	62.8	22.2	4.2	5.7	2.7	2.4
Total	215,165	46.5	32.3	6.3	8.4	3.4	3.0

Source: Office of Economic Opportunity data.

Mr. FLOOD. Because of your prestige and knowledge, particularly on Appalachia, and as chairman of the committee of jurisdiction, your testimony does rate.

Mr. PERKINS. I think I am going to drive through that country today, and when you drive through the outdated mining towns where the marginal operations were put out of business by the hundreds, when you see a lot of strip mining on top of the mountains, but see 90 percent of the homes without water and sanitation in them, it makes you shudder. It is time for us to begin to tie something together to do something about it.

Mr. FLOOD. Thank you very much.

CYSTIC FIBROSIS

WITNESS

DR. PAUL R. PATTERSON, PROFESSOR OF PEDIATRICS AT ALBANY MEDICAL COLLEGE AND DIRECTOR OF THE CYSTIC FIBROSIS AND PEDIATRIC PULMONARY CENTER

Mr. FLOOD. Now we have Dr. Paul R. Patterson speaking for the Cystic Fibrosis Foundation.

Dr. PATTERSON. Mr. Chairman, thank you for the opportunity you have given us to testify before you regarding appropriations for programs relating to cystic fibrosis.

I am Dr. Paul R. Patterson, professor of pediatrics at Albany Medical College, and director of the Cystic Fibrosis and Pediatric Pulmonary Center there.

As have nearly all those persons engaged in biomedical research, I have watched with great pleasure the work you have been doing to assure adequate funding in the field. We all know of the constant battle in which you have been engaged over the last 6 years to assure decent levels of funding, in opposition to the annual administration requests for cutbacks. We know it has not been easy, as each time you found it necessary to rally your colleagues in the Congress in House debate on appropriations but also to rally them against what seems to be a constant stream of impoundments and rescissions.

I know that in the field of research on cystic fibrosis and other lung and digestive diseases that affect children, our researchers and health teams have had their morale buoyed up time after time by your constant successes, in assuring appropriations to continue the necessary work.

Mr. Chairman, representatives of the Cystic Fibrosis Foundation have appeared before you for many years, and we have learned that you and the committee know a good deal about the problems we confront, and the work we do. It is unnecessary for me at this time to go over in detail the problems, the cost of care, and the mechanisms for support of research and care.

However, as there are new members of your committee who might not have full information at their fingertips regarding these concerns, I would like to insert at the end of this statement the relevant portions of the testimony I gave last year before the Ways and Means Committee, during their hearings on National Health Insurance. This testimony developed, in comprehensive detail, the information necessary for Congress to make an informed judgment on the needs of the field. I turn now to our specific concerns on appropriations for upcoming fiscal year 1976.

Generally, there are two major areas of the Federal Government concerned with research and care related to cystic fibrosis and other children's lung and digestive diseases that I wish to discuss with this committee.

They are the Maternal and Child Health Services and the National Institutes of Health.

MATERNAL AND CHILD HEALTH SERVICES

Mr. Chairman, we have recently been informed that the Pediatric Pulmonary Centers currently being supported by the Maternal and Child Health Services program will be funded for at least 1 additional fiscal year beginning July 1, 1975. As I am sure you are well aware, our centers program for several years has been supported by Federal grants in an almost haphazard way. In recent years, funding came through the regional medical programs, and recently, with the phasing out of that program, the Maternal and Child Health Services program has undertaken the funding responsibility. But that program

itself has suffered from the impoundment, rescission, and cutback activity of the administration, so much so that it is not until very late in the fiscal year do we know whether the centers will be funded for the upcoming year. As you are well aware, this creates very great uncertainty in the centers, even as to whether they will be continued the next year. Personnel are upset, not knowing whether they will be retained. Patients and their families are upset, because they do not know whether the excellent care given in the centers will be continued, and because they fear that if Federal support is removed, the reduction in quality and quantity of care may well cause the illness to become more unmanageable, and perhaps fatal.

It seems to us that a stable base of funding at a reasonable level is required. We are entirely supportive of the proposal by the Association of Pediatric Pulmonary Centers that there be earmarked this year a $3.6 million appropriation for these centers, and we hope that this committee will include in the bill report specific language stating that these programs shall be continued and be given some stability. That appropriation would permit the 10 programs now in existence to continue, and would permit, in addition, the establishment of two new centers in areas of this country needing the services of an expanded pediatric lung disease center.

I would like to comment also on the total maternal and child health budget.

We have reviewed extensively the budget justification submitted to the Congress on behalf of the administration for maternal and child health programs, recommending an $83 million decrease in the appropriations level from fiscal year 1975. This decrease of approximately 28 percent is, in therory, to be absorbed by States, but as we know, their financial burdens are equally as difficult as those of the Federal Government. We also beileve that this significant decrease would affect many fine programs that have been established and funded and are providing care to thousands of mothers and children on an annual basis.

We further understand that the proposed funding level for fiscal year 1975 to accomplish current program objectives under the maternal and child health programs and to provide for appropriate inflationary increases would mean that an authorization level of $346.6 million would be needed for fiscal year 1977.

It is becoming clear that despite the excellent support of the Congress for this program, the Department of Health, Education, and Welfare has not been able to implement it properly. And for what reason? Specifically, we have observed over the last several years the decrease in staff support available to States and potential grant applicants to receive assistance from HEW personnel. It is our understanding that there are currently only 102 positions available to the maternal and child health programs where it is believed that as many as 160 positions would be necessary to implement adequately the congressional intent.

While we are dealing with the question of the maternal and child health program, I would like to comment on two administration proposals, which may have serious impact, which are under consideration

by the Secretary of the Department of Health, Education, and Welfare and the Congress.

The first proposal is to eliminate section 516 of title V of the Social Security Act dealing with maternal and child health. As you know, this section was enacted by Congress to provide the formula basis for maternal and child health funds allocations to the States. The intent was to avoid having any State appropriation fall below its previous level for fiscal year 1973.

If this section is enacted, the result would be that States would experience, on an overall basis, a decrease in the matching formula funding levels for maternal and child health programs. We encourage the Congress not to consider this proposal favorably because of its adverse impact upon the important programs supported through title V.

NATIONAL INSTITUTES OF HEALTH

Many of the basic and applied research programs of NIH are related to our field of endeavor. Several of the Institutes are of particular importance to us, and our concerns about them are detailed below.

However, I would like to say a few words about the general funding levels for NIH. As you know, the fiscal year 1975 appropriation agreed to by the Congress was a little more than $2 billion. The administration's requested budget for fiscal year 1976 is for $1.8 billion. This 10-percent reduction overall in the NIH budget, simply, is unreasonable. The administration certainly must know that we have had more than a 10-percent inflation rate this past year, and will have probably a similar rate this year. Thus, rather than a next year reduction of 10 percent overall, the inclusion of the 10-percent inflation rate would mean that NIH programs are in fact being cut back at least 20 percent.

If any of us, as your constituents, can assist you in preventing this reduction, we will be glad to support you in any way possible.

Now I would like to comment on the funding levels for the various Institutes which fund projects in our area of concern.

NATIONAL HEART AND LUNG INSTITUTE

This Institute provides the largest amount of funding for the study of pediatric lung diseases, and a reasonable level of funding is mandatory, if we are to make any progress in the field. However, for the total Institute the administration has requested an appropriation of $292,794,000 for fiscal year 1976, down from $324,130,000 in fiscal year 1975, a drop of over $21 million, or just about 10 percent. However, in the area of pediatric pulmonary disease, the 1976 figure requested is $3,290,514 as compared with $3,708,250, a decrease of $417,746, more than 11 percent.

As I indicated earlier in the testimony, such a cutback, added to inflationary increases, will simply mean that in fact about 20 percent less research will be done next year than the present year if the ad-administration has given justification for this Institute's appropriation request because they have stated that "Pediatric pulmonary diseases present health problems of national dimensions." It is hard to understand why if this is so, much a severe budgetary cutback is requested.

Of course, research going on in other areas of lung disease are important to us as well, and as we study the administration recommendations for appropriations for next year for all of them, we see that the cutback has been just about the same, percentagewise, for each of them, including studies on the structure and function of the lung, emphysema and chronic bronichitis, fibrotic and immunologic lung disease, respiratory failure, and pulmonary vascular disease.

We believe that rather than cutting back the appropriation this year, in fact the budget should be increased to a more reasonable $370 million.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

In this Institute, the administration proposes a cutback from the tration would reduce that level to $148 million next year, a decrease again, of just about 10 percent. This institute has a number of research programs of interest to us, concerned as it is with allergic, immunologic, and infectious diseases.

We know how severely this Institute is strained by the decreasing personnel levels. Programs simply cannot be administered without a steady personnel base. Yet the administration's budget would propose that the total number of permanent positions be decreased from 593 in the present fiscal year to 587 for next year.

Our recommendation is for a funding level of at least $140 million.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASE

Cystic fibrosis is also a metabolic disorder, and NIAMDD has a number of research programs of interest to us.

NIAMDD's current appropriation is $173 million, and the administration would reduce that level to $148 million next year, a decrease of $25 million, which is a decrease of nearly 15 percent. In the area of metabolism studies, we find a reduction of from $22 million last year to $19 million proposed for next year, a $3 million decrease.

We recommend that the current appropriation of $173 million be increased to at least $195 million.

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

This Institute deals, as part of its task, with research in the area of genetics. Inasmuch as cystic fibrosis, and some other respiratory disorders, are genetically inherited, this work is vital to us. The administration budget would decrease the budget for this Institute from $187 million to $161 million to about $42 million.

The study of the human cell and its genetic system is basic research that is fundamental to our hopes for eventual prevention of the disease. To cut back now on these funds, when the entire field of cell biology is exploding with new discoveries, would be unfortunate in the extreme.

We recommend that the current appropriation for this Institute be at the level of at least $210 million this year.

Thank you for your attention, I would be pleased to answer any questions you may have.

Mr. FLOOD. We have done pretty well so far with them.

Dr. PATTERSON. Yes, we have.

Mr. FLOOD. I heard about the resistance movement worldwide but this subcommittee turned out to be the resistance movement lately.

Dr. PATTERSON. I think you have done a marvelous job. You have our gratitude. If we can do anything for you to help, we certainly hope you ask for our services as well.

UNEMPLOYMENT INSURANCE

WITNESSES

FRANK WALSH, PRESIDENT, INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES AND ADMINISTRATION, WISCONSIN EMPLOYMENT DEPARTMENT

JOHN CLARK, ADMINISTRATOR, BUREAU OF EMPLOYMENT SECURITY, PENNSYLVANIA

ROBERT C. GOODWIN, ASSOCIATE ADMINISTRATOR, INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES

Mr. FLOOD. Now we have Mr. Frank Walsh, President, Interstate Conference of Employment Security Agencies and Administration, Wisconsin Employment Department.

Mr. WALSH. I would like to introduce the two gentlemen who are with me. I am sure you know the Administrator of the Employment Security from your own State, Mr. John Clark, and Mr. Bob Goodwin who is a member of our secretariat for the Interstate Conference here in Washington.

Mr. FLOOD. I would like to see you break in these new fellows.

Mr. WALSH. Mr. Chairman and members of the committee, my name is Frank Walsh. I am Administrator of the Wisconsin Employment Security Division and President of the Interstate Conference of Employment Security Agencies, Inc. I appreciate the opportunity to appear before your committee to present the Interstate Conference views on the administration's 1976 States grants budget request.

In our Federal-State system, the States run the unemployment insurance and employment service programs. The public looks to us for efficient and effective service. In recent years budget decisions for State grants have not been adequate to meet urgent local and State needs. We therefore appreciate the opportunity to state our case.

UNEMPLOYMENT INSURANCE

Although we are concerned with both unemployment insurance and the public employment service, we are not now requesting an increase in funds for unemployment insurance. We accept the decision of the Manpower Administration that any additional needs for UI should be submitted in a supplemental after more workload information is available and the extent of carryover from 1975 funds is known. We do ask that all of the UI funds appropriated for fiscal 1976 be made available as base budget and not contingency. The budget constructed in the fall of 1974 made the assumption that UI claims would average 1½ million per week for the year. The figure is more like 5 million.

That budget base is important because it is the foundation for determining "other than personnel" costs. It has been necessary for the Department of Labor to allocate funds to meet some of these additional costs this past year, but this practice does not permit adequate planning.

This whole problem needs careful study for a sound, long-term solution. State problems would be mitigated, however, if the total amount of this appropriation were made available to the base. There would still be a substantial sum available for contingency purposes from the $249 million urgent supplemental.

EMPLOYMENT SERVICE

Employment Service funding is another matter. In the opinion of my fellow State Administrators, it has been seriously underfinanced for several years. This problem will assume crisis proportions under the administration's 1976 request.

From 1967 through 1974 Employment Service personnel strength to get jobs for people ranged from 30,100 to 31,000 positions. Although there were no sharp cuts during this period, neither were there increases to take care of growth in the labor force. The ratio of ES staff to labor force: 1967—1 to 2,527; 1974—1 to 3,098; 1976—administrative request—1 to 3,432.

Employment Service workload goes up as unemployment increases. Ratio of ES staff to unemployed—at any one time: 1967—1 to 97; 1974—1 to 169; 1976—administrative request—1 to 275.

In fiscal year 1975, the administration requested funding for only 27,400 State and local office positions to help get jobs for people. The impact from this cut surfaced late in fiscal year 1974 when reductions were made by the Manpower Administration to dovetail with the lower funds anticipated beginning July 1, 1974.

You will recall, Mr. Chairman, that the Interstate Conference took these problems to the Congress, with the result that you appropriated $41 million more in the 1974 supplemental with a provision for carryover to fiscal 1975. The appropriation was late in the year, with the result that the full $41 million was carried over to fiscal 1975.

In addition to the carryover, the Congress increased the fiscal year 1975 funds available to the Employment Service by $18.5 million over the amount requested by the administration.

All together, for fiscal year 1975, Congress made available for the Employment Service $503,400,000, which would have financed 30,960 jobs.

By these actions the Congress said, in effect, that the Employment Service effort to get people jobs should be strengthened and that the cuts made in recent years should be at least partially restored. Unfortunately, not quite all of the $41 million was released to the States, and none of the $18.5 million. Meanwhile, the State agencies had to shift ES staff to take UI claims as layoffs in industry climbed and unemployment rose.

Thus, although the congressional intent seemed clear that these additional funds were to be used to strengthen the Employment Service, a large part of the money was withheld.

The workload experience of the employment security programs during the past 6 months is too well known to require repetition in detail.

UI claimants seeking help from the employment service have more than doubled in number during that period.

CURRENT REQUEST

In view of this experience, we are coming back to the Congress with a request that we believe represents the smallest amount possible if the ES in this country is to do an acceptable job in helping the unemployed in their search for jobs. We also ask that the Congress make it clear that ES staff is to be used for referrals to jobs and related services.

In order to arrive at the rockbottom job search needs of the unemployed, the Interstate Conference has conducted a survey among the State employment security agencies to determine the minimum resources necessary to meet those needs. The conclusion was that we need 31,035 jobs at a total employment service cost of $562,100,000. This is 3,735 jobs more than the 27,300 jobs requested by the administration and $68,500,000 more than the $493,600,000 requested by the administration.

We estimate that, with the proposed increase, the public employment service will make up to 4.5 million nonagricultural job placements in fiscal year 1976 and about 1.5 million agricultural job placements. It will counsel about 1 million jobseekers and provide labor market information to several million more which they would use in their own job search.

Without the increase, at the staff level proposed by the administration, we estimate that nonfarm placements will drop to about 3.8 million and that placement service to the agricultural sector and job market information to all jobseekers will decline to the lowest levels in recent years. The administration placement estimates for fiscal year 1975–76 cannot be accomplished with the staffing they proposed.

The ICESA request of $562,100,000 to finance 31,035 positions for fiscal year 1976 would cost less than $100 for a unit of job placement or counseling service. This does not include the benefits of the labor market information provided to other jobseekers. Thus the cost to the Nation to help a man or woman who wants to work and who comes to the local employment office looking for work would be modest.

It would cost less than a week and a half of unemployment insurance benefits for an individual.

It would be less than 2 weeks of welfare benefits for a family.

It would cost less than a week of public service employment wages.

Unfortunately, the administration's request is based on an estimated 8.3 percent unemployment rate in fiscal year 1975 and 8 percent in fiscal year 1976. But the unemployment rate was 8.7 percent in March 1975 and 8.9 percent in April. Administration spokesmen say that it may go somewhat higher before it begins to decline appreciably in the middle of fiscal year 1976.

Between two-thirds and three-fourths of all unemployed jobseekers at some time during the year come to the public employment service for job finding assistance.

Even in times of recession jobs are available. Turnover alone runs about 2 percent a month (or 24 percent a year) due to retirement, illness, and production changes. The jobs that are open should be located and filled promptly.

Unemployment duration for jobseekers can be reduced significantly, even in times of economic downturn, when job search assistance and labor market information are provided, according to a recent Arizona State University study.[1]

The President said recently, when he signed the tax bill, that he would consider spending for "urgent humanitarian needs."

Certainly, speeding up job finding and matching of jobseeker qualifications with employer job requirements is such an urgent need. No job at which someone could earn a living in this country should be open—even for a few days or a week—if a qualified person can be found to fill it.

Jobless people can't afford to spend much on job hunting. They may be contacting certain firms, while other firms have the openings. It makes sense to have as many jobs listed as possible in one place, the local employment service office, and to have that office staffed so that it can move quickly to match job openings and jobseekers. The Employment Service is the one nationally available system that exists to get people and jobs together.

With increased applicant workloads, additional employment service positions are needed to restore our capability to:

1. Help find all possible job vacancies and to do so quickly to help in the effort to get jobs for people and people for jobs at a time of unusually high unemployment.
2. Speed job filling. Filling jobs promptly is a boost to the economy.
3. Find openings in a wide range of job opportunities and offer them to unemployment insurance claimants and welfare clients to help determine that they are available for work.
4. Provide special help through counseling and personalized placement assistance to those who need it—handicapped, youth, veterans, and the disadvantaged.
5. Assemble labor market information for those jobseekers who find it necessary to change their occupation or field of work, or are able to use the information in their own job search.

To summarize: The additional funding we request is needed for three compelling reasons:

1. To avoid a further reduction of ES personnel at a time of unusually high workload resulting from high unemployment.
2. To meet increased costs due to inflation; salary costs are up 11 percent and nonpersonal services 7 percent.
3. To restore recent cuts. At no time from 1967 to 1973 did the Employment Service resources to get people jobs fall below 30,300 positions. In fiscal year 1974 it was 30,100 positions. The administration's request for fiscal year 1976 is 27,300 positions. In the face of recession, it is hard to understand the rationale for reducing the effort to help people get jobs by over 12 percent below the level approved by the Congress for fiscal year 1975.

OTHER NEEDS

The ICESA request does *not* include the additional requirements which are being made of the States for employment services. Neither

[1] "Private Returns to Public Investment in Job Search Assistance," by Kingston and Burgess, Arizona State University at Tempe, 1974.

does the administration budget cover these additional workload requirements.

Perhaps the most serious omission is further extension of computerization of job matching. First steps to modernize the ES job-matching system were taken 7 or 8 years ago. Highly successful experiments have been carried on since that time in several States, including my own State of Wisconsin. For example, these systems have increased placements in Corpus Christi, Tex. as much as 25 percent while placements elsewhere in the States were decreasing. In Wisconsin we have an even larger increase. However, due to budget stringencies, online job matching has not been extended widely and we are running the danger of trying to meet the problems of a modern world with an obsolete system of matching. Could such systems merely result in placing each of the 13 million applicants served by the Employment Service 1 day sooner, the reduction in UC payments and benefits to the economy would easily bear the cost of the system. If these systems helped in finding jobs for just 10 percent of these applicants we register but are unable to serve each year, the payoff would be even more significant.

The Conference Board of Directors takes the position that the extension of computerized job matching is highly important and urgent. My discussion with officials of the Manpower Administration led me to believe that they share our concern for lack of progress in this area.

Another requirement is for effective implementation of Judge Charles R. Richey's court orders on a broad range of services for migrants and seasonal farm workers—equity of access to services, particularly in rural areas.

Finally, we are required to give special assistance to workers unemployed because of recent Federal trade legislation.

The State agencies must perform these functions, even at the expense of other vital functions. This emphasizes the minimum necessity of the additional funds we are requesting.

Thank you, Mr. Chairman, for the privilege of testifying today.

[The information follows:]

THE INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, INC.

MEMBERS

ICESA is the official organization of the administrators who manage the public employment services and unemployment insurance programs of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

HISTORY

For 36 years, ICESA was a voluntary association of State public employment security agencies. Its Washington staff was paid by the Department of Labor. In June 1973, ICESA was reorganized as a private, nonprofit corporation, financed by all member agencies.

ORGANIZATION

An elected Board of Directors governs ICESA activities under the policies approved by all members agencies.

OBJECTIVES

To improve the public employment service, unemployment insurance programs, and manpower programs.

To encourage effective State action in training and placing unemployed workers,

paying unemployment benefits, stabilizing the labor market, and developing labor market information.

To engage in public policy research and education in order to secure enactment of sound legislation.

To identify the positions of member agencies and to act as their collective voice in communicating those positions to Federal officials, to national groups, and to the public.

ACTIVITIES

Communications—ICESA enables the State agencies to communicate effectively with Federal officials, labor, business, veteran, minority, handicapped, and other groups. It is also a reliable information source, keeping members informed of both Federal developments and of State activities.

Collective actions.—Through resolutions at its annual and midyear meetings and by mail polls, ICESA identifies and advocates collective State actions and positions.

Management.—ICESA and Federal representatives cooperate across a broad range of management activities including automated manpower systems, cost accounting systems, and training and development programs.

Mr. FLOOD. Thank you.

Mr. WALSH. Thank you very much.

HEW BUDGET

WITNESS

DR. JOANNE FINLEY, COMMISSIONER, DEPARTMENT OF HEALTH, STATE OF NEW JERSEY

Mr. FLOOD. Dr. Joanne Finley, Commissioner, Department of Health, State of New Jersey.

Dr. FINLEY. Thank you, Mr. Flood.

Mr. CHAIRMAN, members of the committee: I wish to thank you for the opportunity to appear before you today. It has been my personal observation that Members of Congress are increasingly becoming the leaders in reflecting the real needs of the American people, and in shaping policy that meets those needs.

The Federal budget is a powerful tool to achieve national goals; but just as a rational budget can achieve goals, so can a witless budget set back goals—for years.

BUDGETS SHOULD BACK NATIONAL GOALS

The 1976 health, education, and welfare budget as requested by the executive branch should be directed to achieving the national goal of raising the health status of our citizens and, consequently, their productivity and their purchasing power. It should be directed toward reforming the health care system so as to lessen our continued dependence on the exotic—the too-little, too-late—and the costly overutilization of acute inpatient hospital care. This is not just a humanitarian view. It is an economic one as well.

A rational, Federal budget should stress and favor a restoration of the lost art of preventive health care. Unfortunately, the HEW budget for fiscal year 1976 does quite the opposite. It proposes the reduction or outright elimination of many of the programs that have been the most successful in preventing costly, lengthy hospital stays or a lifetime of dependence on society to foot the medical bill for failure to attend to a preventable disease.

PREVENTIVE MEDICINE ALSO PREVENTS HIGH COST

In New Jersey, the effect of the proposed 1976 HEW budget is a perfect illustration of the disastrous economic consequences of reduction in preventive health care funds and programs. The elimination of comprehensive health formula grants to the States; the elimination of lead-poisoning control project funds; the drastic reductions proposed in maternal and child health and in crippled children's funds, and in the funds for the Center for Disease Control (CDC)—funds which go toward such vital preventive activities as immunization and venereal disease control—these eliminations and reductions alone will reduce New Jersey's share of Federal funds by nearly $5 million.

This represents about 12 percent of the preventive health service portion of the New Jersey Department of Health Budget for 1976. Another $8 million will be lost from the health facilities construction grant funds the Department has been able to disburse.

This is a huge loss. Last year, after the State of New Jersey succeeded in its suit and Congress disapproved a rescission request from the administration, $11 million was made available to a most carefully selected group of grantees. The HEW budget as proposed would have New Jersey receiving the pittance of $3 million for the coming fiscal year.

Elimination of important programs, and reductions of the magnitude contemplated in the proposed HEW budget, could have severe economic impact on a State like New Jersey. Loss of deserving dollars means loss of hundreds of deserving jobs, not necessarily in a State bureaucracy, but out in the local communities where the needs are greatest, where the State sends the funds received by the Federal Government. It means an adverse effect on thousands of mothers and infants and bright young people who want to grow up, stay well, and produce for their country.

I am aware that many of the losses to New Jersey are reflected in the HEW budget because they await such authorizations as are to be found in the health services and revenue sharing legislation. I know that is not the job of this committee. But the President's veto of that legislation last year, coupled with the HEW budget request before you now, reflect a philosophy. I must illustrate the devastating effect of this philosophy on health care in our State, just as other members of the New Jersey cabinet have shared with you their concerns of the effect of this philosophy on our school children, our workers, and our recently unemployed.

I would like to discuss briefly the effects which the proposed HEW budgets would have on several critically important areas of preventive health care currently being administered by the New Jersey Department of Health:

MATERNAL AND CHILD HEALTH PROGRAMS

It is especially tragic to have administered a demonstrably effective, successful, low-cost, high-yield program such as the maternal and infant care projects * * * and then be confronted with the probability of a $1 million reduction—fully one-third of the funds used to make this program so successful. All available statistics, including New Jersey's, point to a demonstrable decrease not only in infant death rates

but in the number of poorly born handicapped babies. While a monetary value cannot be placed on the emotional trauma of the birth of a handicapped child, economists have written volumes on the value and the savings to society of programs that through timely care, education, and prevention, reduce dramatically the incident of births of damaged children.

Last year in New Jersey, Federal maternal and child health funds provided prenatal care to 2,600 women, over 2,000 infants received neonatal intensive care. The cuts proposed in the HEW budget would mean that at least 500 fewer babies in need could be cared for. These infants may die, or face the possibility of a lifetime of disability such as cerebral palsy or mental retardation.

A million dollars spent this year could save the taxpayers tens of millions in the future in costs to aid or institutionalize those who shouldn't have to suffer from disabilities at all.

The past several years have shown us that family planning programs have also been an effective factor in reducing infant mortality or the numbers of poorly born babies. But the HEW budget as proposed would cut the New Jersey Health Department's funds for family planning by three-quarters of a million dollars.

LEAD POISONING PREVENTION

The HEW budget as proposed totally eliminates support of the central State laboratory program for blood lead analysis. The deaths and permanent brain damage caused by child lead ingestion are totally preventable disasters. Moreover, successful community detection programs, and deleading of households, are highly successful in preventing this terrible problem.

It does not need permanent Federal funding, but it is wasteful and foolish to stop halfway to total success, and elimination of support for the central State laboratory program could effectively destroy the entire effort in this area. The cost of analyzing specimens by private laboratories could well be so prohibitive so as to prevent those most in need of this type of service from receiving it.

CONTROLLING THE SPREAD OF COMMUNICABLE DISEASES

The proposed reduction of 35 percent in this area would all but eliminate New Jersey's venereal disease control program's efforts to combat gonorrhea, the No. 1 reported communicable disease in our State. In recent years, New Jersey has finally slowed the alarming rate of increase in venereal disease, thanks in part to the funds provided by the Federal Government. In 1974, 16,000 cases of gonorrhea and 2,660 cases of syphilis were reported in New Jersey. In most instances, those cases received treatment, and their partners received preventive treatment as a result of education, epidemiologic and screening programs. Without adequate funding, human suffering and death resulting from late complications, would undoubtedly increase—and with increases in suffering and death come increases in economic hardship, both to the family and to society.

New Jersey is further faced with the proposed reduction of 55 percent of Federal funds supporting immunization programs. Just this week, our State enacted a long-overdue law to require immunization of all school-age children for six communicable diseases. Last year, we

experienced a true epidemic of measles in our State, due in large part to the fact that there did not exist any minimum statewide immunization requirements. It is disheartening, at best, to see a noble and honorable goal set by the State through the enactment of a new law, and then to witness a dramatic reduction in funding that would relegate that law from potential success back to a mere piece of paper.

COMPREHENSIVE FORMULA GRANTS TO STATES

The total elimination of bloc grants to States poses perhaps the most serious threat to public health in New Jersey. It is these funds which New Jersey has applied to vital, preventive health programs. We have used the $2.3 million we were receiving in 314–d funds for the solution of some of our most stubborn and special problems.

It is particularly distressing to see a proposed reduction of those funds that have been going toward the very areas which we should be stressing . . . preventive health care programs. The following vital services to the citizens of New Jersey would be reduced by the following percentages if the HEW proposed budget is approved:

	Percent
Tuberculosis treatment and control	65
Chronic diseases control	45
Consumer health services	24
Communicable disease control (including venereal disease)	13
Laboratory services for local public agencies	20
Health education of consumers	17

Tuberculosis has remained a problem in New Jersey. Venereal disease is in double jeopardy. We have made Federal pennies go a long way. We would like to keep up our record. Why the HEW insistence that we return to an epidemic of venereal disease?

HOUSING PREVENTIVE CARE

We recognize the intent of Congress in Public Law 93–641 to continue an assistance program for needed health facilities construction. We realize that supplemental appropriations legislation may be the proper focus for this intent. And in New Jersey, with an excellent planning record and a strong certificate of need law, we have demonstrated our belief in ending the construction of unnecessary new hospital beds.

But when a State has our kind of track record, we feel we should continue to receive the support to disburse needed funds to municipalities for public health centers, and to successful ambulatory programs and neighborhood health centers. These are programs that keep people earning and producing. These are the right programs to give construction workers desperately needed work.

Why, I must ask, are we confronted with an HEW budget that reduces preventive care to its bottom line, and also proposes that it continue to be housed in unsanitary and unpleasant storefronts, or worse * * * not housed at all?

PREVENTION IN PENNIES—ACUTE MEDICAL CARE IN BILLIONS

In the State of New Jersey, I am confronted with the awesome and sometimes unenviable responsibility of trying to control the ever ex-

panding costs of institutional medical care. A chart attached to my remarks illustrates the futility of trying to do this in a society that puts its budgetary emphasis on the wrong priorities.

General hospitals alone in New Jersey are telling us they believe they will need a total of $1.3 billion in 1975 to render the kind of care to the numbers of patients they expect. But all public health programs—State and local, counting all the funds from all sources in the past year—totaled only $60 million. This is a tiny slice of the pie.

And now HEW proposes to make this slice even thinner.

There is something wrong with a health care system that emphasizes institutionalization of those who are sick, when proper emphasis on preventive care would have kept them from becoming sick in the first place.

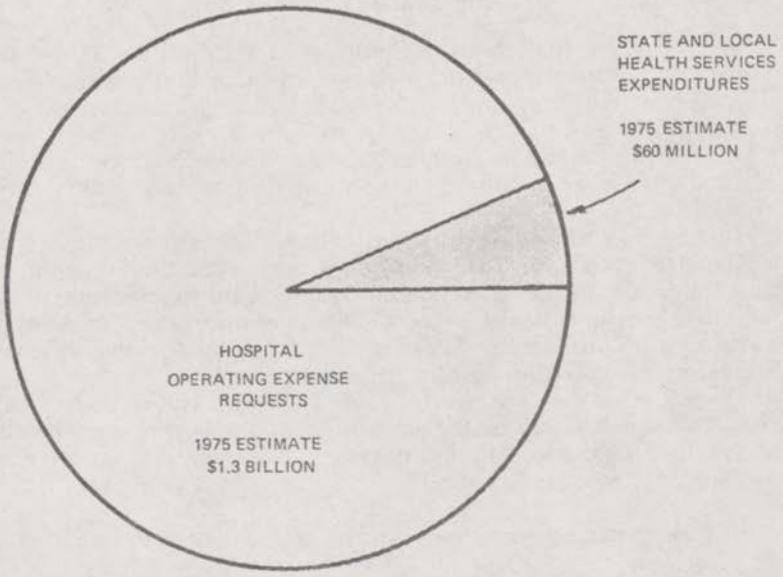
We need more money for preventive health care. We need to start recognizing that only when we develop proper preventive care for our citizens will we truly make our society more productive. We need to rearrange our priorities, and to upgrade our efforts to wipe out such diseases as tuberculosis, venereal disease, lead poisoning, and so many of the other diseases that needlessly afflict our citizens.

With the proper HEW budget, we in New Jersey are prepared to prove how far pennies for prevention can go, and how the high costs of care too late can be brought down.

Thank you very much.

[The information follows:]

COMPARISON OF HEALTH CARE EXPENDITURES IN NEW JERSEY



COMPARISON EXCLUDES NURSING HOMES AND STATE MENTAL HOSPITALS.

Mr. FLOOD. Thank you very much.
Dr. FINLEY. Thank you.

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

WITNESS

MALCOLM McINTYRE, MANAGER, GROUP DIVISION, AETNA LIFE & CASUALTY

Mr. FLOOD. Next we will hear Mr. McIntyre, manager, group division, Aetna Life & Casualty.

Mr. MCINTYRE. Thank you, Mr. Chairman. I am Malcolm McIntyre, manager, group division, Aetna Life & Casualty. I am here today on behalf of the Health Insurance Association of America. The HIAA consists of 325 insurance companies which are responsible for about 85 percent of all health insurance written by insurance companies in the United States today, and as such we are keenly interested in the health aspects of the budget which your subcommitte regularly considers. Our testimony will address itself to the need for adequate funding under the National Health Planning and Resources Development Act of 1974—Public Law 93-641—generally, and particularly the funding of sections 1526 and 1533 of that act.

We support the objectives of this 3 year act and believe that its necessary funding will allow the development of an essential cornerstone for national health insurance. It is critically important that the new agency network created by this legislation receive enough money to function in its intended role of containing the escalation of health care costs and upgrading the quality of health care on a national basis.

Mr. Chairman, other witnesses have adressed in detail the need for funding of the various programs under the act and we are generally supportive of this testimony. We are here today, however, to stress a need for funding and early implementation of two sections of this law which, when used concurrently, have the potential for restraining the current rate of escalation in the cost of institutional services. I refer to sections 1526 and 1533 of Public Law 93-641.

Section 1526 provides for grants to States which have indicated an intent to regulate rates for the provision of health care within the State, with a limit of not more than six States which may receive such grants. Section 1533, among other things, calls on the Secretary to establish uniform systems of cost accounting, and of operating cost and rate calculation for health services institutions. The latter section includes provisos that the system of rate calculation shall be based on an all inclusive rate for various categories of patients, reflecting the true cost of the service, and requiring justification of rate differences to different classes of purchasers.

There was no budget request for section 1526, the authorization level of which is $4, $5, and $6 million, respectively, for the 3 years of the act ending in fiscal year 1977. HEW's failure to ask for money for this section is perhaps best explained in terms of the President's call for restraint on new Federal spending. But I must say, Mr. Chairman, that while we in no way presume to speak for officials of that department, our recent discussions with them reveal an awareness of and an

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appreciation for the potential of sections 1526 and 1533 in restraining institutional costs. Moreover, the Assistant Secretary of Health stated, in testimony to you last month, that the major principles and guidelines for development of the Public Health Service budget would include a continuing emphasis on "the development of better statistical health data."

We respectfully urge the subcommittee's special attention to this feature of the act which while requiring a relatively modest amount of money, has the potential, when working in conjunction with section 1533, for dramatic cost savings for the millions of Americans who utilize our country's hospitals. The HIAA strongly recommends full funding of section 1526.

The cost of hospital care represents the largest single component of the Nation's total health care expenditures, and its rate of escalation is generally subject to ineffective controls. Recognizing and responding to this problem, Congress has laid the groundwork in sections 1526 and 1533 for effective experimentation in the States. The Health Insurance Association of America believes that the results of the experiment could form the basis for determining the best organizational structure and processes for effective control of hospital costs on a nationwide basis under any national health insurance system.

In examining the need for more effective hospital cost controls, there are two fundamental premises:

1. There can be no effective control on total hospital costs unless the control process deals in a uniform way with all sources of patient income.

2. The fragmented controls applied to medicare, medicaid, and Blue Cross have failed to restrain total cost and, therefore, have compounded the historical problem of price discrimination and forced private subsidies.

We are convinced that the sections 1526 and 1533 go to the heart of this matter of cost controls.

It is true that the Social Security Administration currently has authority under section 222 of Public Law 92–603 for experimentation with prospective rate review for institutional services. We believe, however, that this experimentation will be ineffective because the experiments do not apply uniformly to all patients. In our view—and apparently the view of the Congress—Government's efforts should more appropriately be directed to finding ways to stabilize increases in the total cost for the public as a whole rather than focusing on short-range efforts that produce cost predictability for Government but correspondingly increase the price subsidy forced upon the private sector.

Section 222 simply does not come to grips with the increasingly difficult problem of hospital cost controls, because it does not require uniform accounting, nor does the control process deal in a uniform way with all sources of patient income. In other words, we respectfully submit that you will get a far better return for your dollar investment by focusing on the prospective rate review features of Public Law 93–641 and funding this program to the extent authorized by law.

Mr. Chairman, we have submitted to your subcommittee a memorandum expanding on the points in my statement in some detail. Moreover, the Health Insurance Association of America stands ready to

be helpful to you or your staff on these or related matters. I would be happy to answer any questions you may have at this time.

Mr. FLOOD. Thank you very much.

Mr. MCINTYRE. Thank you, Mr. Chairman.

HEALTH PROGRAMS

WITNESS

LEO J. GEHRIG, M.D., VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. FLOOD. Dr. Gehrig, representing the American Hospital Association.

Dr. GEHRIG. I am Dr. Leo Gehrig, the vice president of the American Hospital Association. I would like to thank you on behalf of the association for this opportunity to be heard.

Dr. GEHRIG. Mr. Chairman, I am Leo J. Gehrig, M.D., vice president of the American Hospital Association. Our association represents some 7,000 member institutions (including most of the hospitals of the country, extended and long term care institutions, mental health facilities, and hospital schools of nursing) and over 20,000 personal members. We welcome the opportunity to present our views on the subject of HEW health program appropriations for fiscal year 1976.

HEALTH SERVICES PROGRAMS

I would like to state at the outset that we were very disappointed in the fiscal year 1976 budget proposals sent to the Congress by the President in January. The levels of spending proposed by the administration are, for the most part, highly inadequate. This is especially true in the area of health services. Moreover, the administration's rationale for the proposed hold-the-line spending and many actual cutbacks seems totally unrealistic. Throughout their justification statements, for example, the administration assumes that 1976 dollars will provide the same amount of services as the identical levels of funding in 1975—this in spite of the administration's inflation rate of 6 to 8 percent projected for fiscal year 1976.

Even less credible are the contentions that actual cutbacks in Federal funding will be absorbed through increased spending by State and local government and by the private sector. We submit that the economic problems affecting the country as a whole are no less severe in the private sector or at the State and local government levels than for the Federal Government. Moreover, program cutbacks are being proposed on the grounds that State government will pay a larger share, at the same time that the 314(d) program of formula grants to States for health services, is being proposed for elimination. Given the clear intent of the administration to run a $60 billion budget deficit, it could be argued that the Federal Government is more able, not less able, than State governments to shoulder added responsibilities for health care services.

Migrant Health Services

Mr. Chairman, the Federal migrant health services program is an important and greatly needed Federal Government activity.

The number of migrant and seasonal farmworkers and their families is estimated to be approximately 3 million. While some 390,000 persons will receive ambulatory health care services under this progrm in 1975 through some 640,000 visits, there are no federally aided projects in a majority of the counties in the country that seasonally experience an influx of migrants. Funds for the migrant health program have never been sufficient to the health needs of migrant workers, and every year there are many approved projects for which funds are not available. Moreover, except for some small demonstration programs, existing migrant health projects are financially unable to allocate funds to cover the cost of hospitalization of beneficiaries.

Despite the great need for this program, the administration is requesting decreased funding on the highly dubious grounds that the deficit can be made up through management improvements and increased non-Federal contributions. Past experience argues against the validity of these assumptions, particularly since State and local governments are frequently reluctant to spend scarce funds on persons who tend not to be year-round residents.

Pending authorization legislation (H.R. 4925) would authorize $39 million for fiscal year 1976 funding of this program. This is less than half the amount for fiscal year 1976 contained in the bill vetoed by the President last year and represents what we consider the very least that should be allocated.

Recommendation: We recommend an appropriation of $39 million in fiscal year 1976 for migrant health services.

Community Health Centers

Community health center project grants help low-income persons through the provision of health care in neighborhood and family health centers in medically underserved areas. The administration proposes to reduce by 20 percent the financial support of this program. While ignoring inflation, the administration states that "an estimated increase of approximately 20 percent in non-Federal and third-party reimbursements" will offset this budget reduction.

A study of 48 States and 140 local governments by your Joint Economic Committee points out that State and local governments are raising taxes and lowering spending. Increased State and local government contributions of additional funds necessary to maintain CHC project operations at the fiscal year 1975 level of service cannot be expected as has been assumed by the administration. Rising unemployment and increasing demands on State and local government revenues argues for an increase in this program, not a decrease. In a May 2, 1973, study, "Implementation of a Policy of Self-Support by Neighborhood Health Centers," the GAO concluded that third-party support of such centers at the 20-percent level would be the maximum achievable, and we support all efforts to attain such third-party payments. Third-party participation at a level of 20 percent has been achieved during the current year; a further increase in third-party reimbursement simply cannot be anticipated as assumed in the President's budget.

The ambulatory services provided through these programs are highly cost-effective. According to HEW data, persons served by these centers show a much lower hospitalization rate than the U.S. popula-

tion as a whole. We are convinced that the financing proposed by the administration would require a significant reduction in the program's population coverage—not a fiscal year 1975 level-of-effort as alleged by the administration.

Recommendation: We recommend that $220 million be appropriated for community health centers. This is the amount contained in pending House legislation, H.R. 4925.

Maternal and Child Health

Title V of the Social Security Act authorizes an important program of maternal and child health and cripped children services. Operating on a formula grant basis, this program assists the States to provide such services as maternal and infant care, comprehensivs care for disadvantaged children, and intensive infant care. Since its inception, the program has produced some very dramatic and encouraging results, including: lowered incidence of premature births and birth defects; fewer maternal deaths in childbirth; lowered hospitalization rates; and lowered infant mortality.

Despite the obvious need for, and success of, this program, the administration is proposing a funding cutback from $295 million in 1975 to $211 million in 1976. This proposed cutback of 28 percent, coupled with the current inflation rate, will almost certainly result in one-third fewer services being provided next year unless the Congress rejects the administration's recommendation.

Recommendation: We strongly urge that the maternal and child health program continue at at least its 1975 level of $295 million.

Community Mental Health Centers

As in past years, the administration is proposing to phaseout all Federal support for construction and staffing of community mental health centers. The administration's request for fiscal year 1976 funding for those two activities is $135 million in contrast to $200 million in fiscal year 1975. Additionally, the administration is requesting approximately $25 million for continuation of the child mental health program. The American Hospital Association has vigorously and repeatedly testified in favor of continuation and expansion of this program and we continue to do so for 1976.

The CMHC program has been extremely successful; even the administration admits this. The number of people in State mental institutions has declined dramatically since the program began. The community-based, ambulatory care emphasis of the CMHC program has proved to be cost-effective compared to the cost of long-term inpatient care. The administration contends that the State and local government, private sector organizations and third-party payors will be willing and able to continue the development of this program without additional Federal funds. We disagree with this assumption.

State and local governments presently contribute about 33 percent of community mental health centers funding. All sources of third-party payment to community mental health centers including Federal Government service programs and out-of-pocket payment by patients amounts to about 20 percent of center funding. The existing fiscal problems facing States and the inherent limitations of third-party payment for ambulatory mental health services indicate that the ad-

ministration's assumption is totally unrealistic. The withdrawal of Federal funding will have a serious impact on both existing community mental health centers and on the potential for this program to expand further toward its original goal of some 1,500 community mental health centers nationwide.

Recommendation: We recommend an appropriation in fiscal year 1976 of at least $225 million for CMHC construction, staffing, and child mental health programs—approximately the fiscal year 1975 level of funding.

Comprehensive Health Grants To States

The now-expired section 314(d) of the Public Health Service Act authorized a formula grant program of aid to State governments for health services support. Legislation pending in both Houses of Congress would extend this program under the name "Special Health Revenue Sharing." The States have used these funds in the past for such purposes as control of communicable diseases, environmental health services, chronic disease control, home health services, and many others. The American Hospital Association is convinced because of geographic variation in health problems, that there are many areas of need which can better be identified by State health agencies than by Federal officials. For this reason we continue to support the noncategorical provisions of the 314(d) or the special health revenue sharing program.

The administration has proposed the elimination of the program entirely on the highly questionable grounds that the funds represent only a small percentage of State health departments' budgets, and that the States will be able to "make alternative arrangements" somehow for continuation of high-priority programs. As pointed out earlier, it is difficult to see where States are going to get the additional funds to compensate for the ending of this program, especially in light of the other proposed cuts in Federal health services program which would also have to be made up, in part at least, by State government.

Recommendation: AHA recommends continuation of the health revenue sharing program and an appropriation of $90 million for this program for fiscal year 1976.

National Health Service Corps

Mr. Chairman, much has been said and written in recent years about the geographical maldistribution of physicians and other health professionals. Such a problem exists and the Federal Government has a legitimate role in assisting in solving it. One of the principal Federal efforts in this regard is the National Health Service Corps, created by the Congress in 1971 to provide direct health services in manpower shortage areas. Indications are that the corps can be an effective mechanism to assist in meeting these needs.

The administration is asking that this program be funded in 1976 at $12.5 million, the same level as in 1975. Even discounting the effect of inflation, we do not believe this request represents an adequate response to the problem, given the obvious need and the demonstrated early success of the program. It is our further understanding that nearly twice as many sites have been approved by the NHSC as have been staffed to date. It is our understanding that there is no lack of applicants to serve in the Corps, but that the recruiting effort has

been largely shut down due to the relatively low level of funding received so far.

Recommendation: The American Hospital Association recommends an appropriation of $25 million for fiscal year 1976 for NHSC operational funds.

National Center for Health Services Research

We believe that Congress emphasized the need for increased coordination and expansion of health services research activities with the passage of P.L. 93–353 which formally established the National Center for Health Services Research. Health Services Research, a systematic process of adding to existing knowledge about the relationships between health resources and the health care of the population, complements biomedical research by seeking to improve the networks providing health care so that the benefits of scientific efforts are appropriately applied. These research efforts are particularly concerned with measuring the effect of organization, fiscal policies and the deployment of health resources on the issues of access, quality, and efficiency in influencing health status. It is through NCHSR that the Secretary may undertake and support research, evaluation and demonstration projects on such essential topics as the accessibility, quality, and financing of systems for the delivery of health care. For 1976 the administration is asking only $26 million for the Center which is $16.5 million below the 1975 amount, yet there has been no comparable decrease in the need for systematic research and evaluation. This relatively low level of investment on health services research represents a miniscule portion of total health care expenditures. This investment is inadequate to stimulate the necessary research and evaluation upon which important public policy decisions depend.

Recommendation: We recommend an appropriation of $45 million to maintain the current level of effort in the vital area of health services research.

Emergency Medical Services

Mr. Chairman, it has been estimated that 60,000 lives could be saved annually in this country if our emergency medical services were improved. We in the hospital field have been among the first to agree that much better emergency services need to be developed and we vigorously supported enactment in 1973 of the Emergency Medical Services Systems Act. Grants and contracts are now being made with various entities to develop or improve emergency medical systems, and some research in this area is being supported. While this progress is encouraging, we believe that the 1973 law should be implemented more rapidly. For example, a total of $75 million is authorized for fiscal year 1976, but the administration is requesting only one-third that amount, $25 million.

There is no question that more funds could be productively used, since the program is currently spending at a level of $37 million. The EMS program will assist in the provision of adequately designed and equipped transportation resources, effective communications, and well-trained emergency personnel. Further, the EMS program promises to help alleviate many of the present inadequacies and gaps in community emergency programs by requiring coordination of these community activities.

Recommendation: We recommend that at least $40 million be appropriated for the EMS program in 1976, which is approximately the 1975 level.

PSRO's

Public Law 92–603, the Social Security Amendments of 1972, provides for the establishment of professional standards review organizations (PSRO's) to assume responsibility for comprehensive and on-going review of services covered under medicare, medicaid, and maternal and child health programs. While we appreciate the fact that the administration's proposal requests an increase from $36 to $50 million for this essential program in fiscal year 1976, we are distressed by the inadequacy of this request. The proposed financing provides coverage for PSRO's established through fiscal year 1975 and conversion of a very limited number of planning PSRO's qualified for conditional status. However, at least 49 qualified planning PSRO's will be prevented from obtaining conditional status if additional funds are not provided. Further, no moneys are made available for feasibility or planning grants for 35 to 45 interested qualified uncovered areas. This is a no progress proposal.

Recommendation: We recommend an appropriation of $70 million for this program. The recommended amount coupled with similar increases in subsequent years, would provide for nationwide PSRO coverage by the end of fiscal year 1978.

HEALTH MANPOWER PROGRAMS

Mr. Chairman, our interest in health manpower relates not only to the utilization of personnel in our institutions, but also to the critical role of many hospitals in training health workers. At present, some 64,000 nursing students are enrolled in hospital schools of nursing, and most of the nursing students trained primarily in academic settings receive their clinical education in hospitals. Moreover, some 11,000 interns, 45,000 residents, and a large number of allied health trainees are receiving all or significant portions of their education in hospitals.

The U.S. health system must prepare now for the advent of national health insurance. The resources needed to cope with the increase in demand generally anticipated clearly must be put in place at the earliest possible time, and health manpower is one of the most crucial of these resources. Unfortunately, just at the point in time when we should be concentrating on development of adequate manpower resources the administration is proposing termination or phase-out of most of the highly successful Federal programs of aid to health schools and students. In this regard, I would like to commend this subcommittee for its actions earlier this month in denying the administration's proposed rescission of over $200 million in fiscal year 1975 health manpower funds.

Nurse training

The hospitals of this country in 1971–72 operated 543 diploma schools of nursing. Last year, 40 percent of all nursing students graduated from these diploma schools. I cite this statistic to point out that although there have been substantial increases in other types

of nursing programs, diploma schools of nursing continue to be a vital resource for the education of nurses in this country. We want to emphasize to you our belief that we must utilize fully every available educational resource if we are to continue to meet our nursing needs. We are firmly convinced that a program of adequate Federal support for all nursing education programs is essential.

In an effort to evaluate the extent of the shortage of registered nurses, the American Hospital Association surveyed the chief executive officers of all of the 50 State hospital associations in order to determine the situation in each of the States. As a result of this review, the following were indicated:

There is a shortage of registered nurses today in health care facilities in 36, or 72 percent, of all the States; and

Of 14 States in which no overall statewide shortage was apparent, a majority indicated serious shortages of available registered nurses in certain areas, especially areas of rural and low-income populations.

Mr. FLOOD. You know what we think?

Dr. GEHRIG. I sincerely believe I do. I would hope that you would act in exactly that manner.

This review certainly indicates that the shortage of registered nurses is real, despite reports from some quarters to the contrary. Moreover, hospitals have made concerted efforts to broadly expand their recruitment programs, to provide increased pay and fringe benefits to their nursing staffs, to expand the use of licensed practical nurses in the place of registered nurses, and in some instances have been forced to try to recruit trained nurses from foreign nations. Despite all of these efforts, the shortage of nurses for the health delivery system remains a serious problem in many areas. It has necessitated in shortage areas a decrease in some needed hospital services, or in some instances their elimination; and it has inevitably lowered the quality of nursing care. These circumstances, we believe, underscore our contention that nursing education programs must be supported.

The administration is proposing a drastic cutback in the nurse training programs and is requesting only minimal funds for these programs in 1976. In 1975, 981 schools of nursing received capitation grant awards and 60 schools received financial distress grants; the administration is requesting nothing in fiscal year 1976 for these programs. Legislation pending in both houses of Congress would provide for capitation assistance to nursing schools on the basis of a percentage of the schools' net educational costs per student. We strongly support the approach.

Recommendation: We recommend an appropriation for nurse training capitation support in fiscal year 1976 of at least $50 million.

Schools of nursing are also eligible for construction grant assistance; $19 million was available for this purpose in 1975, but no construction funds are being requested for 1976.

Recommendation: We recommend an appropriation of $25 million for nursing school construction grants in fiscal year 1976.

The administration is proposing to continue the special project grant support for such purposes as curriculum revision, continuing education, and training of more primary care and specialty care nurses; $18 million is being requested by the administration for this program in fiscal year 1976.

Recommendation: We support an appropriation of at least $18 million for special project grants in fiscal year 1976.

Student assistance in the area of nursing education is another program proposed for extinction by the administration. Undergraduate loans and scholarships and graduate traineeships have been available to nursing students for several years now and have been very helpful in allowing financially disadvantaged persons to enter the nursing field and in encouraging the development of nursing instructors and supervisory personnel. The administration is proposing to phase out these programs on the grounds that the basic opportunity grant (BOG) and the guaranteed loan programs of the Office of Education will adequately replace the categorical nursing student assistance programs. We disagree, and would urge continuation of these efforts targeted on the nursing profession.

Recommendation: We recommend the following student assistance appropriations for fiscal year 1976: $35 million for direct loans; $15 million for scholarships; and $25 million for graduate traineeships.

Health professions education

The American Hospital Association is supportive of the programs of assistance to schools and students of medicine, and we would like to draw attention to certain areas of particular interest to us within the general field of health professions education.

I described earlier our concern that the operational aspect of the National Health Service Corps be adequately funded. I would also point out the need for NHSC scholarship assistance in fiscal year 1976. The administration is requesting $22.5 million for these scholarships, although pending House legislation (H.R. 5546) would authorize $40 million for fiscal year 1976.

Recommendation: We recommend that if the Congress increases the administration's request for operational funding of the NHSC, a proportionate increase be made in the scholarship request.

In addition to the National Health Service Corps, there is another HEW manpower program focused on the geographical maldistribution problem. I refer to the Area Health Education Center program funded under the general category of "Special Educational Programs." The association favors the continued support of area health education centers whose purpose is the improvement of quality and quantity of health personnel of the health delivery system, as well as the encouragement of regionalization of educational responsibilities. Operating examples of area health education centers are just beginning to appear, with some preliminary evidence that they are having a positive impact on the training, placement, and effective utilization of health workers in underserved areas. This is being accomplished through the regionalization of medical schools, nursing, and allied health programs, and through the integration of curriculums to permit people trained at one level to receive additional education to function at a higher level.

Recommendation: We support the administration's request for a $16 million appropriation for AHEC's in 1976.

There are two programs in the HEW budget which are directed to the speciality maldistribution problem: Family medicine residencies grants and primary care residencies grants. The family medicine resi-

dencies program provides grants to hospitals to develop training programs in family medicine and to provide financial assistance to students and physicians who participate in such programs. The new primary care residencies program would promote and assist in developing model primary care residency programs.

Recommendation: The administration is requesting a total of $39 million for these two residency training programs and the AHA wholeheartedly supports this request.

Public health training

The pending House authorization legislation would change somewhat the program of aid to schools of public health by making such schools eligible for capitation grants and would continue the program of public health traineeships. In addition a new program of institutional grants would be established for graduate programs in health administration other than those located at schools of public health, along with a traineeship program for students in such programs. Whatever the shape of the programs eventually authorized for public health and health care administration training, we urge the Congress to fund these important programs at an adequate level.

Recommendation: We urge funding for public health and health care administration training of at least $22 million in fiscal year 1976.

Allied health training

The final health manpower item I would like to mention, Mr. Chairman, is allied health training.

As was the case last year, the administration is calling for elimination of categorical Federal support for the allied health manpower program in fiscal year 1976, which provides Federal moneys for the training of technicians, technologists, and other personnel necessary to assist already overburdened doctors and specialized personnel. The funds made available to institutions of higher learning and to clinical teaching facilities have allowed many students to pursue active careers in the health field who otherwise would have been financially unable to do so and have helped to train supervisory personnel in this area. Further, the funds assist in the development of high quality training programs for such personnel.

Recommendation: We recommend that the Congress continue to fund the allied health training program at least at the fiscal year 1975 level of approximately $34 million.

HEALTH PLANNING AND FACILITIES

Public Law 93–641, the National Health Planning and Resources Development Act of 1974, made several very important changes in the Federal Government's role in health planning, regulation, and facilities development. The comprehensive health planning, Hill-Burton, and regional medical programs were merged into a new Federal/State/local system. The American Hospital Association is vitally concerned with the manner in which this new law is implemented, and we have several specific recommandations to make regarding appropriations items.

Health Facilities Modernization and Construction

Mr. Chairman, title XVI of the recently enacted National Health Planning and Resources Development Act of 1974 (Public Law 93–641) provides for continuation, on a substantially modified basis, of the Federal effort in the area of health facilities modernization and construction. As you know, this was formerly known as the Hill-Burton program.

In spite of the Hill-Burton program's success over the years, the need for modernization and construction of health care facilities has not been fully met. HEW estimates that $19.7 billion is needed over the next 5 years for the modernization and construction of health care facilities across the Nation.

The most pressing need is for modernization and renovation of existing facilities, and this represents $12.7 billion of the total estimated capital funds currently required. This includes the need to modernize some 196,000 beds in general hospitals, according to HEW. The need for modernizing and renovating facilities is particularly acute in urban and rural poverty areas where many of the facilities are old and obsolete. These are often the only health care resources for large and economically disadvantaged population groups. These facilities urgently need to be modernized and improved to properly serve these groups.

The demand for additional outpatient facilities continues to grow. It is estimated that in 1974 there were 178,725,000 outpatient visits at community hospitals in the United States. This represents more than a doubling of such visits over the previous 10-years period. The increase can be expected to be even greater in outpatient departments of hospitals and in free-standing ambulatory care centers, with the expanded coverage for such services anticipated under national health insurance. Services that can be successfully provided on an outpatient basis often represent an effective alternative to inpatient care. HEW projects that $945 million of additional outpatient facilities are currently needed in addition to a $750 million need for modernization of existing outpatient facilities.

The administration is requesting an appropriation of $100 million for modernization and construction grants for the new title XVI program in fiscal year 1976. A total of $130 million is authorized for this purpose; 22 percent of whatever is appropriated will be provided, according to the term of Public Law 93–641, on a direct project grant basis by HEW to modernize public hospitals. The remaining 78 percent of these grant funds will be allocated to State planning and development agencies on a modified formula basis to provide modernization and construction assistance in areas of high need.

Because of the well-documented multibillion dollar need for such funds, and in light of the fact that no modernization funds were appropriated for fiscal year 1975, we are strongly recommending that the full amount authorized for health facilities modernization and construction grants be appropriated for fiscal year 1976. Further, we recommend that the subcommittee, in exercising its oversight responsibilities, insure that such funding is used for this purpose.

Recommendation: We recommend an appropriation of $130 million for facilities modernization and construction grants in fiscal year 1976.

As the committee is aware, the statute includes authority for the continuation of funds for the provision of direct loans, guaranteed loans, and interest subsidy. We urge the appropriation of funds necessary to cover the cumulative total of incurred obligations for interest subsidy from prior years under the provisions of the now expired title VI of the Public Health Service Act and an amount for interest subsidy to allocate $500 million of loan principal for fiscal year 1976.

Health Planning

The American Hospital Association has particular concerns about the level of appropriations which will be made to implement various provisions of title XV of Public Law 93–641, the National Health Planning and Resources Development Act of 1974. The programs under this title are specifically focused on the development of effective local and State health planning and resource development as well as State regulation of significant changes in health services and facilities. We hope that Congress will make available sufficient funding to permit the essential implementation of these crucial new State and areawide health planning programs.

The budget proposal of the Department of Health, Education, and Welfare includes a total of $45 million to fund the new areawide health systems agencies for their first full year of operation. The administration projects that 200 such agencies will require funding in fiscal year 1976. While we have no reliable count at this time of the number of health service areas that will be established, we believe that the administration's estimate is conservative.

The statute provides for funding of health systems agencies of at least 50 cents per capita. The population size to be served by such planning agencies in the act is required to be from 500,000 to 3 million persons. Exceptions to this requirement for populations greater than 3 million will obviously be needed in areas such as New York, Los Angeles, Chicago, Philadelphia, et cetera. Where population groups are well below 500,000, a minimum grant of $175,000 is assured. Using the combined U.S. population figure of some 220 million persons, full funding for these agencies will require at least $110 million nationwide plus whatever additional support many HSAs may be entitled to by raising local matching funds, a further provision of this act. A basic tenet of the act, however, firmly establishes that primary funding of such agencies will be through Federal support.

We agree with DHEW that at least 200 HSAs will be ready for funding during fiscal year 1976 and we concur with their assumption that most of these agencies will build their staff and other resources to their full funding requirements over a period of 6 months to a year. It is our estimate, however, that during this first full year of funding, HSAs will require at least 60 percent of full funding rather than the approximately 40 percent requested by the administration.

There are many opinions about why many of the areawide comprehensive health planning (CHP) agencies in the past have not been as effective as they should have been, and these opinions differ widely.

One reason about which there seems to be nearly universal agreement, however, is not only the inadequacy of their funding levels in relation to the magnitude of their assignments, but even more, the uncertainty about whether they would indeed get the funds which they were promised. Many of the areawide CHP agencies were not funded at all because of the inadequate appropriations; many more never received the full funding which their activities required; and all of them have labored under a cloud of doubt regarding their Federal support from year to year. Small wonder that many CHP agencies were unable to attract and hold qualified professional staff and carry on effective areawide health planning programs.

The American Hospital Association strongly supports the development of competent, capable, and committed areawide health planning. We think that despite some flaws, title XV's provisions establishing the health systems agencies create the potential for effective programs. We strongly urge that the committee provide $65 million for support of health systems agencies in the 1976 appropriation. Our purpose in urging this higher level of funding (which is still well below the $90 million which the Congress authorized for the health systems agencies for fiscal year 1976) is to assure that the HSAs have the opportunity to get underway with the resources necessary to do their important job.

Recommendation: We recommend a 1976 appropriation of $65 million for support of health systems agencies.

Mr. Chairman, our sincere and constructive recommendations concerning adequate funding for health systems agencies during the fiscal year 1976 are, as we have indicated, essential to the implementation of this critical program. At the same time there is an important issue related to the transition from existing comprehensive health planning agencies activities to that of the health systems agencies.

We commend the committee for its recent action in denying the administration's request for deferral of budget authority (No. 75–159). This request for deferral of $6,850,000 for comprehensive health planning section 314(b) areawide grants was predicated on the administration's projection that health systems agencies would be developed across the country under Public Law 93–641 by December 31, 1975. Thus, this $6,850,000 would not be required.

While we expect that during the entire fiscal year 1976, 200 or more health systems agencies will be established and require funding for their first year of operation, we are convinced that it is unrealistic to expect that this transition will be accomplished by December 31, 1975. Rather, we anticipate that the continuation of a significant segment of the 314(b) agencies will be necessary into the second half of fiscal 1976. The continuation of many of them will be important as resources for the development of the new agencies and they should not be forced to disband during this critical period. Therefore, your denial of this deferral request will permit additional transition funding beyond December 31, 1975. It was our estimate that approximately $10 million could be effectively utilized for this effort.

We urge the committee to assure that the Department of Health, Education, and Welfare utilizes as necessary these funds to provide as smooth a transition as is possible with the realistic understanding that some of these agencies must be supported beyond December 31, 1975.

Mr. Chairman, the American Hospital Association appreciates this opportunity to present our recommendations to you and the committee and I will be pleased to answer any questions you may have.

Mr. FLOOD. Thank you, Dr. Gehrig.

FUNDS FOR DESIGN AND PLANNING ASSISTANCE

WITNESS

CHARLES H. KAHN, CHAIRMAN, COMMUNITY DEVELOPMENT COMMITTEE, THE AMERICAN INSTITUTE OF ARCHITECTS

Mr. FLOOD. The American Institute of Architects.

Mr. KAHN. Mr. Chairman, I am Charles H. Kahn, AIA, chairman of the community development committee of the American Institute of Architects and dean of the School of Architecture and Urban Design at the University of Kansas. Accompanying me is Harold B. Glover, director of community development for the institute.

Today the American Institute of Architects, the national society for the architectural profession, wishes to express its support for an appropriation of $15 million within the budget of the Community Services Administration to enable that agency to provide financial aid to community-based organizations furnishing design and planning assistance to communities and individuals in urban and rural poverty areas. The design and planning assistance program was originally authorized by section 226 of the Economic Opportunity Act Amendments of 1972 and retained in the 1974 Headstart, Economic Opportunity, and Community Partnership Act.

Community design centers are nonprofit, community-based organizations, established to deliver, without charge, professional services related to architecture, planning, and design to individuals and community groups who cannot otherwise afford them. A prime objective of the centers is to provide the technical assistance necessary to translate neighborhood and community goals into good design programs. Prior to the establishment of community design centers, communities and individuals in poverty areas rarely had access to services accepted as commonplace by business, government, and other more affluent segments of our society.

"Community services" cover a fairly broad spectrum of activities within community governance structures. They include police, fire, water, garbage, and sewer disposal. There are, however, several other services which fall outside these traditional areas. They include legal aid, health care delivery, preventive medicine, and, we believe, design and planning assistance. Legal aid exists as a community service separate from the legal arm of the local government itself in order to avoid the potential conflict of being both prosecutor and defender. In a like manner, design and planning assistance is a community service for which the same potential conflict exists. For this reason, the establishment of an independently funded design and planning assistance entity is crucial to realize the development objectives of the communities served.

In addition to the service function of community design centers, the centers serve another important function. The usual consumers

of design and planning services fully understand the extent, function, and implications of these services. Poverty communities rarely have this depth of understanding and therefore are usually initially unprepared to effectively utilize the professional expertise available to them. This has been demonstrated by the difficulties in implementing citizen participation in the various Federal programs, such as model cities, which require such activity. All community design centers have, as part of their standard function, an educational component, the objective of which is to make the communities they serve sensitive to the character and potential of the services offered by the centers.

Staffed on a voluntary basis by architects, landscape architects, planners, engineers, other design professionals, faculty from professional schools, and VISTA volunteers, community design centers have been chronically underfunded. While Federal antipoverty funds have decreased, the financial needs of the centers, as well as the need for their services, have increased. These centers are the design and planning counterparts of legal aid centers and free medical clinics. Unlike legal aid centers or medical clinics, however, design centers have neither the resources of a numerically great nor an economically powerful professional community to sustain their activities; nor do they have a federally funded program to assist in their operation.

Unfortunately, there is no alternative to Federal funding. Revenue sharing is not a satisfactory source for community design center operating funds for several important reasons. Because design centers operate in widely different geographic areas and not necessarily within one municipality or city, there is often a conflict of interest between projects undertaken by a center in more than one local governmental jurisdiction and projects funded through revenue sharing in only one jurisdiction. In Los Angeles, for example, there are 78 municipalities within the corporate city limits. Community design centers cannot afford the administrative apparatus necessary to obtain revenue sharing funds from each municipality.

Even when revenue sharing funds are available, local governments do not always recognize their responsibilities to provide professional design and planning services to low income groups within their boundaries. We are also concerned that revenue sharing allocations might link a community design center with a project not clearly related to the design and planning services which the center was established to provide.

Community design centers represent the only source of professional design and planning expertise which is responsible, at the grassroots level, to the communities they serve. Such direct responsibility is fully in keeping with the spirit and the letter of the Economic Opportunity Act of 1964 and the Headstart, Economic Opportunity, and Community Partnership Act of 1974.

Considering the severally limited financial resources available to community design centers, the achievements of the approximately 80 design centers operating in more than 40 States are impressive. In Washington, D.C., for example, the Washington Planning Workshop provided documents for the construction of a free health clinic, offered its design services for a fine arts school, now operational for 2 years, which became a part of the District of Columbia school system. The

workshop also provided preliminary design services for a cooperative restaurant, which has been operating for 1 year, and completed a space analysis and site planning project for a 23-unit housing development currently under construction. In Los Angeles, the Los Angeles Community Design Center is currently planning the recycling of 30 underutilized high rise office buildings in the central city for use as housing. The center's proposal for the Los Angeles redevelopment plan has been incorporated into the city's final redevelopment plan. In Tucson, the design center used funds raised publicly and privately for renovating HUD repossessed housing so it would meet local building codes.

In addition to the continuing services which community design centers offer to the poor, the centers represent a vast reservoir of professional talent for use in periods of emergency or national disaster. For example, the flooding in Pennsylvania which resulted from Hurricane Agnes in June of 1972 created an environmental problem requiring massive design and planning services. The community design centers of Philadelphia and Pittsburgh placed their services at the disposal of affected communities and served, with other organizations, in the rehabilitation of these affected areas.

These are but a few examples of community design center accomplishments.

In the absence of Federal funding, community design centers have relied on sporadic support from local foundations and private contributions, funding which has not provided a satisfactory source of daily operating revenues. The American Institute of Architects therefore recommends that section 226, design and planning assistance, as provided in the Economic Opportunity Act Amendments of 1972 and retained in the Headstart, Economic Opportunity, and Community Partnership Act of 1974, be funded at an earmarked level of $15 million for fiscal 1976, as part of the budget for the Community Services Administration. An appropriation of $15 million would provide the basic operating and overhead expenses for 145 community design centers. The projected value of voluntary, professional services contributed to design centers during 1 fiscal year is $45 million, which would result in $60 million of design and planning assistance to low-income communities. We have attached a detailed analysis of our proposal to fund section 226 at a fiscal 1976 level of $15 million.

The American Institute of Architects strongly believes that funding is urgently needed to provide community design centers with the ability to function even more effectively in helping communities and individuals in urban and rural poverty areas participate in the development of their own communities.

Thank you.

Proposed allocation of funds—fiscal 1976—Section 226, Design and Planning Assistance, Economic Opportunity Act Amendments of 1972

65 Community design centers at $75,000	$4,875,000
40 Community design centers at $100,000	4,000,000
20 Community design centers at $150,000	3,000,000
Administrative costs for 145 community design centers	1,125,000
Total program costs	15,000,000

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Projected inkind professional contributions	$45,000,000
Total value of design and planning services delivered to low-income communities	60,000,000

Projected employment impact—Section 226, Design and Planning Assistance, Economic Opportunity Act Amendments of 1972

Professional positions	640
Nonprofessional positions	360
VISTA's and other full-time volunteers	1,450
Drafting and other trainees	500
Total people employed	2,950
Program cost per job	$5,000

Minimum budget for a community design center

Salaries and wages:	
Executive director (1)	$16,000
Architectural director (1)	12,000
Staff planner (1)	12,000
Secretary (1)	7,200
VISTA volunteers (4)	-------
Volunteer professionals (30)	-------
Taxes and fringe benefits at 15 percent	7,000
Total	54,200
Nonpersonnel:	
Space costs (1,200 ft.^{2})	3,000
Equipment	2,000
Consumable supplies	1,200
Travel	800
Telephone	1,200
Postage	500
Copying and reproduction	900
Library materials	300
Insurance	300
Conferences and seminars	400
Total	10,600
Fiscal and administrative services at 8 percent	5,200
Total	70,000

Budget for a community design center serving a large multicounty or metropolitan area

Salaries and wages:	
Executive director (1)	$18,000
Architectural director (1)	14,000
Urban planner (1)	13,200
Landscape architect (1)	11,400
Interior designer (1)	11,400
Community workers at $9,000 (2)	18,000
Secretary/office manager (1)	8,400
Clerk/typist (half-time) (1)	3,600
VISTA volunteers (12)	-------
Volunteer professionals (100)	-------
Taxes and fringe benefits	14,700
Total	112,000

Nonpersonnel costs:	
Space costs (3,000 square)eet)	$7,500
Equipment	3,000
Consumable supplies	3,000
Travel	2,600
Telephone	2,600
Postage	1,800
Copying and reproduction	3,000
Library materials	500
Conferences and seminars	1,500
Insurance	700
Total	26,200
Fiscal and administrative services at 8 percent	11,100
Total	150,000

HEW Appropriations

WITNESS

NARCISO CANO, ASSISTANT NATIONAL DIRECTOR, SER-JOBS FOR PROGRESS, INC., APPEARING FOR RICARDO ZAZUETA, NATIONAL DIRECTOR

Mr. Flood. Mr. Ricardo Zazueta, National Director, SER-Jobs for Progress, Inc.

Mr. Cano. Mr. Flood, my name is Narcisco Cano, and I am the assistant national director. Mr. Zazueta had to have some work done healthwise and asked me to come in his stead.

Mr. Hiram Cintron of the Puerto Rican Forum headquartered in New York City wanted to also testify today but was unable to due to scheduling problems. He asked me to relay his regrets and to speak for him on the plight of the Spanish-origin communities in the Northeast.

CETA has been law for almost a year and one-half. What has been the impact of the CETA on the Spanish-origin community?

It is hard to say. Hopefully by August as we complete a study on that question, funded by the Ford Foundation, we will have some definitive answers.

But preliminary indications give us great concern, and I hope cause you concern as well.

A March 19, 1975 report shows that the Spanish-origin participation rate in manpower training programs operated by prime sponsors has dropped by one-fourth! (Refer to exhibit I.)[1]

Let me say that again. In the first half year of operation of CETA, Latinos across the country are participating at a rate one-fourth less than a similar period the year before. Why?

The answer cannot be that the need of this group of Americans has lessened. According to the Bureau of Labor Statistics, the first quarter 1975 unemployment rate for the Spanish-origin was 12.49 percent,[2] 50 percent greater than the year before. One person out of eight in the labor force is without a job, and we are not counting the other ones who

[1] "Characteristics of Enrollees in CETA Title I and Title II Programs, First Half Year 1975 Compared to Similar Fiscal Year 1974 Programs." Report dated Mar. 19, 1975, Office of Administration and Management, Division of Reporting Operations, Manpower Administration, Department of Labor.

[2] News release of Department of Labor, Bureau of Labor Statistics, Apr. 14, 1975, "Labor Force Developments: First Quarter 1975."

have been turned down so often, they have become discouraged and have dropped out of the labor force.

What about section 301(b) of CETA, which was intended to insure prime sponsors paid attention to persons of limited English-speaking ability, of which the majority are Latino? How much attention has been paid to that?

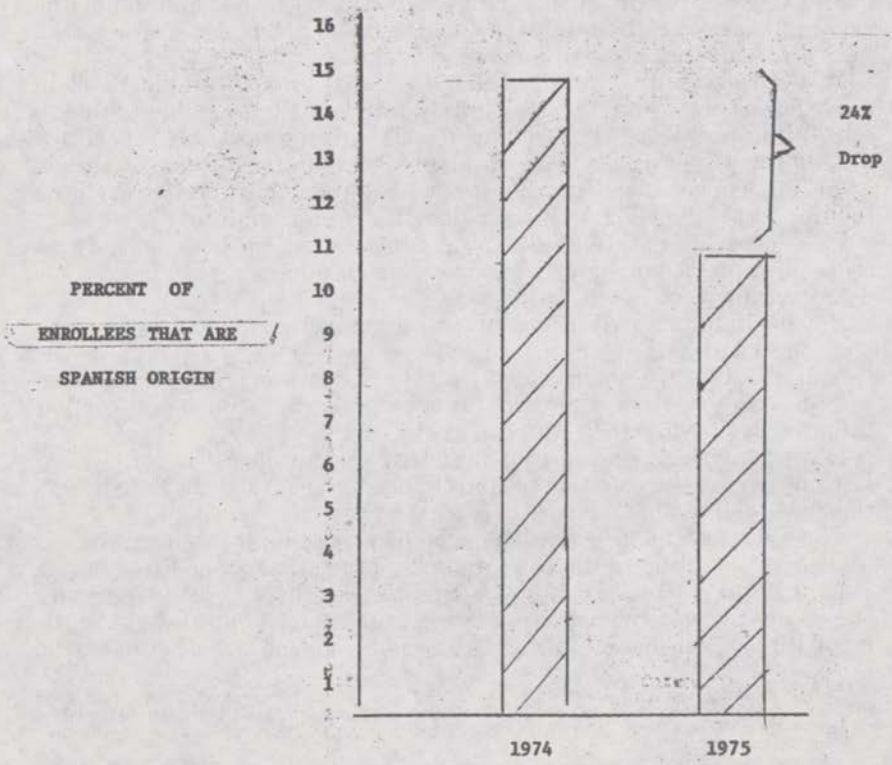
We suspect little. As an indication, regulations on section 301 (b) have yet to be released. And even if released, we are afraid the regulations will only lead to another box for a prime sponsor's staff to check: "I certify this * * * I certify that * * *."

The real problem we believe is that to date section 301(b) has not had the power of the dollar behind it. And we ask you to consider adding $70 million to title III for the Secretary to utilize in carrying out this section. And administratively, the Secretary could take steps to multiply the impact beyond the $70 million.

In addition, we ask the Committee to consider instructing the Department of Labor to insure that the funding of SER for fiscal year 1976 be at least a total of $32 million through a combination of support by State and local sponsors and national contract, from funds appropriated for all titles of CETA.

Thank you for allowing us to present our views.

EXHIBIT NO. 1—PARTICIPATION RATES



WITNESSES

JACOB CLAYMAN, SECRETARY-TREASURER, INDUSTRIAL UNION DEPARTMENT, AFL–CIO

SHELDON W. SAMUELS, DIRECTOR OF HEALTH, SAFETY, AND ENVIRONMENT

PHILIP DAUGHERTY, LEGISLATIVE REPRESENTATIVE

Mr. FLOOD. Next we have Mr. Clayman, secretary-treasurer, Industrial Union Department, AFL–CIO.

Mr. CLAYMAN. Mr. Chairman, my name is Jacob Clayman. I appear here on behalf of the 6 million members of the Industrial Union Department of the AFL–CIO. With me are Sheldon Samuels and Philip Daugherty, members of my staff.

First let me say that we support the proposals the AFL–CIO will present at a later date and that our purpose this morning is to supplement their testimony.

Since testifying last year, this committee has accomplished a great deal. We are finally beginning to provide the funds and develop the human and physical resources necessary to do the job of protecting workers' health.

Since last year, as a consequence, we have begun to observe subtle changes in the direction of this program that have resulted not only from increased people and positions, but also from the prescriptive language of your report.

It is important that your interest continue. Death, disease, and injury among workers have not begun to disappear, especially in small business. I won't bore you with numbers, except to say that a recent University of Washington study done for NIOSH confirms what we have been saying for many years: Occupationally related death, disease, and injury are grossly underreported in this country. In effect, Mr. Chairman, we don't even bother to properly count the dead, dying, sick, and injured.

As you know, our primary concern is the budget for agencies created by the Occupational Safety and Health Act. This isn't because the other agencies aren't important. On the contrary, they are very important and often essential if we are ever going to stop this greatest of all American tragedies. But we are the only major constituency for the OSH Act. For this reason, we have a special obligation.

In passing, however, we would like to note that—according to a recent study by the American Public Health Association—only 2 percent of the budget of the National Cancer Institute is for the study of "causes and prevention." It is our own observation that the Institute is plagued by severe personnel shortages jeopardizing efficient administration. They do too much contract work and haven't even sufficient personnel to properly develop and monitor their contractors.

The situation at the National Institute for Environmental Health Sciences is critical. This unique and essential organization is the key-

stone of our environmental health research effort. Its work on the intergenerational effects of chemicals and physical agents is absolutely essential if we are to ever develop a sane environmental policy in this country. (There are about 1,000 largely unidentified mutagens in the workplace.) They need space in which to work ($11 million for a new building) and 50 new positions. They can effectively use $42.7 million. I might add that it has been our observation that the administration of NIEHS has been exceptionally well administered and well coordinated with the Governmental effort as a whole.

The NIOSH situation is a little better since last year. We have already begun to see good changes during the few weeks in which their able new Director has been in office. But he needs a great deal of help from you. You must provide what the administration does not ask for, because of their deficient and shortsighted policies rather than the needs of the Nation.

NIOSH needs 113 new positions. They need $8½ million for occupational carcinogenesis research and standards development.

All of us know, learning of the impact of occupational exposure and its association with cancer, every week virtually we read a new frightening, awe-inspiring story about the impact of that association. And in spite of that growing body of knowledge, we are still parsimonious in the area of developing standards which would cut down the impact of occupational exposure as it results in cancer.

We have asked for $8.5 million, which incidentally NIOSH originally requested but was eliminated. I can not overstress the importance of this need as we become aware, as I have indicated, every day of the desperate need of developing new effective standards.

Technical assistance needs to be augmented ($500,000). They have a mandate for manpower development, but no funds. We request at least $2 million for this purpose initially and much more next year. (We will elaborate on the manpower needs below.) Engineering research almost does not exist, although the development and extension of technology to properly design and control the industrial processes make everything else we do meaningful. While this is primarily the obligation of the private sector, management needs to be stimulated, guided, and often assisted. The key to the success or failure of the act lies in the concept of feasibility, essentially an engineering problem. We recommend $1.8 million for this effort. These changes would mean a total NIOSH budget of approximately $45 million, a tiny sliver of the tax dollar that will save millions of lives and end needless suffering.

The problem of feasibility from an administrative point of view is really one of a variety of interfaces with other agencies and the private sector. OSHA's input on questions of feasibility, however, must not be so dependent upon external sources as to paralyze their ability to act knowledgeably and, therefore, effectively. Yet this has been the case.

Beginning with the vinyl chloride episode, OSHA's Office of Standards began to seriously attack this problem. It took a lot of prodding on the part of some of us to get the apparatus into action.

Their first efforts are primitive. Yet, as in the case of vinyl chloride, they have been important. This aspect of their work needs to be radically bolstered and artificial barriers—such as restricted travel that prevents field studies—these impediments need to be removed.

If I may quickly make a point that does not appear too adequately in our statement. Here we are in enormously vital issues that need careful exploration and because of budget restraints OSHA can't do the kind of fieldwork necessary because in a sense we are penny-wise and pound-foolish, if I may use that homely bromide.

But the problem of feasibility does not begin or end in the Office of Standard. The compliance activity in Washington (currently buried) needs to be reinforced so that information on what can be done to meet OSHA standards reaches field units quickly, uniformly, and accurately.

The compliance staff in the central office needs to be closely integrated with the work of the Office of Standards. But the difficulty is that the compliance staff virtually does not exist. We are critical of their work: the major problem lies in the absence of personnel. They have a low priority. Other high-priority portions of OSHA—such as the failing State programs activity—are overstaffed. Some direction from the committee obviously would be useful.

There needs to be some readjustment and relocation of the funds to the more vital activities rather than less critical activities.

We recommend that $5 million be allocated between the Office of Standards and the Office of Compliance specifically for the purpose of assessing and transmitting feasibility data. None of these moneys should be spent for economic studies.

Because of the limitations of time, I will stop my formal presentation at this point and transmit for the record an analysis of the manpower and education problems which deserve special attention and cannot be easily summarized.

[The remaining, unread portion of the statement follows:]

ANALYSIS OF MANPOWER AND EDUCATION

Manpower needs can be classified into four categories: (1) Enforcement; (2) Research; (3) Health and Environmental Services; (4) Teaching.

Existing occupational health and safety manpower does not meet our needs. Nor is a serious effort being made to meet them. Yet we are unable to provide full and meaningful protection to workers until adequate numbers of trained professionals become available. What we do have is diminishing. The average age of available trained occupational safety professionals is 50 years and of available trained industrial hygienists is 41 to 42 years. As the needs increase, the shortage will grow by attrition for age unless training resources are improved through grants to universities and colleges for professionals, through grants to community colleges for paraprofessionals and through short-term technical training courses to upgrade the competency of personnel now employed in occupational safety and health disciplines to supplement their on-the-job training.

Further indication of insufficient manpower is the fact that only 6 out of approximately 10,000 annual medical school graduates go directly into occupational medicine, with approximately 75 percent of the 75 occupational medicine residency positions going unfilled each year. A recent survey by the American Occupational Medical Association indicates that 4,100 U.S. physicians practice occupational medicine as a primary or secondary specialty out of an estimated 335,000 physicians (about 1 percent of the total).

The act will not, and is not, properly functioning because we have not faced the manpower issue. If OSHA and NIOSH are to be effective, we cannot permit poor quality manpower or lack of sufficient manpower.

The report by the Government Accounting Office (September 28, 1973 states that:

"NIOSH has channeled a portion of its monetary resources into research contracts and agreements with private organizations and other governmental agencies. At the end of fiscal year 1972, however, it had not expended $800,000 of its total appropriation for that year and it had not expended an estimated $600,000 at the end of fiscal year 1973, despite the magnitude of its problems. NIOSH officials said these funds could have been directed into contracting but were not because the lack of personnel prevented any further development and monitoring of contracts."

To this we would add the observation made in previous testimony that NIOSH (despite these unspent funds) is forced to contract when this method is inappropriate.

OSHA inspectors who are insufficiently trained or overloaded can produce an ineffective enforcement program and one with the wrong emphasis. OSHA's training institute in Chicago can handle only about 200 students in a maximum 3-month program. But few—if any—hygienists or compliance officers receive this much training. Six weeks is normal. Only 2 weeks of retraining is available.

We recommend expansion of the Chicago training facility to include a 6-month curriculum (additional $600,000). The British Government is designing a 6-month program for their compliance program. In addition, the Public Health Service developed a similar 6-month program which we believe was a success in the air pollution control field.

Assistant Secretary Stender's request to the Department for an additional $10 million for in-house, employer and employee training was modest and should not have been turned down. Less than half that amount is in the President's budget. More, the dollar amount has actually decreased—a shortsighted action.

Unless both employers and employees know more about their obligations, the problems they face (and how to solve them), the current chaos and bitterness that characterizes OSHA will prevail. Yet less than $600,000 was expended last year specifically for employee education; $2.4 million was spent for employer education. Employee education—essentially by two land-grant universities and the construction trades—has been a success and needs expansion.

Both efforts are limited in their ability to expand by the lack of skilled teachers. Here we pay the price of having tolerated the Nixon administration's new federalism applied to this field: returning responsibility for occupational health and safety to the States, including the development of enforcement manpower. This contraction of Federal involvement in the enforcement area is simultaneous with cuts in occupational health and safety manpower funding in general and places the burden on the private sector to involve itself and pay for training.

The NIOSH manpower training program, divided into long-term training based on grants to colleges and universities and short-term training, operated by NIOSH itself, was once a decent program. As of July 1973, all NIOSH direct funding for training of occupational health and safety personnel was phased out, including funding grants to universities and colleges and NIOSH short-course training, which is now provided without subsidy on a fee basis. The elimination of free courses—which were over-subscribed by approximately 4 to 1—and stipends offered as a result of direct grants to colleges by NIOSH reflects the present administration's desire not to pay for occupational health and safety manpower training.

Since industry has been a primary employer of the existing manpower, it has borne some training costs. Occupational medicine residents—for example—usually pay for their first 2 years of training, residents in other specialties earn between $5,000 and $10,000 a year during their residency training, and they usually receive salaried third-year clinical training with a company. They rarely receive financial assistance for training in an academic setting or hospital. These facts explain the generally poor quality of industrial health care delivery. The company doctor system is perpetuated by current administration policy. The policy creates tremendous disincentives to meeting manpower needs in the entire field of occupational health and safety.

OCCUPATIONAL SAFETY AND HEALTH PERSONNEL

(Source: Nicholas Ashford, MIT)

Category	Presently Employed	Production[a] Per Year	Demand Per Year	Need[b]	Shortage[c]
*Occupational Physician	< 500	5	15	1,750	> 1,250
Industrial Physician	2,700**	50	100	6,900	4,200
*Occupational Nurse	< 1,000	75	100	9,400	> 8,400
Industrial Nurse	17,000	200	900	36,700	19,700
*Safety Engineer	2,000	100	150	8,700	6,700
*Industrial Hygienist	500	75	300	5,500	5,000
OSH Specialist[d]	15,000	200	1,000	26,700	11,700
Totals	< 38,700	705	2,565	95,650	> 56,950

Table Clarification Notes:

a
Production includes formal academic degree short-course training, self-study and practical professionally supervised experience.

b
Need figures are levels of manpower to provide uniform services to each worker to the extent feasible "which assure that his working environment is safe from hazards and that he is adequately protected from the injurious effects of hazards that cannot be eliminated."

c
Author's calculation based on Needs figure less Present Employment figures.

d
Includes professionals moving towards qualified levels as safety engineers and industrial hygienists, i.e., non-certified, and technicians.

*Qualified by some accreditation or board certification process.

**Other estimates which include non-industry physicians are between 6000-8000).

Mr. CLAYMAN. I hope the necessities of cutting the statement does not diminsh the sense of urgency we feel and hope we can transmit to the chairman who has always been aware and friendly to projects of this nature.

Thank you, sir.

Mr. FLOOD. Thank you very much.

WITNESS

JOSEPH A. HOFFMAN, COMMISSIONER OF THE NEW JERSEY DEPARTMENT OF LABOR AND INDUSTRY

Mr. FLOOD. Dr. Joseph Hoffman, Commissioner of Labor, New Jersey.

STATEMENT OF DR. JOSEPH A. HOFFMAN

Dr. HOFFMAN. Mr. Chairman, I understand that you are quite pressed for time. I will not read my statement.

[The statement follows:]

Dr. HOFFMAN. Mr. Chairman and members of the committee: My name is Joseph A. Hoffman. I am commissioner of the New Jersey Depart of Labor and Industry.

I wish to express my appreciation to the members of this subcommittee for the opportunity to discuss the impact of the Federal fiscal year 1976 budget on the programs of the Department of Labor and Industry in New Jersey. I would like to confine my remarks today to the problems of highest priority resulting from these appropriations.

In the face of the deepening national recession, it is difficult to understand the rationale underlying the $70 million reduction in the national employment service budget.

As a matter of fact, the recent survey made by the International Conference of Employment Security Administrators on the rock-bottom needs of all State agencies indicates a need in 1976 for an additional 3,735 jobs and $68,500,000 beyond the administration's request of $493,600,000 for 27,300 jobs.

These additional moneys are necessary:

To meet the increased workload resulting from high unemployment.—At a time when the national unemployment rate is close to 9 percent and applications for work are outpacing our processing capabilities, we should not be considering a budget cut.

To meet increased costs due to inflation.—Salary costs over the past fiscal year have increased 11 percent; nonpersonal services have increased by 7 percent. It is clear that just to stay even—in order to provide the same quality and quantity of services as last year—will require substantial budgetary increases.

To restore recent cuts.—From 1967 to 1973 the employment service strength never fell below 30,300 positions. It is revealing to note that in 1967 we had one employment staff member for every 97 unemployed workers. In 1976 under the present budget proposals we would have one employment service staff member for every 275 unemployed workers.

This diminishing ratio becomes even more alarming when one realizes that the total unemployed during a year is at least three times the number at any one time, the great majority of whom come to the local employment service office for job-finding assistance.

The impact of this appropriation on the State of New Jersey would be disastrous. We stand to lose a minimum of 180 employment service

positions, even assuming the most generous regional office discretionary allowances. This reduction of professional staff will result in a loss of over 27,000 individuals placed in employment.

This reduction is all the more devastating in New Jersey because of the magnitude of our economic problems. In April, the latest month for which we have statistics, 11.1 percent of New Jersey's labor force was unemployed. This represents 400,000 people. Just to keep pace with projected labor force growth, which hopefully will be augmented by the return of our now discouraged workers, we will need to place an additional 50,000 to 55,000 people in jobs each year into the foreseeable future.

It is clear that to restore full employment in New Jersey will be a monumental task in which there is a critical need for a strong, viable employment service to support our economic development efforts.

Despite the current unemployment rate, 89 percent of the workforce in New Jersey is still employed. Employers are hiring, if only to replace turnover and those who die and retire. With additional staff to contact employers and offer positive placement services, many unemployed people can be returned to gainful employment.

This is not wishful thinking. States like New Jersey, Illinois, and Pennsylvania have already demonstrated that a positive "Hire Now" campaign can develop job openings and place the unemployed if properly planned and staffed. Job development of this kind costs more than the traditional labor exchange functions of the employment service. It takes more time to contact employers and find job openings; further, many applicants need more intensive help to encourage them to change occupations and seek new fields.

Yet I believe that such an effort is practical and effective. Throughout the country at least 20 million hiring transactions will take place in fiscal year 1976. If the employment service can increase its penetration of this market by only an additional 5 percent, it can put a million more unemployed persons to work during fiscal year 1976.

Such an improvement in placement performance would result in a $400 million savings in unemployment insurance, welfare, food stamps, and related income maintenance costs. These facts justify an investment of government funds to finance the 31,035 positions projected in the State's survey—3,785 over the fiscal year 1976 appropriation request.

We have developed many other innovative programs to deal with the particular problems we are experiencing in New Jersey but which cannot be implemented because funds are not available.

At the heart of our problem, and that of many other States, is the balance placement formula which has the unique feature of punishment for a State in economic difficulties and reward for a State not in economic difficulties. Thus, the impact of this formula is that the more economic ills a State is experiencing, the less support for employment service functions it can expect.

Looking at the balanced placement formula itself, there are serious inconsistencies in its structure. Studies done by or financed through the U.S. Department of Labor indicate the significance of labor market variables as they impact on job placements. Yet, the balanced placement formula remains essentially unadjusted for such variables except for the unemployment rate. Particularly important, but disre-

garded, are such economic phenomena as the rate of new job creation and the proportion of low-pay status jobs. This militates against successful placement performance in an industrial State like New Jersey where our high unemployment rate is compounded by the shift we are undergoing from a manufacturing to a service economy.

To make the balanced placement formula fair and reasonable, a variety of variables must be analyzed, their impacts noted, and the appropriate adjustments made.

One of the most costly negative impacts of the balanced placement formula is on the continuing problem of the cities. I would like to highlight the Newark situation as a specific example as what I see as the problem with the balanced placement formula for New Jersey. For the first 6 months of fiscal year 1975, our statewide placement per man-year figure—field staff only—was 169.2. In our Newark offices it averaged 103. If we simply dropped Newark out of our calculations, the average would rise to 184.3.

To put it another way, if we let Newark drift off the coast of New Jersey by a slender threat and did not include its record as part of our formula reporting, our total annual performance at 184.3 placements per man-year would reach 104,682, or 89.5 percent of our goal.

This is a clear illustration of how problems with one major city can push overall performance, measured by the balanced placement formula, significantly downward. Surely the Federal Government does not suggest that we cut Newark off from the rest of the State and let it float up and down off the Jersey shore. Yet, the "numbers game" we are being forced into by the balanced placement formula could push us and other industrial States in this direction.

There is another more disturbing feature of this balanced placement formula system. When States are completely dependent for funding upon conformance to rigid specifications prescribed by Washington, they lose the freedom to develop innovative solutions to their problems. I would like to emphasize the importance, in a long-range sense, of this situation.

If you review the history of our country, it is clear that most of what is our "ethic" are ideas which originated and action which was initiated by individual States. One only need look for the source of the lasting monuments to our society which resulted from the New Deal—the Civilian Conservation Corps, the public works program, and the Works Progress Administration of Franklin Roosevelt's administration during the Great Depression—to understand the meaning and impact of what I am saying. Roosevelt's policy advisors went to the States for their ideas and solutions. Most of what we consider to be New Deal programs had their origins several years before as the efforts of individual States to come to grips with their problems.

The answers to our current economic and social problems are not as easy to come by. This results in part from the problems being more complex today then they were during the 1930's. But more importantly, it results from the States having been discouraged to find solutions without essential funding. It is the systematic lack of freedom of States to be innovative and creative in developing solutions to the issues confronting them that is crippling our Nation's economy and our ability to cope with our economic and social problems today.

Therefore, I would recommend that discretionary money be available to the States to undertake studies, develop programs, and initiate action as they see appropriate, based on their reasoned judgment.

I think it is imperative to invest in efforts that States think most appropriate and necessary to meet their needs. Intensive innercity job development and placement efforts, availability of "risk money" for business and industry locating in urban areas, storefront offices for youth summer employment problems are but a few of the programs which States like New Jersey need but are unable to fund through the balanced placement formula system.

In closing, may I voice the hope we will receive from this committee the guidance and help we need to solve our problems on a State level.

Thank you very much.

Dr. HOFFMAN. I would like to point out to you two areas for which I appear before this committee. I am Joseph Hoffman, commissioner of labor and industry in the State of New Jersey. My interest here today is with the cuts which have been suggested by the Department of Labor in the employment service budget. New Jersey presently is suffering an unemployment rate of some 11.1 percent; 400,000 people are out of work in our State. The economic erosion continues. We can ill afford a cut in our employment service budget at this time.

The International Conference of Employment Security Administrators said that the rock bottom needs for the 1976 budget were 3,735 jobs, or $68 million investment, beyond the administration's request of $493 million.

In 1967, the ratio of employment staff members, unemployed workers, was 1 to 97. Today in New Jersey it is 1 for every 275. We stand to lose a minimum of 180 employment service positions, which would result in the loss of some 27,000 individuals placed in unemployment next year.

Nationwide, if you just increased employment service production by 5 percent next year, you could put 1 million more people to work, which would be a $400 million savings in unemployment insurance, welfare costs, and the like.

Basically that is the position of our group. Our employment service instituted many reforms in the past year. It is working hard and doing a job in the face of tremendous adversity. We simply cannot afford a cut in the face of these problems of some 200 people. That is what the impact of the national cuts suggested by the Department of Labor would have on our State.

A second point I would like to make is that the Department of Labor utilizes a productivity formula for funding employment service which is called balance of placement formula. That formula simply is not geared to the variables in our economy. What it does is it penalizes the States with the greatest economic difficulties and it rewards the States which have no or little economic difficulties. For example, the only variable in the formula—and this is the formula used for funding employment service throughout the country—is the unempolyment rate. The extent of that variable among the 50 States is some 16 percent.

Mr. FLOOD. Are you 11.1 statewide?

Dr. HOFFMAN. Yes, sir. In some areas it goes up in BLS areas as high as 17 percent. In some of our cities it is as high as 25 or 30 percent. It is quite a serious situation.

What happens is that, as I said, the unemployment insurance rate goes into this factor formula by which we get funded and it only has a range among the 50 States of 16 percent variation. There is 100 percent difference among many States in unemployment. Between Arizona and us there is 100 percent difference. It does not take into consideration such variables as the erosion of the economy or the growth of the economy. It does not take into consideration the kinds of jobs and the quality. It puts into the equation only the quantity of placements. It does not put into the equation the quality of placements and the difficulty of placements.

As a result, in my State, if I played the numbers game with the Department of Labor I could pull all of my Employment Service people out of the city of Newark and have one of the highest productive rates in the country. That means I am not putting service where it most belongs.

I think this committee should take a good, hard look at the way they fund, using that formula, because, as I say, the States on the bottom of the list are New York, New Jersey, and the cities with great economic problems.

Basically that is what our testimony consists of. I appreciate the opportunity to appear before you.

Mr. FLOOD. Thank you very much.

FAMILY PLANNING AND RESEARCH ACT OF 1975

WITNESSES

DR. WILLIAM A. LYNCH, CHAIRMAN, SCIENCE COMMITTEE, HUMAN LIFE FOUNDATION
MS. MARY K. WILLIAMS, ASSISTANT DIRECTOR

Mr. FLOOD. Dr. William Lynch, chairman of the science committee, Human Life Foundation.

Ms. WILLIAMS. Mr. Chairman, Dr. Lynch is en route from Minnesota this morning and was due in at National Airport a while ago. I know he is the last speaker on your agenda. I am Mary K. Williams, assistant director of the Human Life Foundation. With your permission I would like to read a brief summary of his remarks.

Mr. FLOOD. Please proceed.

Ms. WILLIAMS. Mr. Chairman, the Human Life Foundation was founded by the American Catholic Bishops in 1968 to sponsor research and education in methods of family planning which employ no chemical, mechanical, or hormonal means in controlling fertility.

Mr. FLOOD. Family planning as distinguished from abortion?

Ms. WILLIAMS. That is correct.

We seek to identify a minimal period of abstinence, accurately determined by measurements of normal biological reproductive rhythms, through which couples could control their own fertility.

Mr. Chairman, I believe Dr. Lynch is here now and I would like for him to proceed. Thank you.

STATEMENT OF DR. WILLIAM A. LYNCH

Dr. LYNCH. As I understand it, the young lady was reading my statement at the end of the second paragraph.

This is not of the calendar rhythm of 1926 nor of the temperature rhythm of the fifties; the chemically treated tape of the sixties; nor merely the "mucous ovulation observation" of the Billings of the seventies. We are not speaking of methods whose efficacy is untested nor whose teaching standards were so poor as to give the entire movement a bad name. We speak of natural family planning which commonly employs four indicators of ovulation and the fertile period of woman. These indicators are becoming more accurate by the year and the teaching of them is becoming realistic. We speak of a method Dr. Louis M. Hellman, Deputy Assistant Secretary of HEW for population, finds "acceptable," and Dr. Philip Corfman, of the National Institute of Child Health and Human Development, calls "highly effective." The method is inexpensive—there are no costly medicines, hormones, pills, injections, or gadgets.

There are no known side effects.

It has proved to be as effective as many artificial methods and more accurate than most.

We recognize that it does require full cooperation of the male. Any method varies with the commitment of the couple. But with natural methods the male does not place the burden on his wife alone.

It is ecological. It does nothing to the patient.

Moreover, the training sessions prior to autonomous practice of the natural methods present excellent opportunities for both individuals and couples to explore and develop fundamental attitudes toward themselves and each other. Concomitant with an increasing fertility awareness, there is an increased sense of inner worth and self-mastery which adds incentive to personal growth and maturity of the individual, plus the maintenance of open communication and cooperation between the sexual partners. The result is not only family planning but also responsible and dynamic participation in helping resolve an important demographic issue without compromising the rights of the individual.

Its greatest expense involves research of a refined variety. Its greatest expenditure is personal time and effort in teaching couples and other teachers. To this end the Human Life Foundation under contract with HEW has just completed the first Government sponsored curriculum training outline for teachers of natural family planning.

Earlier this month, the Human Life Foundation was privileged to play host to representatives of natural family planning efforts in 11 nations as we convened a research conference in Boston. Meeting with distinguished members of our own scientific advisory committee were representatives of the Ford Foundation, Rockefeller Foundation, Population Council, Family Planning International Assistance, AID, the National Institute of Child Health and Human Development and the World Health Organization. More than two dozen prominent American educational and research organizations were represented as well.

This was not some international team toying with Vatican roulette—an expression which bespeaks ignorance—nor visionaries pursuing pie in the sky—an expression which adds insult to ignorance. They were serious scientists and teachers representing many continents, cultures, creeds, and racial groups. They came together in a pragmatic approach to improving natural methods of family planning already seen as effective in their present form.

The 4-day meeting established three major priorities:

1. Finance the work for 5 years of an experienced, interested, creative, university based investigator.

2. Detailed comparative study of the mucus or billings method.

3. Investigate the contributions to be made by psychiatry and the social sciences in this field.

Dr. Corfman recently told a Senate subcommittee that $1 million a year for three or four years is needed for natural family planning research. We applaud such support but are cautious about a specific dollar figure. Our experience shows that this has been born anew: New irons have to be struck. New leads must be followed. Our own publications on the educational side are now in three languages to meet the communication needs of a movement now spreading in 50 nations.

Our neighbor is everybody because he is anybody, but perhaps most of all because he is there. As physicians we add and he needs our help.

I am here representing practitioners of the science of medicine to seek your help that we may help our neighbors in the most proficient and simple manner possible. As practitioners of the art of medicine we seek your help in translating the interest from the scientific side to its application on the art side of medicine with the purpose in helping our neighbor in this sensitive area without doing things to him, but doing things for him in a natural, ecological, simple, and effective fashion.

Research has traditionally been the largest item of an investigator budget. It is no less important in the family planning subject we are discussing today.

Mr. FLOOD. Are you a doctor of medicine?

Mr. LYNCH. Yes, sir. I am an obstetrician.

But with natural family planning, education is of at least equal importance and demands at least an equal share of the budget. In all methods of family planning, there is always at least one troublesome cause of failure. In natural family planning, that cause is lack of proper education and motivation. For that reason natural family planning clinics started by knowledgeable and committed people are of critical importance to both the cause of good education and sincere motivation.

For this reason, the Human Life Foundation finds itself totally committed to the concept that natural family planning is a valid service to be provided to the American public but sincerely commends to the attention of the Congress that it has special educational and environmental needs for effective delivery of this service.

The Human Life Foundation further contends that whenever public funds are allocated for family planning research and delivery of service that a portion of these funds should be allocated for service and research in natural family planning. We support the intent of section

204 of H.R. 4925, the Health Revenue Sharing and Health Services Act of 1975, as it provides for the inclusion of natural family planning methods.

Thank you.

Mr. FLOOD. Thank you, Doctor.

FAMILY PLANNING

WITNESS

JESSMA O. BLOCKWICK, DIRECTOR, DEPARTMENT OF POPULATION OF THE BOARD OF CHURCH AND SOCIETY OF THE UNITED METHODIST CHURCH

Mr. FLOOD. I understand that Jessma Blockwick is here now. She is the director of the department of population of the board of church and society of the United Methodist Church.

Since you last heard from us they changed the rules on us; we have to be on the floor at a quarter to 12. You have 5 minutes instead of 10.

Ms. BLOCKWICK. My name is Jessma Blockwick, and I am director of the department of population, board of church and society of the United Methodist Church. Our denomination has had a long-standing commitment to the health and well-being of individuals and families and consider the access to family planning service crucial to that well-being. In 1972, the General Conference of the United Methodist Church, in a resolution on responsible parenthood, stated that:

> As developing technologies have moved conception and reproduction out of the category of a chance happening into the realm of responsible choice, the decision whether or not to give birth to children must include acceptance of the responsibility to provide for their mental, physical, and spiritual growth, as well as consideration of the possible effect on quality of life for family and society.

Responsible decisions are difficult without access to the means of carrying them out.

The idea of responsible family planning has become so widely accepted in our society that we tend to forget what a remarkable and rapid social change this actually represents. Just a few short decades ago information, distribution or use of contraceptives was illegal. Now having access to information and services to regulate fertility is recognized as a basic human right in the 1968 Tehran Declaration on Human Rights of the United Nations.

At the opening plenary session of the World Population Conference last year, Secretary of HEW Caspar Weinberger, who headed the U.S. delegation, spoke proudly of the record of the United States in acting to make family planning services available to all, and also of the Federal biomedical and social service program of research in human fertility and its control. "Our government," he said, "insists that the voluntary choice of each individual participant must be fully safeguarded. We believe this choice is strengthened by information and by a full range of fertility controls. We are concerned about growing numbers, but we are equally concerned to help parents avoid the conception of an unwanted child—which I call a population crisis all its own."

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We do indeed have much to be proud of in this field, and there are surprisingly few critics of the family planning and population research legislation. I respectfully submit that now is not the time to pull back, to lessen our commitment to the goal of bringing the means to plan one's family to every individual who wants such services.

May I just briefly remind us of some of the benefits of these programs, which go far beyond that of simply limiting births.

Family planning, which enables parents to have only those children which they want and can support, has been a means of lifting many families out of poverty or low-income status.

The family planning programs have meant improved maternal and child health, for having too many children or having births too close together no matter the number are associated with increased maternal, infant, and fetal deaths, higher prematurity rates, a greater chance of child abuse, increased incidence of infectious diseases in both parents and children, poorer growth in height and weight, lower IQ scores among the children, and higher prevalence of certain diseases among the parents.

These human values served by family planning programs are the most gratifying results, but from a fiscal standpoint they have also been highly beneficial. Since this Federal program was begun, cost per patient visit has been reduced, which has increased the value of the funds allocated to individual projects. It has been estimated that by reducing unwanted births, the program has saved more than $2 for every dollar spent.

Mr. Weinberger said by reducing unwanted births the program has saved $2 for every dollar spent. This is not the same as to stand still or fall backward.

May I say again, the great success of this landmark legislation should not obscure the fact that there is still much to be done in this area. Estimates are that there are at least 3 million individuals wishing family planning services who do not yet have access to them due to economic reasons, or inaccessibility of the services. There is still an unacceptable level of unwanted or unplanned pregnancy in this country. We might note that the baby boom of the 1950's is now entering the period of high fertility. So for the near future, there will be an increase in the numbers of women who need fertility-related services.

On the research side, many people still have reservations about the contraceptive technologies we have, even though they do represent great strides forward. These reservations apply especially to the most effective, nonpermanent means—the pill. Development of simpler, safer, less-expensive contraceptives could not only be a boon to our Nation, but to the developing nations which are struggling with the tremendous burdens of rapid population growth.

One more example of an area which needs intensive study is the problem of teenage pregnancies in the United States, which exists in near-epidemic proportions. A 1974 study found that about 10 percent of the overall teenage female population is likely to have experienced pregnancy outside of marriage.

To marry and then to conceive is the exception among teenagers, characterizing only about one-fourth of all first conceptions in this age group.

Health hazards for both mother and child are compounded where the mother is very young, and where marriage takes place because of the pregnancy. There are greatly increased odds that the marriage will be unstable and short-lived. Our society seems permeated by sex; how is it then that so many teenagers know so little about responsible use of sexuality? In fact, many do not seem to know even the basic facts of sex, and many others who do, choose not to use proper safeguards against pregnancy. We need to know far more through research studies why we have this tragic situation, and how we can best deal with it.

Last year's World Population Conference brought the largest number of governments together to attend any U.N. conference. All delegations, including our own, adopted a plan of action calling for increased commitment to bring this basic human right to all. This year is International Women's year, which again is expected to affirm the ability to control fertility as basic in making it possible for women to assume other roles and to realize a fuller range of options for their lives.

The ability to control fertility is crucial to raising the status of women and making it possible for them to have a fuller range of options.

The Family Planning and Population Research Act of 1975 is our own affirmation of this right. So long as there are individuals not yet reached, and there are millions of them, we should be moving forward, not faltering in reaching the goal.

We, certainly, can all sympathize with the difficult task Congress has this year in trying to hold Federal expenditures down in a period of economic uncertainty. Cutbacks need to be made selectively, however, and we believe strongly that this legislation is not the place to cut back, or even to hold to current levels which comes to the same thing.

Appropriations here demonstrably prevent the need for additional social expenditures later when unwanted births have occurred. This program has a splendid record in preventing deaths, disease, and much suffering in our society. It has enabled individuals and families to improve their economic status and to rise out of poverty. It has given the United States a position of leadership in an area which many consider one of the gravest crises facing the world.

As we understand it, the administration recommendations are based on the idea that gaps in services caused by cutbacks in this program will be picked up by new programs under the new title XX of the Rehabilitation Services Act. Again, we would only say that there seems no good reason for changing a process which has been so eminently successful and moving to an untested one.

We respectfully urge this committee to appropriate for the Family Planning and Population Research Act, title 2 of the Health Revenue Sharing and Health Services Act of 1975, at a level of $175 million for services and $75 million for research. The sums are tiny in terms of the social goods which benefit our total society.

Thank you.

Mr. FLOOD. Thank you very much.

PREPARED STATEMENTS

Mr. FLOOD. We have a number of statements which have been submitted to us by interested individuals and organizations as well as from several Members of Congress. These statements will be placed in the record. In accordance with our usual custom, we will hold the hearing record open for several days for the purpose of permitting additional statements, which we understand are on the way, but which have not yet been received. They will also be included in our hearings.

[The statements referred to follow:]

HEALTH PROGRAMS

STATEMENT FOR THE NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES, NATIONAL INSTITUTES OF HEALTH, BY IRWIN C. GUNSALUS, PROFESSOR OF BIOCHEMISTRY, SCHOOL OF CHEMICAL SCIENCES, UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

Thank you very much for this opportunity, as a citizen, to present a formal statement on that portion of the fiscal 1976 budget which you have under consideration for the National Institutes of Health, General Medical Sciences Institute. This Institute, charged with that portion of the basic sciences required for the solution of problems in the maintenance of the health and the alleviation of diseases of American citizenry, is indeed a most critical component. In addition to providing assistance to the other Institutes which may turn to the General Medical Sciences Institute for new methods, data, and leadership in elucidating the basic principles of biomedical sciences, this Institute has identified five areas of special concern in America at this particular time. The General Medical Sciences Institute has also an important responsibility to maintain and to advance the number of highly trained educators and to provide the best intellects with the most essential skills and probes for the biomedical sciences' research effort.

The areas of my competence over the past 40 years of biomedical science education and investigation have elucidated the structure and the role of two forms of vitamins active in protein formation and in the energy release processes. These are the vitamin B6, a form of pyridoxal phosphate essential to protein formation, and lipoic acid, essential to the liberation of energy at the branch point of respiration. The past 8 to 10 years have been focused on two complementary areas—the respiratory systems that form the hormones necessary to the regulation of body functions, and the revelation of a new class of respiratory systems, the oxygenases. Similar systems in the body also remove the toxic substances which enter the body as medicines or environmental pollutants. To build this area and to complement the chemical studies, the genetics of diversity have also been explored.

These studies, under finance of the Division of General Medical Sciences, have also brought physics professors, students, and new methods into the medical field. They have led to collaborations which have produced a new generation of professional investigators to supply the emerging skills required to solve some of the most pressing biomedical problems. Among these is the structure-function relationship and activities of the blood and muscle pigments that transport oxygen and the properties of the oxygenases which detoxify the foreign substances mentioned previously. The supply of essential skills, even of the most intelligent students, requires not less than 10 years beyond high school graduation, and 6 to 8 years beyond the college baccalaureate. To combine the essential skills of physics, chemistry (including biochemistry), and genetics to animal studies for the benefit of man is a difficult and time-consuming process. This education and experience cannot be turned on and off, but must be carefully nurtured over a long term of continued planning in support for stability. The programs in our best graduate and medical school systems, the problems of food, health, and environment, are not becoming more readily solved, but more difficult. Europe sent us a generation of teachers and professional investigators. We must now continue to educate these for ourselves and, if possible, to extend aid to the emerg-

ing countries for our own, as well as for their benefit. The solution of critical problems is a basic fundamental and a timeless sword of education. The earliest introduction of methods from physics, genetics, and chemistry to biomedical problems is made possible only by a generation of new workers based on the broadest experience of each preceding generation. Minimum timelag for use is transmitted to new intellects to build maturation and skills. The best intellects in the best graduate and medical centers need the quality use of funds, brains, and experience to solve emerging problems once these are visualized and stated by the advance in discovery. The teaching of these centers and the dissemination of their students to other secondary educational centers, to medical, clinical, and investigative centers, assure the health care of the American people.

Research planning and stability of both programs and funding are requisite to the health care, education, and continued research in causes of disease—genetic, somatic, environmental, and nutritional, from foreign viruses, microorganisms, and insects. Programs cannot be quickly turned on and off without loss of momentum and capable teams making certain of the fundamentals that permit solution of their immediate and practical problems. And the solutions are not possible, no matter the strength of the wish or demands, without an understanding of these fundamentals to permit a statement of experience, interpretable and investigatable for the problems at hand. Stability in programs planning by informed, experienced directors with the communication and the confidence of the biomedical community is essential. A modest gain in budget based on gross national product or other appropriate societal index is far superior to the indeterminate slash budget and late funding with multiple possible programs switched for reasons not understandable to the investigator or to the planners and interpreters. The fiscal 1975 NIGMS budget for education, research, and programs is an improvement over recent budgets. The advance of the biomedical sciences component of GMS will depend on the continuity through some new programs financed in fiscal 1976.

The availability of biomedical research health care is dependent on the planning and accomplishments which will require directors of the first quality in experience, education, and intellect. The present salaries at the Director level in NIH is insufficient to attract these in all but rare cases. The continuity of the people within the Institute is not at this time stable. The number of acting incumbents in various administrative posts attests to the lack of adequate funding and assurance of the time to plan and carry through programs of the needed quality and magnitude. Not only is the acquisition of the top personnel in the intramural complex under risk, but their maintenance as well. The funding of the educational, professional, and extramural programs are also, in many instances, undersalaried, making it difficult to attract the most competent people.

Curriculum Vitae, Irwin Clyde Gunsalus

Date of birth: June 29, 1912, Sully County, S. Dak.

Education:

Baccalaureate, Cornell University, 1935.
Graduate Studies, Cornell University, M.S., 1937; Ph. D., 1940.

Postdoctorate and Fellowships:

University of Wisconsin (with W. W. Umbreit), 1941.
Stanford University (with C. B. VanNeil), 1948.
New York University (with S. Ochoa): Guggenheim Fellowship, 1950.
Brookhaven National Laboratories (with M. Gibbs), 1950, isotopic methods.
Institut Edmond Rothschild (with Wurmser and Grunberg-Manago), 1959–60.
Cold Spring Harbor, Resident Laboratory.
Scripps Clinic and Research Foundation, La Jolla, California, 1968.

Previous Faculty Positions:

Assistant to instructor in bacteriology, Cornell University, 1935–1940.
Assistant professor to professor of bacteriology, Cornell University, 1940–46.
Professor of bacteriology, Cornell University, 1947.
Professor of bacteriology, Indiana University, 1947–50.
Professor of bacteriology, University of California at Berkeley, Summer, 1949.
Professor of microbiology, University of Illinois, 1950–55.
Professor of biochemistry, University of Illinois 1955; Head, Biochemistry Division, 1955–66.

Professional Assignments:

Council, NIH National Institute Allergy and Infectious Diseases, NIAID Criteria Subcommittee.
National Academy of Sciences—National Research Council, NAS Executive Committee, Division of Biology and Agriculture.
Biochemistry Training Committee of the National Institutes of Health General Medical Science Section.
National Research Council, U.S. National Committee for I.U.B., Chairman, 1972–76.

Societies:

American Academy of Arts and Sciences.
John Simon Guggenheim Foundation Educational Advisory Board.
National Academy of Sciences.
American Society of Biological Chemists, President, 1974.
Center for Advanced Study, University of Illinois, Associate Member.
American Association for the Advancement of Science.
American Chemical Society.
American Society for Microbiology.
Biochemical Society (British).
Harvey Society of New York (Honorary Member).
New York Academy of Science.

Honors and Awards:

Shared Mead Johnson Award in Biochemistry with E. E. Snell, 1946.
Fellowship of John Simon Guggenheim Memorial Foundation, 1949, 1959, 1968.
Chairman, U.S. Committee, International Union of Biochemistry, 1973.
President, American Society of Biological Chemists, 1974.
Councilor, National Academy of Sciences, 1975–78.

Editorial Boards:

Biochemistry.
Analytical Biochemistry.
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NATIONAL HEART AND LUNG INSTITUTE

(Letter From Gerald R. Riso, Managing Director, American Lung Association)

MAY 12, 1975.

Hon. DANIEL J. FLOOD,
Chairman, Appropriations Subcommittee on Labor-HEW, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN FLOOD: Our organization wishes to address your committee on two appropriations items. The first is the appropriation for the National Heart and Lung Institute which is the Federal agency most involved with research in chronic respiratory diseases, the major program interest of lung associations.

The other matter concerns future funding of formula grants for health services, now provided for under section 314(d) of the Public Health Service Act, but whose continuation is included under H.R. 4925. These grants constitute the only Federal support available for basic public health operations in the States; as such they help finance TB control programs in many areas where health departments have been able to allocate 314(d) funds for this purpose.

We realize the fiscal crisis in which the country finds itself and the choice the administration and Congress must make among many deserving programs. However, we believe there are special reasons why the National Heart and Lung Institute and formula grants for health services should both receive adequate funds. We request your committee to review these reasons before making its decisions on these components of the proposed budget.

NHLI

At the time the authority of the National Heart Institute was expanded in late 1969 to encompass a major thrust in pulmonary diseases, the medical and scientific community involved with pulmonary problems had been working for more than a decade to get the Federal Establishment to increase its attention to chronic obstructive lung diseases, such as emphysema. A focus on these conditions did exist in the then National Heart Institute but the pulmonary disease activities of the Institute were minor in scope and influence.

Since then, the Division of Lung Diseases has been established and its financing has been more commensurate with the problem with which its program is designed to deal. Increased funding has come about primarily as a result of the mandatory allocation to pulmonary disease of 15 percent of NHLI funds as required under the National Heart, Blood Vessel, Lung and Blood Act of September 1972.

The 1976 appropiration must be evaluated in relation to the short span of time that these increased funds have been available. As late as 1970, when financial support of pulmonary diseases had already been markedly increased, the pulmonary program of NHLI received only $10 million. Yet emphysema, chonric bronchitis and asthma had been a major cause of death for some years, as well as a leading cause of premature retirement. Both of these statistics are still true today.

Since 1950 the death rate from these diseases has increased faster than for any other major cause of mortality. Just in the past 5 years deaths have jumped 25 percent. Chronic obstructive lung dieases now cause more than 40,000 deaths annually. They rank as the sixth cause of death (even higher among white males). Payments by the Social Security Administration for disability from these conditions approximate $500 million annually and this does not include an even larger sum paid annually for black lung benefits.

Chronic respiratory conditions, such as asthma, also are serious causes of illness and mortality among children. Hyaline membrane disease and other respiratory diseases of early infancy are major causes of death among the newborn, causing close to 40 percent of the deaths in this age group.

Unfortunately, our knowledge of the causation of these various conditions is extremely limited. A number of factors are implicated but many clues are still undiscovered. The National Heart, Blood Vessel, Lung and Blood Act required the development by NHLI of a 5-year plan which has enabled that Institute to outline its priorities and direct its resources to those priorities. It has facilitated the bringing together of scientists with diverse skills to attack those priorities in a multidisciplinary approach never before possible in the pulmonary research program.

The advantages of this approach have been already demonstrated in pediatric pulmonary medicine where research has made possible a significant decrease in mortality from hyaline membrane disease. Unfortunately, these research advances can be utilized only where there is manpower skilled in applying this knowledge, which brings us to the equally distressing problem of inadequate numbers of trained manpower.

Even though increased funding of research investigators has resulted in an increase of pulmonary specialists on medical school faculties to 657 from 593 in 1971 there is still a serious deficiency of well-trained teachers. Medical schools now have a total of 260 vacancies they can not fill because of lack of qualified candidates. These schools project an additional equal number of teachers needed over the near future.

The momentum which has finally built up in the pulmonary research field can not be halted without severe damage to the population of respiratory disease patients which continues to grow. There is reason to believe that the type of progress illustrated in hyaline membrane disease can be duplicated in other areas but certainly not without adequate funds. The host of environmental assaults to which the lung is exposed in our highly technological society makes it imperative that research on the lung be continued at least at the present rate. To do otherwise will mean loss of opportunities difficult to recapture.

For that reason, we recommend that Congress appropriate $356 million for NHLI for fiscal 1976. This sum represents a 10-percent increase over funds appropriated for the Institute in fiscal 1975. It will mean $4.8 million more

for pulmonary disease research, as contrasted with a $4.7 million decrease for pulmonary diseases if the President's budget prevails.

If there is to be a real and significant commitment by the Nation to one of its most serious disease threats, there must be adequate funding of research into the causes of these canditions. In our opinion, a 10-percent increase is the least that will allow the Division of Lung Diseases to keep pace with inflation and also achieve some modest expansion of activities.

HEALTH SERVICE GRANTS

Federal support for TB control is today confined to 314(d) grant funds; TB control programs are eligible to compete with other public health programs for this support. In many areas of the country, health departments have relied heavily on these grants for controlling their TB problem.

In 1973 more than 30,000 persons were reported as new active cases of TB in the United States and 3,200 previously treated persons were estimated to have reactivated. Thus, the country is far from eradicating this communicable disease.

Treatment of TB today takes place largely in the outpatient area which is a considerable advance over the long hospitalizations necessary in the sanatorium era. However, patients must take drugs for several years and be supervised to assure that this tedious regimen is maintained. Contacts of a new case must be examined immediately upon discovery of the case. All these duties fall upon the health department which has legal responsibility for protection of the public health from communicable diseases.

In this economy, alternative sources of funding from States and local jurisdictions are simply not available for health department operations being financed by Federal funds. Despite the pronouncement by the administration, other Federal funds do not exist to pick up these costs. Thus the elimination of 314(d) support will spell the end of many activities which are the very substance of public health control. It seems incredible that the administration can propose to eliminate Federal aid for basic public health operations.

A survey of States to see how TB control programs would be affected in the event of a rescission of 314(d) funds during the last quarter of fiscal 1975 showed that consequences would indeed be serious. For example, the proportion of TB control costs paid for by these grants is approximately 90 percent in Kansas, 50 percent in Iowa, and 25 percent in Illinois; the actual amounts which would be lost to these States by elimination of comprehensive health formula grants is $233,000, $45,000, and $343,000 respectively. In your own State of Pennsylvania, $834,000 of comprehensive health formula funds are spent for TB control and an additional $1,068,000 from this source helps support programs concerned with other chronic pulmonary diseases (exclusive of coal miners' diseases). This Federal support represents 25 percent of the total expenditures by the State for these designated purposes.

For these reasons, we trust that the committee will not tolerate the termination of these grants as proposed in the budget and will provide the same level of support that was available to the States last year.

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We will appreciate your careful consideration of the data we have presented for support of these particular Federal programs. We request you to evaluate whether an inadequate appropriation will result in future higher costs for the country. We hope that you will agree with us that such will be the case, and take appropriate action.

Yours truly,

GERALD R. RISO,
Managing Director.

NATIONAL HEART AND LUNG INSTITUTE

STATEMENT AND LETTER FROM MR. MAX PAGLIN, TASTE AND SMELL FOUNDATION

Mr. Chairman and members of this subcommittee: My name is Max D. Paglin and I reside at 3001 Veazey Terrace NW., Washington, D.C. 20008. I am at present a member of the Atomic Safety and Licensing Board Panel of the U.S.

Nuclear Regulatory Commission. Prior to this appointment, I served for almost 30 years with the Federal Communications Commission in positions of varying responsibility, including that of General Counsel and, later, Executive Director of the Commission.

I am submitting this statement, at the invitation of the subcommittee, on my own behalf as a patient at the Taste and Smell Clinic of the National Heart and Lung Institute—as well as to express the concern of some 2,000 other patients who are suffering from various disorders of their senses of taste and smell, and who strongly urge this subcommittee to direct the authorities at NIH to support the continuation of this important medical program. I am also submitting this statement as the President of the recently organized Taste and Smell Foundation, which has been formed with a view of ultimately shifting research in this field to the private sector and continuing the search for a cure for these baffling and widespread disorders.

This statement is also submitted in support of the testimony given on behalf of the foundation before your subcommittee by David Austern, Esq., attorney for the foundation, and Mrs. Mary Shipp, Secretary-Treasurer of the foundation, on May 14, 1975. Due to an apparently inadvertent loss of my letter to Chairman Flood dated April 24, 1975, I was prevented from appearing before your committee during its hearings for public witnesses; however, through your kind consideration, our representatives, Mr. Austern and Mrs. Shipp were permitted to present our views. I am attaching hereto, for the subcommittee's reference, my letter of April 24, 1975 to Chairman Flood requesting permission to testify before this subcommittee. In the letter, I make reference to the hearings on last year's NIH budget before the Senate Appropriations Subcommittee, and I respectfully request that this subcommittee incorporate by reference the materials appearing in the Senate Committee's hearings, as well as the excerpt cited therein from the Senate Committee Report No. 93–1146 of September 11, 1974.

By way of brief background, the Taste and Smell Clinic of NIH has, for the last 6 years, been the only facility in the United States, and perhaps the world, where an interdisciplinary research and treatment program on taste and smell disorders has been conducted by Dr. Robert I. Henkin, chief of the section on neuroendocrinology, hypertension-endocrine branch. The need for research regarding this widespread and heretofore unrecognized disease has been detailed in many medical publications and in two editorials of the Journal of the American Medical Association (see reference in Senate Subcommittee Hearings, infra). The several thousand victims of this loss of two of their vital senses have been wholly dependent on the meager resources of the Taste and Smell Clinic.

Last year, when a shutdown of the clinic was threatened by the NIH authorities, several of the patients appealed to the Senate Subcommittee on Appropriations for HEW and NIH. After hearing their testimony, the Senate committee directed the NIH to continue the Taste and Smell Clinic at the 1973 level and to report back to the committee as to the steps to be taken to continue care of the patients. (See Senate Appropriations Committee Hearings on H.R. 15580 (Labor, HEW, etc.), Part 7, pp. 5442–5472; and Senate Committee Report No. 93–1146, Sept. 11, 1974 at p. 47.) This year, through the continued efforts of the Taste and Smell Clinic patients, after they and their referring physicians had again been formally notified that the clinic would be terminated on June 30, 1975, and through the action of the Senate Subcommittee on Appropriations for NIH, Dr. Theodore Cooper, then Acting Assistant Secretary for Health, advised Senator Magnuson by letter dated April 23, 1975 that the National Institutes of Health would continue the Taste and Smell Clinic until June 30, 1976.

While we are no doubt relieved by this further extension of the existence of the clinic, we are concerned by the actions of the NIH authorities during the past year. Despite the aforementioned directive of the Senate committee that the clinic be continued at the 1973 level in terms of resources, the fact of the matter is that, during 1974, the administration at NIH has so restricted Dr. Henkin, in terms of necessary laboratory technicians and equipment, clinical assistants, and secretarial assistance, as compared to 1973, that it has not been possible for him to make the significant contributions to the patients' problems of which he is capable and which we so desperately need. Moreover, we have become aware of efforts by the NIH administration to "banish" Dr. Henkin to a Public Health Service Hospital in one of three distant cities as a ward physician in general medicine. It seems to us that such action is not only in direct defiance of the Senate committee's directive to NIH, but would make a sham of their commit-

ment to continue proper treatment of the patients at the clinic, since Dr. Henkin not only originated and organized the clinic, but is the only physician who presently has the necessary knowledge to carry on this program in an adequate manner. Not meaning to be facetious in such a serious subject, the comparison could be made to a city being given a football franchise, but not being given a stadium to play in, the football players, or the necessary resources and equipment for making the franchise a reality.

As has been indicated to you by Mr. Austern during his testimony, the patients had, in the past year, become thoroughly frustrated in fighting the NIH bureaucracy and in being subjected to the needless and damaging restrictions on the resources of this program. Consequently, several of us have now formed the Taste and Smell Foundation, incorporated in the District of Columbia on March 11, 1975, with a view to ultimately shifting research and treatment in this field to the private sector. We are pleased to inform this subcommittee that we have virtually concluded arrangements with the Georgetown University Hospital and Medical School, in Washington, D.C., for the establishment of a taste and smell research and treatment program at the medical school, as well as the establishment of an Institute of Molecular Nutrition and Sensory Disorders, under the direction of Dr. Robert I. Henkin.

It is the purpose and objective of the foundation to support the conduct of both clinical and basic research into the problems of taste and olfaction, using the techniques devised by Dr. Henkin, all to be carried out with an interdisciplinary approach, where the disciplines of several clinical approaches can be combined with the appropriate biochemical, biophysical, and neurophysiological techniques such as are now being carried out at the NIH clinic. In addition, it is the purpose of both the foundation and the institute to continue and support this new field of research and treatment by providing the necessary resources for Dr. Henkin to set up a program whereby other physicians could be trained to evaluate and treat the many thousands of citizens throughout the country who are similarly afflicted, instead of having to restrict his program so that only a few patients can get even some semblance of adequate care. It is proposed that the foundation would ultimately provide the financial resources for these programs by seeking grants-in-aid from Government agencies as well as from private foundations and other organizations interested in research in the fields of nutrition and taste and smell.

However, a period of orderly transition is necessary before the work of the Taste and Smell Clinic can be reestablished on a viable basis at the Georgetown University Medical School. Therefore, we are appealing to the Congress to direct NIH to continue the funding for this comparatively modest program (approximately $200,000 for some 2,000 patients) for another year at the level of funding and support it received during 1973, with Dr. Henkin in charge and with the resources sufficient to carry on an adequate program of research and treatment for the patients. As has been indicated, it is our view that such a solution would be most advantageous, not only to the patients, but ultimately to the Government.

The committee should know that there are many thousands of citizens who are suffering from these baffling disorders of taste and smell dysfunction, with serious consequences to their safety and well being, who will otherwise be deprived of any hope for restoration of these two vital senses. Dr. Henkin has in his files some 5,000 letters from people all over the country and in other parts of the world who have learned of the work of the Taste and Smell Clinic and have sought assistance for these disorders. In addition, there are in his files some 6,000 letters from doctors who have learned of his unique work through the medical literature and other journals and who have written to seek assistance for their patients.

The disabilities which are represented by taste and smell disorders have critical aspects of safety and health, in addition to the diminution and destruction of a most important part of the quality of life, represented by the senses of taste and smell. It has been shown that without a sense of smell, without a sense of taste, there is a real danger of accident and phyical harm by, for example, not being able to detect the smoke of a fire in its early stages, or the smell of gas in the kitchen, or the taste of spoiled food which could sicken or even kill a person or a whole family. In addition, for those unfortunate persons who have a taste and smell dysfunction where everything tastes or smells repulsive, it is their lonely fate to become depressed, to lose weight, and to have their entire lives altered by these problems. The work done by Dr. Henkin,

which we hope will be continued through the foundation, has represented the only hope for a cure for what has come to be recognized as a "new disease".

We, therefore, respectfully urge this subcommittee to assist us in carrying on this important work. We would urge the subcommittee to direct NIH not only to support the clinic adequately in this year of transition but, equally importantly, to assist the foundation in carrying on this work in the future by directing NIH to obligate its research funds in the form of a grant-in-aid to the Taste and Smell Foundation to cover the phasing out of the Taste and Smell Clinic at NIH during fiscal year 1976 and the initiation of the Taste and Smell Clinic at Georgetown University Hospital during the three years covering fiscal years 1976, 1977 and 1978. Our estimate is that funds in the amount of $600,000 for the three-year period would be required so that the necessary equipment, facilities, manpower and patient support needed to continue this vital, unique and scientifically valid program could be maintained.

Allow me, in conclusion, to express my deep appreciation, as well as that of all the patients being treated in the Taste and Smell Clinic and those thousands of others who are seeking help, for the interest of this subcommittee in our plight and for its assistance in permitting us the opportunity to request our Government to continue this unique and essential medical research for the benefit of its citizens.

Respectfully submitted,

MAX D. PAGLIN,
President, Taste and Smell Foundation.

Attachments

Hon. DANIEL J. FLOOD,
Chairman, Subcommittee on Labor, HEW House Committee on Appropriations, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in connection with the upcoming hearings of your subcommittee on the fiscal 1976 budget for the National Heart and Lung Institute (NHLI) of the National Institutes of Health. My interest in this matter is based upon my participation as a patient, together with some 500 other patients, in the Taste and Smell Clinic of the NHLI for the past 3 years, and is motivated by the planned termination of the clinic by NIH authorities as of June 30, 1975.

By way of brief backgrounds, the Taste and Smell Clinic has, for the last 6 years, been the only facility in the United States, and perhaps the world, where an interdisciplinary research and treatment program on taste-smell disorders has been conducted. The need for research regarding this widespread and heretofore unrecognized disease has been detailed in many medical publications and in two editorials of the Journal of the American Medical Association. The several thousand victims of this loss of two of their vital senses have been wholly dependent on the meager resources of the Taste and Smell Clinic, conducted by Dr. Robert I. Henkin.

Last year, when a similar shutdown of the clinic was threatened, several of the patients appealed to the Senate Subcommittee on Appropriations for HEW and NIH. After hearing their testimony, the Senate Committee directed the NIH to continue the Taste and Smell Clinic at the 1973 level and to report back to the committee as to the steps to be taken to continue care of the patients. (See Senate Appropriations Committee Hearings on H.R. 15580 (Labor, HEW, etc.) part 7, pp. 5442–5472; and Senate Committee Report No. 93–1146, Sept. 11, 1974 at p. 47.) The need still continues on an urgent basis, and yet this program is again being terminated.

As a result of the restrictions on this program and the frustrations of fighting the NIH bureaucracy, several of the patients have now formed the Taste and Smell Foundation, of which I am the president, with a view to shifting research in this field to the private sector, and continuing the search for a cure for these disorders. We are also discussing with Georgetown University Medical School the feasibility of establishing a program there for taste and smell research and treatment.

However, a period of orderly transition is necessary before the work of the clinic can be reestablished on a viable basis. Therefore, we are again appealing to the Congress to direct NIH to continue the funding for this comparatively modest program for another year, until such transition is accomplished. It seems to us that such a solution would be most advantageous not only to the patients,

but ultimately to the Government. Otherwise, the thousands of citizens who are suffering from this baffling disorder, with serious consequences to their safety and well-being, will be deprived of any hope for restoration of these two vital senses.

Accordingly, and in behalf of the urgent needs of the patients involved, I respectively request the opportunity to appear and testify at the subcommittee's hearings for the NHLI budget for fiscal 1976 in support of the continuation of the important research and treatment program of the taste and smell clinic. At the chairman's discretion, my appearance would be in a form of a prepared statement and brief oral presentation.

I would appreciate being notified of the time and place for your forthcoming hearings on this matter, and if I am accorded the privilege of making a statement, when I would be scheduled to appear.

Respectfully.

MAX D. PAGLIN.

NATIONAL HEART AND LUNG INSTITUTE

STATEMENT OF DR. MICHAEL E. DE BAKEY, BAYLOR COLLEGE OF MEDICINE

Mr. Chairman and members of the committee, I welcome this opportunity to speak to you again on behalf of the appropriations for the National Heart and Lung Institute and the national heart, blood vessel, lung, and blood program.

As you are aware, this national program has potential value for every citizen in our country. Heart, blood vessel, lung, and blood diseases affect all age groups, men and women, all ethnic groups, and all strata of our society. More than 30 million Americans suffer from these diseases. The annual economic costs exceed $40 billion. And heart and blood vessel diseases alone are responsible for more deaths than all other causes combined.

I am particularly pleased to be able to report to you that for the first time in a quarter of a century, deaths from the No. 1 killer—coronary heart disease—have shown a slight decline. Since 1969 mortality from coronary heart disease has declined approximately 2 percent per year and deaths from stroke, hypertension, and rheumatic heart disease are continuing their downward trend. The death rate from emphysema and chronic bronchitis, after years of sharp increases, has also leveled off.

Fortunately, through scientific research, there is hope that this vast amount of illness, death, and economic loss can be checked. By application of present knowledge and by acquisition of new knowledge in medicine and technology, U.S. scientists and their colleagues worldwide are seeking ways to prevent, relieve, and cure these diseases.

The passage of the National Heart, Blood Vessel, Lung, and Blood Act and the initiation of the national program through this legislation have been important in many ways which have been discussed in reports of the Director of the National Heart and Lung Institute and in the first and second annual reports of the National Heart and Lung Advisory Council of which I am a member.

Of great importance is the fact that the program provides the public and the scientific and medical communities alike with tangible evidence that U.S. Government leaders realize the importance of health for the future of our Nation, and that you are taking steps to raise the health status of our citizens. Perhaps more importantly, while most health programs in the past have focused strongly on the acute care of disease, this national program focuses equally strongly on the importance of maintenance of health and on the prevention of disease. It recognizes the key roles that the individual and society as a whole play in implementing the goals set by the President and the Congress in enacting this legislation.

As a member of the National Heart and Lung Advisory Council I have participated in extensive reviews of the programs of the Institute and its proposals for future work. The Council has found that substantial progress has been made and that research results are being translated rapidly into improved health care. Clearly, under the act, much has been accomplished. Important information is being obtained, as detailed in the recently completed second annual report of the Council. This new knowledge is being applied to improve medical diagnosis and treatment. However, the Council also has concluded that, because the appropriations authorized by the act have not been forthcoming, many things have not been accomplished as planned in the national program plan of 1973. For example, the public education programs are less than completely implemented, and

only three of the National Research and Demonstration Centers have been established.

Although full implementation of the act has not been possible, the Council has determined that the national program has made substantial progress in many areas addressed by the act. Therefore, the Council has recommended that the act be renewed, and the latest Council report details the accomplishment that form the basis for this opinion.

While commending the Congress for its efforts to assure a high-quality pattern of life for our citizens, including important national health strategies such as the national plan. I must again register my personal pleas for more adequate funding for this program.

As you know, the authorizations in the act were $400 million, $460 million, and $520 million for fiscal years 1973, 1974, and 1975, respectively. These resources have not materialized, and the proposed fiscal year 1976 budget for the Institute is approximately $31 million below the 1975 appropriation.

Over the years I have had the opportunity to serve on many distinguished advisory groups on matters of national health priorities. It is indeed disheartening to contemplate that many of the new opportunities for improved national health identified years ago by these advisory groups have not yet been pursued to their full potential. For example, the establishment of national research and demonstration centers was one of the key recommendations in the 1964 report by the President's Commission on Heart Disease, Cancer, and Stroke, of which I was chairman. This recommendation has been repeated by several important advisory groups since then, and finally, the 1972 act authorized the establishment of 30 such centers. As mentioned earlier, the implementation of this provision of the act has been very limited due to the lack of funds.

As in previous testimony before this committee, I would like to give specific examples of opportunities which, in my judgment, need additional emphasis at this time.

First of all, I would like to call to your attention the need to establish additional National Research and Demonstration Centers in heart and vessel diseases, in lung diseases, and in blood diseases. As required by the act the Institute has gone ahead with the planning of these centers and has established three out of the thirty centers authorized by the Act. I would urge the committee to provide $20 million for additional centers during fiscal year 1976. I would also recommend again, that $60 million be made available for needed construction of new facilities for the centers and for other new programs within the national plan. Present physical resources are overcrowded and antiquated in many hospitals and research institutions across the Nation. I should like to remind your committee that these centers were first proposed in testimony before Congress in 1958, almost two decades ago. Thousands of our citizens have been deprived of help and the transfer of knowledge from the laboratory to the patient's bedside has been unjustifiably delayed, while we continue our discussions year after year. I think you will agree with me that it is time for action.

Substantial progress has been made in several areas that hold great promise for diminishing death and disability from coronary disease. A variety of methods for determining the size of a heart infarct have been developed and soon will have wide clinical application. Promising measures to limit infarct size and to decrease the threat of heart failure have come from laboratory investigations and will be tested soon in clinical trials. The population at risk of sudden death has been defined by several carefully conducted retrospective studies. Most of those individuals who died suddenly had severe coronary heart disease but no acute occlusion of a coronary artery; thus electrical instability of the heart probably caused a fatal disturbance of cardiac rhythm. Surgical operations on coronary arteries to bypass obstructive lessions have been shown to relieve angina pectoris, one of the serious symptoms of coronary heart disease. The Institute has recently initiated specialized centers of research in ischemic heart disease to intensify the study of all phases of coronary heart disease. I recommend that an additional $6 million be provided for these centers in fiscal year 1976. Also I would recommend that an additional $10 million be provided to significantly expand studies on coronary heart disease—the greatest killer in our Nation, and to further develop the new opportunities identified above.

Although congenital heart disease is now more adequately managed surgically than it was a decade or two ago, the problems of congenital heart disease in the neonate continue to be serious and difficult. This is a period of very substantial mortality and also a period in which the infant is so small that diagnostic techniques and therapy have risen to the fore. I recommend a budget allocation of at least $2 million for fiscal year 1976 to launch this program.

As a result of research done by or with the support of the National Heart and Lung Institute we can now identify the 20 percent of the population who are most likely to develop 40 percent of the heart attacks, 50 percent of the strokes, and 50 percent of the clinical peripheral vascular events over a subsequent 6-year period. Once such susceptible individuals have been identified, getting them to modify their life styles or take some medical treatment is a difficult task, and how to achieve such changes in acceptible manner for large segments of the population remains to be determined. I recommend that a limited number of community preventive cardiology centers be established to undertake research into practicable techniques for accomplishing primary prevention of coronary heart disease, stroke, and hypertension through identification of high risk susceptibles, introduction and evaluation of measures for reduction of risk status including dietary measures, drugs for lowering lipids or blood pressure, reduction of smoking, and modification of life style. These community preventive cardiology centers would provide a needed setting to identify, evaluate, and disseminate information on these aspects of prevention. I recommend that $3 million be made available to establish and operate a small number of these centers, and an additional $10 million for other programs of prevention, control, and education identified in the national plan.

I wish to call to your attention the urgent need to increase funds for research grants. Currently only 35 to 45 percent of approved research proposals are being funded by the Institute. The most significant advances in prevention and treatment of heart, blood vessel, lung, and blood diseases will come from enhanced understanding of the underlying disease processes. This understanding must be provided by innovative, creative, imaginative scientists, because it is these people who can, and will, develop the necessary new information. The administration's 1976 budget proposes a decrease in the grant line of approximately $15 million. I urge that this decrease be restored and that a further increase of $10 million be appropriated to provide the adequate funding for approved research grants.

Arrhythmias and other electrical disturbances of the heart cause important symptoms and aggravate many forms of heart disease. They are frequently the immediate cause of heart failure and death. Identification of arrhythmias that carry a high risk of sudden cardiac death is fundamental for the development of preventive measures. A major goal of the national program is to develop and evaluate methods for understanding and preventing arrhythmias, particularly those which may cause sudden death. I recommend that an additional $10 million be appropriated for this purpose.

Finally, as I have pointed out during previous testimony to this committee, there is a need for research manpower development to assure the success of the national program. The program requires a steady flow of young investigators who can develop into mature scientists. The uncertainties created by the recent changes in manpower training programs have turned young people away from research careers. The National Research Service Award Act of 1974 has returned some stability to this program but has not solved the problems entirely. To assure the continuation of this vital program in the years to come a stable policy of manpower development in biomedical research should be established and implemented consistently. The development and maintenance of highly skilled manpower at all levels are of great importance to our national effort against heart, blood vessel, lung, and blood diseases. I recommend that the Institute funds for the training of scientists be increased by $10 million for fiscal year 1976 in order that the quality and the momentum of the national program be maintained.

Thank you again for the opportunity to present my statement to this committee. I should also like to express my continued appreciation for the concerted efforts this committee has made in support of these research activities.

SUMMARY TABLE—NATIONAL HEART AND LUNG INSTITUTE

Additional funds fiscal year 1976

Activity:	*Millions*
National research and demonstration centers	20
Construction	60
Specialized centers of research in ischemic heart disease	6
Coronary heart disease followup studies	10
Specialized centers of research in congenital heart disease	3
Community preventive cardiology centers	3
Prevention control and education programs	10
Basic research in heart, blood vessel, lung, and blood diseases	25
Sudden cardiac death and arrhythmia trials	10
Training	10
Total	167

NATIONAL EYE INSTITUTE

STATEMENT OF DR. CHARLES SCHEPENS, PRESIDENT, THE RETINA FOUNDATION

Mr. Chairman and members of the committee, since I was unable to appear before your committee in person, I take the liberty of submitting this written testimony.

A brief summary of my background, qualifications, and credentials is as follows. I received my M.D. from the University of Ghent in Belgium in 1935 and an additional 3 years training in pharmacology at this university. My training and practice in ophthalmology was at Moorfield Eye Hospital in London, and at the Clinique St. Jean and Elizabeth in Brussels as assistant to Dr. L. Hambresin. I served as a captain in the medical corps of the Belgium Air Force, and in the Belgian and French Resistance. I came with my family to the United States as a fellow in ophthalmic research at Harvard Medical School in 1947. Shortly thereafter, I became head of the newly formed Retina Service of Massachusetts Eye and Ear Infirmary. My present appointments and positions are director emeritus, Retina Service, Massachusetts Eye and Ear Infirmary; senior consulting surgeon, Massachusetts Eye and Ear Infirmary; associate clinical professor of ophthalmology, Harvard Medical School; president of the Eye Research Institute of Retina Foundation and director of its department of Retina Research; member of the Advisory Council, the National Eye Institute. I am a member of 12 medical and professional societies, and have published 191 scientific papers relating to eye disorders and their treatment.

During my career at Massachusetts Eye and Ear Infirmary, the success rate for retinal detachment surgery has increased from 40 to 95 per cent. I mention this as germane to the body of my testimony since, in large measure, this vast improvement is traceable to diagnostic instrumentation, procedures, and technology created by research at our Institute.

As an eye surgeon, researcher, and teacher, I have spent all my professional life in efforts to prevent and cure blindness. At this time, thanks to unique progress made in many branches of science and technology, there is an unusual opportunity for uncovering many causes of blindness and either preventing their occurrence or curing them. In the past year alone, research results have been obtained that are likely to have a strong impact on sight preservation. The significance of some of these research results have been presented by other witnesses. I would like to add two examples of accomplishments by staff members of the Eye Research Institute of Retina Foundation. These examples pertain to the measurement of retinal circulation and to the treatment of eye cancers.

MEASUREMENT OF RETINAL CIRCULATION

To form accurate images of the outside world, the retina must be transparent since images form in its most external layer. Being one of the most active tissues in the body, this layer requires the circulation of comparatively large amounts of blood. However, in order to preserve its transparency, it must contain as few blood vessels as possible. Nature has solved this problem by having blood circulate at higher speeds than elsewhere in the body through blood vessels that are quite

sparse in number and extremely small. This means that any disruption of blood circulation in the retina is likely to bring about severe and sometimes catastrophic changes in the eye's visual performance.

For some time, it has been felt that it was essential to find techniques to measure accurately the flow of blood circulating through individual retinal vessels. These vessels in a human may vary in diameter between two-thousandths and six-thousandths of an inch. Until recently, measurements of the volume of blood circulating through these tiny individual blood vessels was extremely difficult. In humans it could be accomplished only by using complex and time-consuming techniques.

During the past year, a new technique called fluorophotometry has been developed. It permits to measure accurately how much blood flows through a retinal arteriole and through its corresponding venule. The measurement technique, developed at our Institute, is non-invasive, harmless, and painless, and its full clinical usefulness is now being evaluated on specific groups of patients.

The potential value of these measurements is enormous:

(1) It may help predict the occurrence of acute circulatory accidents in the retina, such as vascular occlusions or thrombosis. If such accidents could be predicted, they might be prevented by medication.

(2) Many degenerative diseases of the retina may occur as a result of insufficient blood flow through the retina. However, accurate diagnosis and possible prevention of degenerative conditions of the retina due to circulatory insufficiency must await further development of the above-described technique or some similar procedure.

(3) Since the retina is brain tissue, the retinal vessels are the only brain blood vessels that are visible without surgery. Accurate measurements of the flow of blood through the retina gives valuable information on circulation of blood in the brain. Such information could be of life-saving value during critical stages of anesthesia and in a number of other emergencies.

TREATMENT OF EYE CANCERS

The Department of Physics of Harvard University possesses one of very few cyclotrons available in the country for the treatment of human cancer, by the production of proton irradiation. A few years ago, this apparatus was saved from destruction and replacement by a larger machine that would have been unfit for medical use. Saving this cyclotron for medical use was due to collaborative efforts by several Boston institutions concerned with medical research.

It was anticipated and experimentally confirmed that one of the most useful applications of treatment with proton irradiation is in certain types of eye cancer. In the eye, proton irradiation is probably capable of destroying a tumor 25 times more efficiently than can be accomplished by X-rays. This means that eye tumors that are not radiosensitive could effectively be destroyed by proton irradiation, thus saving the patient's eye, and possibly his life. The most frequent eye cancer (choroidal melanoma) is not sensitive to X-ray treatment and is generally treated by removal of the eye.

Treatment in humans of carefully selected eye cancers with proton irradiation will be started this year on a trial basis.

The above examples emphasize the outstanding opportunities that are now available to scientists in the field of vision research. However, if these opportunities are to be exploited, adequate financial support is indispensable.

May I ask you, therefore, that your committee consider and approve the Citizens' Budget request of $77 million for the National Eye Institute in fiscal year 1976.

The following is a breakdown of this proposed budget:	*Thousands*
Noncompeting research grants	$29,700
Competing research grants	26,511
Core center grants	3,500
Research training	5,869
Research contracts	2,822
Direct operations	8,598
Total	77,000

Noncompeting research grants ($29.7 million) are those which have been approved in prior years and funded with a commitment for several years. Competing grants ($26,511,000) are new applications or re-applications. The above level of support would permit the National Eye Institute to honor its previous commitment for grants and to fund a majority of the competing grants that will be submitted and approved (about 15 percent of grant applications are not approved on scientific grounds).

Core Center Grants ($3.5 million) would provide support to a small number of outstanding research centers to pay for basic services needed by a number of researchers of the center. For example, these grants might support such needed facilities as a machine shop, an electron microscopy facility, or a high speed computer laboratory. This type of support is especially important because it would help centers of excellence in eye research to do a better job in bringing research results to bear on patient care delivery with the shortest possible delay. A gradual and judicious development of core support could help substantially in reducing the time lag between research improvement in patient care.

Research Training ($5,869,000), under the form of fellowships, training grants, and research career programs are three vital mechanisms by which young scientists can be attracted to, and trained in, the techniques of eye research. It is indispensable that the National Eye Institute continue to interest young scientists in making a career of eye research. It is only in this way that we can hope to maintain a high degree of productivity in research aimed at sight preservation. At the Eye Research Institute alone, we have lost in recent years at least three highly qualified physicists who were forced to return to industry for lack of adequate financial support for their training in the life sciences. This has meant the postponement for an indefinite period of time—of promising research. If this research had been carried out, it could probably save many from blindness today.

The expenditures for direct operations ($8,598,000) cover the cost of operating the National Eye Institute. This includes laboratory and clinical research; biometry, epidemiology, and field services; and management of intramural and extramural operations.

If approved, the Citizens' Budget of $77 million will be spent according to a plan that was most carefully laid out, and covers all problems pertaining to visual disorders. This plan was recently published by the National Eye Institute under the title of Vision Research Program Planning.

Of upmost importance in the plans of activity for the next few years, is research into the causes, cure, and prevention of diabetic retinopathy. This disease is the fastest growing cause of blindness in the United States today. A rare disease in 1922, it caused blindness in 44,000 Americans in 1940, 65,000 Americans in 1960, and by 1964, the U.S. Public Health Service identified 151,000 diabetics with no useful vision in either eye (not to be equated with blindness). At the present rate of growth, by the year 2000, there will be as many people blind from diabetic retinopathy as from all other causes of blindness put together. Obviously, more intensive research in this field is urgently required.

I wish to thank you, Mr. Chairman, and the members of your committee, for this opportunity to present my views about the budget of the National Eye Institute.

NATIONAL INSTITUTE FOR NEUROLOGICAL AND COMMUNICATIVE DISEASES AND STROKE

Statement of Mr. Charles W. V. Meares

I am Charles W. V. Meares, former chairman of the board and chief executive officer of the New York Life Insurance Co. Just over 1 year ago, I finished my assignment as the Chairman of the National Advisory Commission on Multiple Sclerosis. This Commission came into being as a result of passage of Public Law 92-563.

Our nine member Commission composed of five scientist-physicians and four laymen was assisted by a panel of 53 experts in the various medical and scientific fields most concerned with finding an answer to the cause and cure of multiple sclerosis. And the Commission was fortunate in having as its Executive Director a man whom many believe played a most important administrative role in solving the polio problem—Dr. Harry M. Weaves.

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At the end of a year's concentrated study of what was needed to develop through research practical means to solve the problem of multiple sclerosis, I came away with the belief that the problem of multiple sclerosis can be solved and that we have many dedicated scientists who are ready, willing and able to undertake the requisite research to accomplish this goal.

I would now like to direct your attention briefly to the Commission's conclusions about management and organization of the effort aimed at finding the causes of, cure and prevention for, multiple sclerosis. The Commission very wisely recommended a dual approach; viz pursuit of both basic biomedical research in the neurological sciences and of those obvious leads that relate directly to multiple sclerosis.

The Commission believes the very history of medicine provides adequate support for the belief that new and promising leads to multiple sclerosis are likely to emerge from basic biomedical research with no apparent relevance to any particular disease when the investigation began; and such leads are most likely to emerge from basic biomedical research of the highest scientific merit being conducted by an investigator endowed with unusual capacity for creative imagination and sustained hard work. It must be considered that even when the pursuit of basic biomedical reserach fails to yield a definitive new lead to a specific disease, it may nevertheless expand and make more precise that body of acknowledge which forms the basis of plans for productive research. In other words, the more we know about the body and disease in general, the better we are able to plan effective research aimed at conquering a particular disease.

It was the Commission's finding that in fiscal year 1973 the National Institute for Neurological and Communicative Diseases and Stroke had expended approximately $31.5 million in basic biomedical research in the neurological sciences. After careful study, the Commission concluded that for fiscal year 1976, the support of that kind of research should be increased by approximately $12.5 million to a total of approximately $44 million.

Now, regarding research specifically relevant to multiple sclerosis, it was the Commission's finding that in fiscal year 1973, just under $3 million was spent on research of this kind. The Commission—again after careful study—concluded that for fiscal year 1976, the sum of just under $6 million in additional money should be spent on research specific to multiple sclerosis, or a total of $9 million.

I'm not going to describe the various investigations that relate to multiple sclerosis and that have neither been undertaken or have not been completed. These are well outlined on pages 174–192 of volume II of the Commission's report. Attached to this memo are three copies of this volume for your easy reference.

It is urgently hoped that your committee will see fit to propose that the additional $6 million for research specifically relevant to multiple sclerosis be specified as a line item so that these funds will be expended for the purposes indicated and not for some other purpose, however worthy. Your committee knows, I am sure, that knowledge of the existence of money being available for a specific purpose will encourage creative imagination on the part of scientists—a very essential ingredient to meaningful research.

There is no question that scientists were stimulated to pursue the specific problems recommended by the Commission when its report was submitted some 15 months ago. This enthusiasm has been lost in part by a delay in coming to a specific recommendation for funding—for example, the lack of a specific line item appropriation indicating congressional approval of funds to support the Commission's specific recommendations, deleterious effects of the President's recent threat of rescission, et cetera.

If we are to engender the enthusiasm in the scientific community evident some 15 months ago to get on with the problem of multiple sclerosis, we need a specific line item appropriation to fund the specific research recommended by the Commission.

In conclusion, may I restate that we believe in accordance with the Commission's recommendation for fiscal year 1976 that there is a need for an additional $12½ million for basic biomedical research in the neurological sciences, and just under an additional $6 million for research specifically related to multiple sclerosis, the latter in a line item appropriation. Gentlemen, with your support, significant progress against multiple sclerosis can be accomplished in the foreseeable future. To be a part of this contribution to all humanity is something of which we can all be proud.

Thank you.

MATERNAL AND CHILD HEALTH PROGRAMS

LETTERS FROM CONGRESSMAN EDWARD I. KOCH, NEW YORK

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., May 20, 1975.

Chairman DANIEL FLOOD,
Labor/HEW Appropriations Subcommittee,
Washington, D.C.

DEAR MR. CHAIRMAN: I am enclosing a letter I received from the Citizens' Committee for Children of New York, Inc. commenting on the fiscal year 1976 Labor/HEW appropriation bill.

I would very much appreciate your including this letter in the record of hearings on this matter. Thank you.

Sincerely,

EDWARD I. KOCH.

Enclosure.

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.,
New York, N.Y., May 19, 1975.

Hon. DANIEL J. FLOOD,
Chairman, House Labor-HEW Appropriation Subcommittee,
Washington, D.C.

DEAR CONGRESSMAN FLOOD: The attached letter sent at Congressman Koch's request regarding title V Maternal and Child Health appropriations for fiscal year 1976 is for your information.

MRS. MAX A. ASCOLI,
Chairman, Health Section.

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.,
New York, N.Y., May 19, 1975.

Hon. EDWARD I. KOCH,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN KOCH: In response to your written request that we comment on Maternal and Child Health appropriations for fiscal year 1976, we are pleased to comply. In our view it is essential that $340 million be appropriated for title V programs in fiscal year 1976. We know that you are aware that title V programs are among the most important child health programs in this country. They have led the way in providing quality services to children and to pregnant women and their infants. We believe that the following appropriations for fiscal year 1976 are necessary:

Grants to the States:	
MCH	$204,000,000
Section 516	25,000,000
Crippled Children's Services	80,290,000
Research and training	27,960,000
Sudden infant death syndrome (SIDS)	2,750,000
Total	340,000,000

The Congress has required that each State develop a program of five projects including intensive care for high risks infants, family planning services, children and youth, dental services, and maternity and infant care. Additional funds are necessary if these projects are to be implemented. If all of them were created in each State of the Union it would cost $100 million. Knowing that it will probally be necessary to phase them in over a period of years, we believe it urgent that $27,325,000 of new funds be appropriated for MCH so that the States may progress in establishing the required projects.

Crippled Children's Services have led the Nation in providing essential care to handicapped children for many years. An increase in funds of $15,390,000 is necessary to meet the rise in costs and increasing numbers of children who need medical rehabilitation.

It is important that these appropriations be approved quickly and that the Senate be urged to act with speed so that the services can continue and plan for the coming year. The delays last year were destructive to the programs with many of them losing staff because of congressional delay.

In our view as a research and child advocacy organization, the title V programs are among the best we have seen anywhere. They provide essential health services to children, some such as the C. & Y. projects, provide the only comprehensive health care available in the Areas covered. The family planning programs are obviously essential.

We will be pleased to supply you more detailed information on these programs or any other members of the Congress with any other information you or they might wish. Thank you for your positive consideration of these recommendations.

Sincerely,

MRS. MAX ASCOLI,
Chairman, Health Section.

REGIONAL PRIMATE RESEARCH CENTERS

STATEMENT OF CONGRESSMAN LES AUCOIN, OREGON

Mr. Chairman and members of the subcommittee. I want to comment this morning on the request for funds for the Regional Primate Research Centers. While I admit that my knowledge of the work done at these laboratories is limited to the one located in Oregon, I can say that if the Oregon Regional Primate Research Center is typical of the national centers, then this is one of the very best examples I have seen of a responsible return on the taxpayer's dollar.

The theme of the Oregon center is reproductive biology. Working with primates, the center research offers the promise of better, more effective, and less expensive means of birth control. It offers hope for eliminating the grief and frustration of thousands of couples who long to have their own children but are biologically unable to do so.

Over the past 5 to 10 years, Federal support for biomedical research has tended to level off and even to decline (in terms of constant dollars, after the bite of inflation has been removed). Many promising new programs with fine potential have not been funded, and many good programs have been dismantled. A cut of $600,000 from the Primate Research Center budget in a year when increases in research costs have outstripped the general level of double digit inflation is a flat admission that we are reducing our priority for the health and well-being of Americans. It disregards the tremendous advances that led to the elimination of dread diseases commonplace two generations ago, when the current forward thrust in biomedical research began. Millions of Americans are alive today who would not be here if such research had been placed on the back burner then.

I hope we will not be penny-wise and pound-foolish. I request your aid in providing adequate support for the excellent program of the Primate Research Centers.

EMERGENCY MEDICAL SERVICES

STATEMENT OF HON. ROBERT H. MOLLOHAN OF WEST VIRGINIA

Mr. MOLLOHAN. Mr. Chairman, the subcommittee is currently reviewing the administration's budget request for various health programs, and I appreciate this opportunity to comment on the woefully insufficient request for funds to operate the emergency medical services program in fiscal year 1976 under authorities granted by the Emergency Medical Services Systems Act of 1973 (Public Law 93–154).

The EMSS Act was passed by the 93d Congress in recognition of the very critical need that exists throughout America for improved and coordinated systems of regional emergency medical services. The act authorized the appropriation of $35 million for fiscal year 1974, $65 million for fiscal year 1975 and $75 million for fiscal year 1976.

Because the EMSS Act was not signed until after fiscal year 1974 budget requests had been submitted by the administration, the Congress very wisely appropriated $27 million to implement the program in fiscal year 1974.

Last year, with $65 million in authorization against which to seek appropriations, the administration requested only "status quo" funding of $27 million for fiscal year 1975. At that time, I approached this subcommittee and suggested that this figure be increased. This distinguished body agreed and appropriated $37 million. All of you can be justly proud of that decision.

As we move into the third year of this program, I am quite frankly distressed to note that the administration is asking only $25.1 million in fiscal year 1976 for EMS. At a time when this program should begin moving more rapidly to accomplish the objectives set forth in the EMSS Act, the Administration appears to be impervious to the needs addressed by this program and is seeking reduced funding that can only result in a strangulation of the effort to improve emergency medical services.

To save the 60,000 lives that experts believe can be saved each year with improved emergency medical services, the Department of Health, Education, and Welfare believes we must ultimately develop about 442 regional EMS systems under the authorities provided in Public Law 93–154. It is simply not possible to do this with $25 million a year. Furthermore, Congress did not intend for funding levels to be so obviously insufficient, as the authorization bill clearly illustrates.

The Department of Health, Education, and Welfare, particularly those dedicated public servants working in the emergency medical services program, has done an admirable job to this point in allocating available funds in such a way as to maximize their effectiveness in meeting the objectives of the legislation.

With the $27 million available in fiscal year 1974, EMS program personnel in the Health Services Administration funded 53 systems planning grants, 10 initial systems implementation grants and 11 advanced systems implementation grants. In addition, 18 research grants were approved, and 79 training programs were established. These grants went to deserving and well-prepared organizations in every sector of the Nation.

At the moment, EMS program personnel are reviewing applications for the $37 million available in fiscal year 1975. According to information provided to me by the Health Services Administration, a total of 154 applications requesting $81,451,378 has been received from across the Nation for funding under sections 1202, 1203, and 1204 of Public Law 93–154. This compares with the $32.5 million in fiscal year 1975 funds actually on hand for these sections. (The remaining $4.5 million in fiscal year 1975 funds is earmarked for research grants under section 1205 of the public law.)

These figures suggest very strongly that there is a genuine interest throughout America in developing the kind of coordinated regional emergency medical services intended by and envisioned in the Emergency Medical Services Systems Act.

But these same figures also demonstrate forcefully that we cannot move forward with this program without adequate funding. And to this point, funding levels have not been adequate to do the kind of job that can be done and must be done.

Public Law 93–154 authorized the expenditure of $100 million over the 2 fiscal years 1974 and 1975—but only $64 million has actually been appropriated and spent. We have authority to appropriate $75 million in fiscal year 1976, but the administration has only requested $25.1 million.

Mr. Chairman, I urge the subcommittee to give careful and positive consideration to appropriating the full $75 million authorized for EMS in fiscal year 1976. This level of funding is badly needed to make the EMSS Act function as Congress intended.

The alternative is to underfund this program and if we do, we must be prepared to live with the following results:

(1) A failure to meet the legislative intent set forth in Public Law 93–154.

(2) A failure to take quick and positive measures to save lives through development of an adequate number of improved regional EMS systems throughout the Nation.

(3) An unnecessary postponement of EMS systems implementation in the interest of short-term economies, which ignores the higher costs that must inevitably be paid later to develop EMS systems we could have right now.

Mr. Chairman, I do not believe my suggestion that the full authorization of $75 million be appropriated by this subcommittee for fiscal year 1976 is unrea-

sonable. On the contrary, I believe it would be a prudent decision by every member of this distinguished body.

With this level of appropriation, we can move more quickly to save lives and do it more cheaply than we can do it 5 or 10 years from now when the needs, if unmet, will be even greater and costs will most assuredly be higher.

I appreciate your attention to these views and do hope you will give favorable consideration to this recommendation.

NEIGHBORHOOD HEALTH CENTERS

STATEMENT OF LEON J. DAVIS, NATIONAL UNION OF HOSPITAL AND HEALTH CARE EMPLOYEES

Re: Statement on H.R. 4925.

To: House Committee on Appropriations, Subcommittee on Labor-HEW Appropriations.

From: Leon J. Davis, President, National Union of Hospital and Health Care Employees, RWDSU/AFL–CIO.

The National Union of Hospital and Health Care Employees represents nearly 100,000 workers in a wide variety of health care institutions. Several hundred of these workers are employed in a number of neighborhood health centers in New York City.

We are greatly disturbed at the senseless administration proposal to slash 20 percent off existing funding levels for neighborhood health centers. This program was started to fill a gap in the health delivery system by providing medical and dental assistance to poor people in areas with little or no health care services. Neighborhood health centers made health care both accessible and affordable to those most in need.

Estimates for 1975 indicate that some 177 health centers will serve 1.6 million poor, unemployed, and elderly people. Approximately 15,000 are employed by the centers. The administration's proposal would force the closure of 68 centers, cut off 300,000 people from the centers and throw 3,000 employees out of work. This is not only appalling from a human standpoint, but also in monetary terms.

Over 10 million Americans are presently unemployed or underemployed. The combination of inflation and recession has had its most dramatic effect on the elderly, the unemployed, and the working poor. However noble sounding the administration's arguments are, in real terms the fact is that this is yet another example of callous disregard for the interests and needs of poor Americans.

The irony is that this is one of the most beneficial and well operated programs to come out of the "Great Society" initiatives of the 1960's. People denied access to the centers will either go without health services or seek care at the already overcrowded and understaffed hospital emergency rooms and outpatient departments. The monetary drain on municipal and voluntary hospitals in these departments is already at a critical level and more and more such institutions will be forced to refuse treatment to people unable to produce a medicaid card or other third-party payment.

As Congress considers the administration's so-called budgetary restrictions, it should keep in mind that dollar savings are illusionary in this case. It costs considerably more to provide health services in hospitals than it does in health centers. Money will only be "saved" if poor people are totally denied health services. If this is the President's position, we can only react in shock and with total condemnation. His position is morally indefensible and fiscally irresponsible.

Given the increasing numbers of unemployed seeking medical care in federally funded programs, the prospect of continuing high levels of unemployment in the foreseeable future and in recognition of high levels of inflation in the past few years, we believe the funding level of neighborhood health centers should be substantially increased, not decreased, by $50 million in the next 2 fiscal years. We support the views of Congressmen Ottinger and Murphy, who dissented from the majority view of the House Interstate and Foreign Commerce Committee and urge the House to raise the appropriation levels contained in H.R. 4925 to those of the already passed Senate bill, S. 66.

ALCOHOLISM PROGRAMS

RESOLUTION OF THE COUNCIL OF STATE AND ALCOHOLISM AUTHORITIES, INC.

Resolution on national funding priorities in alcohol abuse and alcoholism

Whereas The CSTAA is dedicated to the further development of strong and effective leadership by the single State alcoholism agencies;

The CSTAA is committed to nurturing a strong and close working relationship with the NIAAA and desires to make important contributions to the accomplishment of national objectives;

During the initial years since the passage of Public Law 91–616, Federal fiscal policy related to the alcoholism program has been confused by impoundments, proposals to rescind appropriations, and other conflicts. This has created a "feast or famine" situation and has made fiscal planning at all levels extremely difficult;

Inconsistent fiscal policy at the Federal level has created a situation in which requirements for NIAAA project grant continuation funds during fiscal year 1976 will be dramatically increased in contrast to previous years. Furthermore, it is clear that the administration's pending 1976 budget request for the NIAAA project grant program is inadequate to meet anticipated continuation costs. This provides no resources to achieve new priority objectives;

In light of important research and evaluation results, many existing policies and priorities of the NIAAA should be reviewed for possible modification;

The CSTAA would deplore inflexibility within the NIAAA budget at a time when changing priorities are likely to become necessary to meet newly acknowledged needs, that is, children, women, improved service delivery systems, and so forth;

The CSTAA and the respective single State alcoholism agencies are prepared to assume an increased responsibility in achieving new and changing national priority objectives. It is therefore

Resolved that: The NIAAA and the CSTAA jointly seek ways to examine the need for changes in existing national priorities and to form a more effective partnership between the NIAAA and the State alcoholism agencies to achieve priority objectives.

The NIAAA explore effective ways to achieve the maximum possible budgetary flexibilities to permit the commitment of Federal funds to implement potential changes in alcoholism abuse and alcoholism priorities during fiscal year 1976.

The NIAAA, the NHEW, and the U.S. Congress consider placing a greater proportionate emphasis upon the State formula grant program to achieve State and national objectives.

The CSTAA also resolves to make serious efforts as necessary to exercise all reasonable policies and encourage the adoption of programs among the State agencies which promise the greatest likelihood of accomplishing objectives which are jointly established by the States and the NIAAA.

AIR POLLUTION DISEASES

STATEMENT OF DR. HENRY J. PALACIOS

Reasons why not yet recognized and which also explain some of the causes for the excessive cost of medical care, unnecessary surgery, some of the shortcomings of medical specialization, and why research is not improving the cure of disease much.

There is no question that air pollutants derived from the combustion of fuels consist of highly toxic materials with potential even for causing cancer, but which according to EPA are not a direct cause of human or animal disease and still not among the chief priorities of research by NIH. From clinical evidence that I have obtained in hundreds of patients during the course of my work in general practice, air pollution is a most important agent of human or animal disease in the respiratory system, skin, middle ear, in the system where our inmunity against disease is developed, or in cases with chronic conjunctivitis. Air pollution effects play an important role in cases where our resistance to infection is lost—patients with chronic staph infection of the skin, females with

the chronic and distressing infection due to the yeast Monilia, and patients where repeated attacks of pneumonia, colds, sore throat, or mouth sores are part of their lives. Published data of research demonstrates the development of skin allergies from substances which reach this structure through the circulation and which according to my findings consist of afterburn pollutants. Having learned of their presence in the circulation, we must realize that pollutants must come in contact with every cell in the body and perhaps explaining the origin of cancer and some of the many important diseases still uncured. If we knew their cause, there would be a far better chance for developing specific or direct methods of treatment for the attack of disease at its roots or where really counts, than waiting for the results of basic research directed toward the abnormalities that develop in the body after disease strikes, or the symptomatic relief which nowadays is the only form of treatment available against many important diseases resulting from air pollution.

Lack of knowledge about the connection of air pollution and animal or human disease is one of the main reasons for the stratospheric medical costs and less than satisfactory results achieved with many of the standard forms of treatment or surgery nowadays utilized against chronic diseases in the respiratory system, skin, middle ear, chronic conjunctivitis, and cases with decreased resistance to infection as I described before, in essence unrecognized allergies. The increased incidence in the population of asthma, chronic bronchitis, emphysema, sinusitis, frequent colds, ear problems, eczema, neurodermatitis, certain forms of psoriasis, dryness of the skin, dandruff or the hair loss that goes with it are well explained by the progressive deterioration of the environment and the great need for better forms of treatment of what is available in the following areas:

Topical or local forms of treatment with creams, lotions, et cetera, for eczema and other important skin conditions, being costly and inefficient it is a consequence not of successful research but from old-fashioned ideas which prevail because of tradition and the support of FDA and NIH, being accepted by a medical profession lacking better alternatives.

Asthma is a distressing chronic respiratory condition said to be caused by one or several among many substances in the environment and affecting only those individuals who are susceptible, hypersensitive, or allergic to materials not affecting normal individuals. Following some trends of allergy treatment, patients are given frequent injections which according to the 1972 testimony of Dr. Dorland Davis of NIH to this subcommittee "are costly, wasteful, and inefficient." With the term of chronic obstructive pulmonary disease being used instead of asthma, its allergic origin and possible control or cure by the means of specific therapy are ignored and the emphasis is placed instead in the elaborated study of the abnormal physiology of the lungs, the symptomatic relief of asthma and rest of the chronic respiratory conditions, and the treatment of complications likely to develop when these disorders are counteracted by specific therapy—frightening and life-threatening crisis of respiratory failure, frequent infections in the lungs and severe forms of heart disease developing on these cases.

Ear, nose, and throat operations are nowadays the most frequent type of surgery performed in the country and another area where lack of progress about the effects of air pollution in our organism has not allowed to establish that allergy is in the background of great many ear, nose, and throat cases. However, the existence of allergy in this area is almost always obtainable with a $5 laboratory test consisting in the microscopic examination of mucous from the nose stained with Hansel's stain and available to any laboratory.

Reasons why air pollution diseases have not been recognized also serve to explain the failure of a medical system specialized in excess and why the research establishment is not scoring better in the actual cure of disease:

The subdivision of human diseases among the different specialties precludes the possibility that any one field would undertake the task of making a thorough study of air pollution diseases consisting of multiple symptoms in different parts of the body—nose, middle ear, skin, lungs, et cetera—and depending each one on the symptomatic relief provided by every specialty. On the other hand the effective cure or control of the multiple manifestations of air pollution disease is usually obtained within a few weeks or months with the simple approach provided by the administration of an FDA-approved product known as House Dust Antigen, made from ordinary house dust liquefied and sterilized, in the market for many years and by chemical analysis resembling the composition of polluted air.

In many instances of "basic research" and where the main emphasis of NIH is toward the determination of the biochemical alterations and abnormal physi-

ology that develop in our organism after disease strikes and only little concern given to what causes disease. Under this basis NIH researchers fancy calling themselves as the biochemical research establishment, in a number of instances carrying out research of subjects already elucidated or which are endless, pointless, or impractical, and always complaining about the scarcity of research funds. Recently, the journalist Daniel S. Greenberg was able to point out the lack of success in most forms of cancer treatment or research, contradicting some of the claims about progress made in this area, and concluding that with a budget of over $600 million a year the National Institute of Cancer is not going to accept any good ideas toward the solution of cancer problems. Recently Dr. Paul Sabin of the famous polio vaccine abandoned an unfinished high-priority project in connection with cancer and claiming to a medical audience that he aim of research is not always for improving health, that somebody should look over the shoulder of the research establishment, and that simple methods of clinical research with direct application toward the cure of disease should be given preference over the highly sophisticated methods nowadays prevailing.

By law, the final word about the use of research funds is in the hands of outside consultants to NIH and which representing different specialties have to share their loyalties with their modus vivendi, the prerogatives acquired by their respective fields, and the progress of science. Therefore, it should be seen that the progress of science is given first consideration in the case of air pollution diseases which undivided could be considered under one heading and one form of treatment, but nowadays being the bread and butter of several specialties.

Medical investigators working for EPA and studying air pollution effects in laboratory animals or normal subjects have yet to prove the development of human disease as a result of pollutants with well-known toxic or lethal properties. What is acknowledged by every air pollution investigator is that in presence of high levels of pollution there is great increase in the incidence and severity of acute respiratory affections, asthma, chronic bronchitis, emphysema, eczema, cancer of the lung, heart attacks and decreased ability to perform physical or scholastic activities. Without knowledge of veterinarian medicine EPA investigators have searched in vain for evidence of respiratory disease developing under the influence of air pollutants in animals and where there is far greater prevalence of skin disorders over respiratory affections. Furthermore, investigations in animals have failed to produce in a few months or weeks diseases like bronchitis or emphysema that as a result of pollution or smoking take many years to develop in humans. With the clinical means of a practicing physician, it is not difficult to prove the existence of air pollution diseases in humans or animals after suspecting their presence and later on corroborating their existence in subjects receiving House Dust Antigen and improved, not a difficult task but outside the experience and background of the official experts in the field of air pollution diseases. Despite their shortcomings air pollution investigators are naturally reluctant to accept clinical findings of investigation performed in the course of practicing medicine for the purpose of making a living for this activity.

Much to blame is a medical system of payments by a third party and which is not dependent on the actual cure of disease or its prevention, but directly proportional to the number and complexity of the services rendered. There is suspicion that at times the services covered by third party payments are overused and resulting in unnecessary surgery, unnecessary hospitalizations, unnecessary testing and enlargement of all kinds of medical facilities or personnel. With much richness as a result of much unconquered disease, ideas like the air pollution concept of disease that I am presenting here are not always accepted at first.

First to blame for a complete lacks of progress in the extensive area of air pollution diseases is old-fashioned ideas trying to hide the fact that it is only a handfull of allergies which affect the greatest majority of the population, depending on the most ineffective methods of allergy treatment that are available, and ignoring an efficient method which has been available for over a decade and where 10 to 12 injections a year is all that is needed for a year around allergy like asthma, chronic bronchitis, eczema, etcetera. Realistically speaking, house dust allergy or air pollution disease is behind most cases with chronic forms of allergy, a small percentage of acute allergies resulting from a limited number of pollens and during the short periods of time when pollination takes place, less frequently being the result of industrial chemicals or household substances, or in individual instances allergy developing from foods or medications.

Conclusions

Air pollution as a direct cause of human disease was well demonstrated in two-thirds of adults in a New Guinea tribe exposed to heavy smoke produced by fires made inside their huts, manifesting severe forms of chronic pulmonary disease and usually dying from pneumonia or some other acute complication. Despite that over 80 million tons of toxic pollutants every year are released in the atmosphere of the country, air pollution investigators have failed to prove what House Dust Antigen has done so well in the way of establishing the connection between pollution and cases with acute or chronic forms of disease in the respiratory system, skin, middle ear, or cases with chronic conjunctivitis. Furthermore, knowledge of the circulation of pollutants throughout the entire system opens the doors to new ideas for research in areas where medical acumen is all exhausted—cancer, rheumatoid arthritis and half a dozen important diseases in the same group, sarcoidosis, some of the thyroid conditions, neurological disorders, internal conditions of the eye, and in general the large group of disorders of unknown origin and uncured. The sophisticated methods and narrow points of view of the specialties involved with air pollution diseases, as well as the research establishment, fail to see a large medical area which is well visualized if seen as whole, but completely misunderstood if broken down in pieces and each component considered apart from the rest and belonging in a different medical field. Without this new knowledge of air pollution diseases could we improve the quality and costs of medical care in this extensive medical area? The only answer to this question is a loud "NO."

MINORITY SCHOOLS BIOMEDICAL SUPPORT PROGRAM

Statement of Miles Mark Fisher, IV, National Association for Equal Opportunity in Higher Education

The minority school biomedical support program was started in fiscal year 1972 to strengthen the institutional health related research capabilities of 4-year colleges, universities, and health professional schools in which student enrollments are drawn mainly from ethnic minority groups.

The predicate for the effort was the Senate Committee on Appropriations of the 92nd Congress, Report No. 92-3116 which stated:

"The committee . . . encourages the General Research Support Branch to initiate a program for the development of the health sciences at predominantly black colleges which have been unable to provide adequate preparation for definitive training in health research fields and the health professions. Since historically black students have not had equality of opportunity to become investigators in health research fields and to become physicians, dentists, and other health professionals, chiefly due to a lack of adequate research and teaching facilities and the inability of black institutions to compete for sufficient numbers of professionals, it is incumbent upon the Federal Government to rectify these inequalities. To this end, the committee suggests that $2 million be used to launch this program in fiscal year 1972."

The response to this program was so great that for the initial sum of $2 million for fiscal year 1972, proposals were generated from the eligible ethnic minority institutions requesting $12 million for the first year of support and about $53 million for the duration of the institutions' proposed programs.

Appropriations

The appropriations for the minority schools biomedical support program have been as follows:

Fiscal year 1972	$2,000,000
Fiscal year 1973	5,000,000
Impounded fiscal year 1973 funds	−1,000,000
Total	4,000,000
Fiscal year 1974	7,000,000
Restored fiscal year 1973 funds	+1,000,000
Total	8,000,000
Fiscal year 1975 budget request/$7,165,000 estimate	7,270,000
Fiscal year 1976 budget request	7,165,000

The following consideration on indirect cost has implications for the real need of additional appropriations in this program.

NEED FOR INDIRECT COST

Since its inception, the minority schools biomedical support program has operated on the prohibition that has applied to general research support programs as pertains to indirect cost. The basis for this was imposed because entitlements under the related programs general research support grants and biomedical sciences support grants were comprised of both direct and indirect cost components of regular research project support.

The minority biomedical support grants are comparable to other research project grants rather than to the general research support grants and the biomedical sciences support grants. Since they are based on competitive applications rather than entitlements, the minority biomedical support grantees incur indirect cost in the same ways that research project grantees do.

It is because of this distinction as well as the fact that the institutions involved have historically been discriminated against with regards to funding that we solicit your support in providing additional funds in order that these grants can carry indirect cost in addition to adequate size grants. Hopefully, this cost would not be taken from the grants but would be added on through the appropriation of additional funding.

As one president has indicated, "Present programs add to the total upbuilding of institutions on one hand, but, on the other hand, take away funds to pay the cost of overhead that institutions need to maintain other needed programs.

"Without allowing funds to pay the types of expenses usually considered overhead, the program places an additional strain on our limited budget."

Using 1975 figures of $7.165 million with a 30-percent indirect cost added on, there would be a need of $9,314,500 to provide for the existing participants in this program.

At any rate, to offset inflation cost, provide for the increased pool of eligibles, increase the participation of more institutions, and take into consideration the indirect cost, we would be talking in the neighborhood of $12 million for this program in fiscal year 1976.

EXPANSION OF ELIGIBLES

Care should be taken that institutions, where there are large numbers of minorities that are not necessarily a majority, are closely followed to assure that the effort for those that this program is intended to serve will be protected.

The minority schools biomedical support program has had a significant impact during its relatively short lifetime by providing the institutional support for biomedical research and research training necessary for the professional development of both faculty and students, thereby increasing the number of ethnic minority persons in this field and enhancing the pool of talent available for biomedical research.

It is hoped that substantial sums of money will be appropriated in fiscal year 1976 and succeeding years to approximate the needs and maintain the effort to help these institutions begin and continue to prepare the human resources for an ongoing society. This initiative should be encouraged through additional appropriations.

NATIONAL CENTER FOR HEALTH STATISTICS

STATEMENT BY KERR L. WHITE, M.D.,
PROFESSOR OF HEALTH CARE ORGANIZATION,
THE JOHNS HOPKINS UNIVERSITY

Mr. Chairman and members of the committee, I wish to record as public testimony my support for a substantial increase in the appropriations of the National Center for Health Statistics.

Following a period practicing and teaching internal medicine, I have spent more than 15 years in efforts to improve the allocation, organization, and administration of resources to meet the perceived health needs of individuals and popoulations. For 10 years I have been professor of health care organization at

the Johns Hopkins University. In recent years I have been chairman of the Health Services Research and Development Panel of the President's Science Advisory Committee, rapporteur of a World Health Organization Expert Committee on health statistics, and council member of the Insitute of Medicine of the National Academy of Sciences. I have worked with the National Center for Health Statistics as a consultant on numerous occassions since 1966, and I am thoroughly familiar with its substantial achievements in the past, its reputation as a center of excellence, and its potential for future development.

IMPORTANCE OF HEALTH INFORMATION AND STATISTICS

My first point relates to the fact that health care is now the largest public service industry in the United States. As you know, estimates for fiscal year 1974 place total health spending at $104.2 billion, an average of $485 perperson. The public share of this expenditure reached nearly 40 percent. For an enterprise of this size, our level of investment in "intelligence" or "marketing" information is clearly inadequate. The current budget of the National Center for Health Statistics, the principal Federal agency responsible for producing and coordinating health statistics, is about $22 million; this is less than one-tenth of 1 percent of current Federal health expenditures, which totaled $28,343 million in fiscal year 1974. Even if the Center's budget were increased to the present authorization level of $30 million, it would still be a very small proportion to spend on gathering, analyzing, and disseminating the basic facts and figures needed to manage resources of this magnitude and inform the decisions of policy makers.

In the United States up to the present there have been few constraints on health care resources, few effective planning processes that relate the flow of funds for manpower and capital to community needs, and no clear foci of responsibility and accountability. Therefore, there has appeared to be little urgency about the development of comprehensive National, State, and local health services information systems. The recent Federal PSRO legislation and the Health Planning and Resources Development Act, together wih a widespread sense of frustration in the face of rapidly rising medical costs, have dramatically changed this situation. The new PSRO's in their attempts to monitor the quality and costs of medical care, and the new health systems agencies and State health development authorities now being established to better allocate scarce resources, cannot function withtout adequate information and personnel skilled in applying this information.

Although we have made substantial progress in the development of national baseline statistics, we do not yet have the network of information sources and systems to provide each community with the basic facts it needs. Many PSRO's, for example, will not have available to them statistics showing the average length of stay by diagnosis in short-stay hospitals in their areas, and few will have any data at all for evaluating the quality of care in nursing homes and other long-stay institutions and in ambulatory care settings.

We are faced both as public servants and as individuals with a series of hard decisions about how best to spend our finite resources. Above all, we need a sound foundation of facts and figures, and of information and understanding, to make these decisions. We will be building on sand if we move aheard into these and other costly ventures like national health insurance without first developing the essential knowledge and skills.

THE NATIONAL CENTER'S NEW MANDATE

My second point is that Congress has explicitly recognized these needs for health information in Public Law 93-353, entitled "Health Services Research, Health Statistics, and Medical Libraries Act of 1974." This legislation significantly expands the mandate of the National Center for Health Statistics, which must now be provided with sufficient funds to carry out its new responsibilities.

Some features of Public Law 93-353 merits special comment.

1. The new legislation gives official status for the first time to the National Center for Health Statistics, which has existed as an administrative unit since 1960; it extends the existing authorities of the Department of Health, Education, and Welfare to develop, collect, analyze, and coordinate health statistics; and it consolidates these authorities within the newly designated NCHS. NCHS was

not elevated to the status of the Bureau of the Census or the Bureau of Labor Statistics, with a presidentially appointed Commissioner, as some advocated, and this may be something to consider in future legislation. Nevertheless, it now has much greater visibility and potential for leadership, and the stage is set for a much more active role in the development of public and private health information systems and sources.

2. The Secretary of Health, Education, and Welfare is specifically directed to coordinate the Department's health statistical activities, through NCHS "to the maximum extent feasible." One of the great difficulties in a country as diverse as ours in its health care arrangements has been to establish uniform standards, definitions, and classifications for health information, and to coordinate the overlapping and conflicting data systems and requirements within the Federal Government and within the Department of Health, Education, and Welfare itself. As a result, we have a vast flow of data that can seldom be pieced together into an intelligible picture of what is actually happening in the health care industry and what effect these activities are having on the health status of individuals, communities, and the country as a whole. And it remains difficult if not impossible to compare the health of different populations and the performance of different health services systems and to make valid measurements of the trends that are occurring. Here again, the new legislation provides the potential for better coordination of our health information systems, if sufficient funds are available to enable the Secretary and NCHS to move ahead in this important direction.

3. The new law requires that annual reports be submitted to the President and Congress describing and analyzing the health statistics collected by the Department. These reports can become a valuable tool for decisionmakers at all levels. Additional funds must be provided to develop these annual reports and to initiate new collection activities to answer the questions that arise as we review our progress in health care and reexamine our priorities.

4. The newly formulated cooperative health statistics system for building a network of baseline health information at the Federal, State, and local levels receives strong endorsement in the new legislation. This is an important program of the National Center of Health Statistics. It provides new incentives and opportunities for collaboration between public and private health agencies and organizations in the collection and use of a broad range of health data. It promises to avoid much of the current duplication of effort, to provide States, local communities and PSRO's with the essential data for planning and evaluation they now lack, and to encourage a much greater degree of basic uniformity. To achieve these worthwhile objectives, the Center clearly requires new funds for grants and contracts to State and local agencies and organizations and for experienced personnel within the Center to guide the program.

5. Another feature of the 1974 legislation is official status and a broad mandate for the U.S. National Committee on Vital Health Statistics. This small advisory board of experts dates back to 1948; it has worked effectively on behalf of NCHS and has achieved considerable prominence as a rieview body for health statistics, as a source of new policies, and as spokesman and liaison body for the Federal Government with national and international organizations. In the past it has operated on a shoestring, so to speak, and should now be given the means to expand its committees and intensify its efforts. One example of the work confronting this committee is the forthcoming revision of the international classification of diseases (ICD). We learn from the successes and failures of others, and it is by means of such basic classification systems that we are able to relate experience within and between countries. Objections to the official version currently approved for use in the United States (ICDA–8) have resulted in the development of a competing system (H–ICDA). It is important that the next revision adequately reflect the changes that have occurred in scientific knowledge and our understanding of health and illness and be widely accepted nationally and internationally. The U.S. National Committee on Vital and Health Statistics is the vehicle for this and other efforts to develop a common language for describing health needs and evaluating health services.

6. The legislation reaffirms the responsibility of NCHS for a broad range of health statistics, and it is a tribute to its foresight that despite limited resources, it has designed, tested, and launched several important new national surveys of immediate concern to legislators and other decision makers. These surveys include the national nursing home survey and the national ambulatory medical

care survey. Both coincide with increasing concern on the part of the public and the medical profession not only about acute short-stay hospital care but also about ambulatory or primary care, nursing home care, mental health care, and the fate of the chronically ill and the elderly. The methods developed in these surveys are equally suitable for use at State and local levels. They merit generous funding so that they can be continued, improved, and exapnded. The fate of the national ambulatory medical care survey, in particular, is uncertain because of a shortage of funds. This continuing survey of the content of office-based practice is the first scientifically designed national sample of ambulatory care to be undertaken in any country. It has been well received by the profession and the first results, to be available this summer, promise to be interesting and informative. Indeed, they will provide the critical information needed for developing the educational objectives and manpower requirements for primary medical care. And they will help us to examine more critically our large investments in expensive hospital equipment and procedures. For example, at the rate that the new EMI brain scanners are being installed in medical centers (140 ordered by March 1975), there will soon be capacity for doing at least a million brain scans per year at a cost of an initial investment of about $70 million and annual operating expenditures of $300 million. If we use as a rough estimate of need preliminary figures from the national ambulatory medical care survey of about 16 million physician visits per year for headaches, this assumes that perhaps one in 16 physicnan visits for headaches is associated with a serious risk of a brain tumor. The latest available mortality figures for the United States indicates that in 1969, 6,085 persons died of malignant brain tumors and another 197 of benign tumors, or a total of less than 6,300 persons. The overall risk of having a brain tumor of those with headaches consulting physicians is, therefore, about one in 2,500 visits, yet we are gearing up with a highly expensive technological test as if the risk were one in 16 visits. Even if it is argued that all those with any form of diagnosed cerebrovascular disease should have it confirmed by a brain scan, there were only 530,000 persons discharged in 1971 from U.S. short-stay hospitals categorized under this ISDA diagnostic rubric, so that we will shortly have twice the necessary capacity to deal with their problems. The national ambulatory medical care survey will help to broaden our perspective of health needs and counterbalance our tendency to concentrate scarce resources on highly specialized inpatient techonology for the relatively few at the expense of everyday care for the many.

In summary, therefore, at this juncture in our development of health policy in the United States, when health care costs are rising, when public involvement is growing, and when new Federal initiatives like PSRO's and more extensive community planning have been legislated, I consider it essential to follow through and provide the National Center for Health Statistics with sufficient funds to carry out its new mandate.

In the difficult decisions that confront us in health care policy, the very best we can do is to provide ourselves with the best foundation of information. I am firmly convinced that looking back over the years we will find that of all our public health programs, the one that has been the most cost-effective and has best stood the test of time will be our very modestly supported efforts to develop sources and sysems for basic health information.

STATISTICAL PROGRAMS OF THE DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE

Statement of Federal Statistics Users' Conference

This statement is submitted on behalf of the Federal Statistics Users' Conference to express its views on certain items in the fiscal 1976 budget for statistical programs of the Department of Labor and the Department of Health, Education, and Welfare.

FSUC is an association comprising 198 organizations generally classified as business firms, labor unions, nonprofit research organizations, State and local governments, and trade associations. These members have a common interest in obtaining adequate, timely, and reliable information from Federal programs in the light of certain criteria which FSUC has established, the principal one being that a statistical program should provide data of optimum usefulness at minimum cost.

The FSUC Board of Trustees has undertaken a careful study and review of the proposed statistical programs of the Bureau of Labor Statistics, the National Center for Health Statistics, and the National Center for Education Statistics for fiscal 1976. Members of the Board reviewed the programs that were outlined in special analysis G of the President's budget and in the appendix to the budget. Representatives of the Bureau of Labor Statistics, the National Center for Health Statistics and the National Center for Education Statistics attended a special meeting of the Board of Trustees in order to describe their proposed programs in more detail.

We believe that the proposed programs represent a minimum that is both necessary and essential in times of fiscal stringency. Aside from the need for initiating programs for the collection of new statistical data, a most important aspect of the development of the Federal statistical system is the need for improving some of our ongoing, current statistical series. We have found that in many instances too little attention or concern is given to certain inadequacies or weaknesses in some of our statistical data and the need for improving them. Certain programs are proposed by these three agencies that are designed to improve some of their current statistical series, mainly in the way of improving the reliability of some of the series and extending coverage of others in areas that are considered most necessary.

On the other hand, rapid changes in both our economic and social structure often require the initiation of new series of data to meet our emerging needs. It is important here that a step-by-step approach be taken and appropriate developmental work be undertaken. We believe that these agencies are making a conscientious effort to take a step-by-step approach to obtaining a higher degree of accuracy and precision in their ongoing statistical series, as well as in initiating new series.

BUREAU OF LABOR STATISTICS

The statistical programs proposed in the 1976 BLS budget are aimed at eliminating certain deficiencies and filling certain gaps in our economic data base. The information is needed to provide a better understanding of certain segments of the economy and as a guide to assist in the making of important policy decisions. We respectfully urge your serious consideration and support of these programs

BLS proposes to improve the annual National Survey of Professional, Administrative, Technical and Clerical Pay (PATC survey), as recommended by the General Accounting Office. This is an important survey that is used to adjust pay for both Federal-civilian employees and military personnel. BLS proposes to make improvements in this program. In addition to speeding delivery of the survey results by 1 month, it is anticipated that bonus payments will be included in the survey, and the industry and establishment-size scope will be expanded.

FSUC has consistently supported the step-by-step approach taken by BLS to improve various measures of prices and the price indexes. We supported the original program to develop price indexes needed to measure the price trends of U.S. imports and exports and the price competitiveness of U.S. products in world markets. The plan for 1976 is to increase coverage of export prices from 40 percent to 60 percent of total exports and of import prices from 25 percent to 40 percent of total imports. This is a necessary step which needs to be taken in order to achieve the long-run objectives of this program.

There has been a long time need for making improvements in the wholesale price index and the industry sector price indexes. In this program BLS proposes to improve the reliability of the weighting and the sample design used in these indexes. It also proposes to expand industry coverage.

In view of the current economic situation so far as employment and unemployment are concerned, it is most important that BLS undertake steps to improve these important measures. For its current employment statistics program, BLS proposed to conduct research and experimentation to test alternative approaches for counteracting a downward bias in current employment estimates believed to be due to failure to include new establishments in the program sample during the period of initial hiring. In addition, the quality of the sample used for preliminary estimates will be strengthened and research on sample and estimation methodology will be conducted.

It is also proposed to develop revised procedures for processing State quarterly employment and payroll data (the ES 202 program) and for monitoring State performance to improve the timeliness and quality of the data, which are im-

portant for making wage estimates in the national accounts and for benchmarking the current employment statistics (790) program.

Although statistics on the social and economic characteristics of the unemployed are regularly available from the current population survey (CPS), the CPS does not provide data which indicate how seriously unemployment affects the economic well-being of workers and how hard the unemployed try to find jobs. In view of this need for additional information, the BLS fiscal 1976 budget submission contains a request for funds to finance the periodic supplementation of the CPS to provide data on the characteristics of the unemployed. This proposed program has been strongly endorsed by the Council of Economic Advisers as well as the Subcommittee on Economic Statistics of the Council of Economic Policy. The program is designed to provide detailed data on the most recent job-related earnings of the unemployed; their income from other sources; their family relationship; and their jobseeking behavior. In this latter area, the emphasis of the program will be to determine how hard and where the unemployed search for employment, as well as what kind of job offers they refuse and at what wages. The development of this kind of information—not now available—will add greatly to our ability to analyze and understand the impact of unemployment. Further, it should provide an additional fund of information necessary to assist in making important policy decisions and in taking corrective actions to deal with the problem of unemployment.

Another important program is the revision of BLS series to the 1972 Standard Industrial Classification. This revision will increase comparability among statistical series produced by the Federal Government through conversion of all BLS establishment-based series to the revised (1972) standard industrial classification (SIC). Such conversion will permit comparative analyses of current and previous data. In 1976, BLS proposes to initiate retabulation and benchmarking of all national, State and local series affected by the revisions in the SIC.

An area of major interest to members of the Federal Statistics Users' Conference is that relating to consumer income and expenditures. BLS proposes to develop plans to collect data on consumer expenditures on a continuing basis. The data collected would be used (a) to revise the consumer price index (CPI) on a quinquennial basis, and (b) to expand analytical work on consumer expenditures as well as on consumer income and savings patterns. The important role which the CPI plays in economic planning and policymaking can't be overemphasized, and the need for maintaining its accuracy is self-evident. The current program calls for a decennial revision of the CPI. As the revision program now stands, a revised CPI will be published in the spring of 1977, 13 years after the previous revision. Certainly, more frequent and efficient revisions in this program are essential. If this is to be achieved, it is important that steps be taken to gather current information on consumer expenditures as well as on consumer income and savings patterns. The availability of more current data on patterns of consumption are particularly important when rapid changes are occurring within the economy and important policy decisions must be made in both the public and private sector. Two issues of major concern today are energy policy and tax policy. More current data on consumption patterns would be most helpful in dealing with these problems. It is also essential that we be aware of shifts in consumer expenditures and be able to develop early warning signs indicating possible shifts in these patterns.

NATIONAL CENTER FOR HEALTH STATISTICS

This agency has a clear-cut, important mission of providing data that identify, define and describe the state of health of the American people and the changes that are taking place. The Federal Government's efforts to gather accurate and extensive information about the health of the Nation's population have grown steadily over the last decade.

We sincerely urge the subcommittee to give serious consideration and support of the following National Center for Health Statistics programs:

A major feature of the 1976 program is the continued development of a cooperative Federal-State-local health data system under which basic data needed for Federal, State and local purposes will be collected by State and local agencies in accordance with Federal standards and specifications. In this system responsibility for identification of the data elements to be collected and the costs of this collection will be shared by the three levels of Government. The data elements

are chosen to meet the needs of the Federal Government as well as those of the State and local governments. Responsibility for collection of the data eventually will lie with the States and localities. It is estimated that through this system, in 1976, the number of States providing the Federal government vital statistics data will increase from 23 to 35; States providing health manpower data will be increased from 9 to 15; health facilities data from 5 to 12; and hospital care data from 2 to 5. An additional 15 to 20 States will be funded in a developmental stage.

With regard to the aforementioned program, the FSUC Board of Trustees believes this represents a necessary expansion of reporting States. However, the Board was concerned about the impact of the expansion on the financial and manpower resources of the States and local governments and their ability to meet the requirements of the program.

We are pleased to note that the national survey program conducted by NCHS will be maintained at the current level. However, this is an important Program because the various surveys in the program provide national statistics on the extent and nature of the illness and disability of the population; health resources; utilitzaton of health care; health care costs and financing; and family formation, growth and dissolution.

NATIONAL CENTER FOR EDUCATIONAL STATISTICS

We especially endorse an expansion in the budget for statistical programs of the National Center for Educational Statistics for fiscal year 1976. Various studies over the past several years have expressed concern about the adequacy of our present educational data collection efforts to meet our planning and policy-making needs. The report of the Committee for Educational Finance Statistics, issued in March, 1970 stated that "Traditional USOE activities such as the collection, analysis and publication of educational statistics have been faced with increasing demands for services while being sorely limited by both personnel and budget." We believe that the statistical function of the National Center for Educational Statistics has not received the emphasis it deserves within the Office of Education and in comparison to that of other general purpose statistical agencies of the Federal Government.

There was a restructuring of the National Center for Education Statistics within HEW under the educational amendments of 1974. Our hope is that this change will strengthen rather than weaken the operations and functions of this most important agency. We understand that the Center has some serious personnel and staffing problems which should be resolved as quickly as possible if it is to carry out its ongoing responsibilities as well as to undertake new activities proposed for fiscal 1976.

Significant new activities of the Center will include several new surveys and the establishment of an interagency consortium to provide Government agencies, the Congress, and the public better access to educational data. Special emphasis will be placed in 1976 upon surveys and analyses concerned with the changing nature of postsecondary education, the characteristics of participants in Federal programs of assistance to State and local education agencies, equitable financing of elementary and secondary education relative to the needs of target populations, characteristics and trends in nontraditional education, the teacher supply and demand.

In general, the FSUC Board of Trustees supports the basic statistical programs of the National Center, although it does not feel qualified at this time to comment specifically upon the new programs proposed in the 1976 budget, nor upon some of the programs mandated by the educational amendments of 1974 for the Office of Education.

However, there are two ongoing programs of NCES that FSUC has supported in the past and continues to support. These include the common core of data program and the program of National Assessment of Educational Progress. The common core of data program is a significant one because it is specifically designed to assist State and local agencies in improving their statistical and data collection activities. NECES, as well as other Federal departments and agencies, should take a leading role in providing assistance to State and local agencies in connection with their data collection activities.

We especially urge that NCES take steps that will improve the quality and timeliness of its major statistical series.

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CONCLUSION

The Federal Statistics Users' Conference appreciates the opportunity afforded by the Subcommittee to present our views on the budget request for statistical programs of the Bureau of Labor Statistics of the Department of Labor and the National Center for Health Statistics and the National Center for Educational Statistics of the Department of Health, Education, and Welfare.

COMMUNITY ACTION PROGRAMS

LETTER FROM MR. WILBERT C. RUSSELL, CHAIRMAN, NATIONAL COMMUNITY ACTION AGENCY LEGISLATIVE FORUM

Hon. DANIEL J. FLOOD,
Chairman, House Subcommittee on Labor, Health Education and Welfare Appropriations, U.S. House of Representatives, Washington, D.C.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: I am grateful to have the opportunity to submit these comments to your consideration of funding levels for the fiscal year 1976 budget of the Community Services Administration. My remarks result from two perspectives: my experience as executive director of the Monmouth County New Jersey Community Action Agency, and my tenure as chairman of the National Community Action Agency Legislative Forum, an open, deliberative body which has been charged to determine legislative policy for the CAA world.

As we anticipated during the legislative fight to extend the Economic Opportunity Act last year, serious problems are surfacing relative to increased local share requirements and proposed reductions in Federal funding levels for CAA's in the coming fiscal year. Already, CSA is indicating to CAA's that dollar levels of basic Federal grants for CAA's will be reduced beginning July 1, 1975, in line with the President's proposed budget for CAA and increased local share requirements.

It is ironic that the Congress, after strongly resisting efforts of the former administration to dismantle OEO and defund its programs, is now giving serious consideration to a budget proposal which will, ultimately, achieve the same end in many areas.

If implemented, the President's budget will dictate that many small CAPs, already operating on narrow margins with limited staffs, must close down altogether. Other CAA's will be forced to drastically curtail needed services and advocacy. Rural CAA's anticipate an eight (8) to 12 percent dollar loss from the budget proposal. Yet nothing in the Community Services Act requires a reduction in Federal dollars to CAA's. It is the administration's interpretation that a larger local share demands a dimunition of Federal dollar input. It is our contention that the local share requirement may (and can only) be met by greater in-kind contributions to augment the basic Federal support. This amount must continue at least at current dollar levels to ensure the continued value of CAA's.

John Gunther, the executive director of the U.S. Conference of Mayors said in a testimony before the House Committee on Education and Labor last April that:

"This (increased local matching share) will hurt local programs, local people, and local government. This revision can only hurt those least able to deal with the problem. The poorest communities, the most hard-pressed cities, all of whose resources are fully committed to dealing with fundamental governmental services, will be forced into untenable choices demanding elimination or abandonment of one service to produce matching funds for another service."

Witness now the current financial plight of New York City.

CAA's would like nothing better than to see an increased fiscal cooperation with local government. That marriage, however, must be formed from a clear assessment of each of our capabilities as matched to meeting the needs of poor people. I do not have to speak in this arena to the fact of increased need, or to the tragic, simultaneous dwindling of local resources to meet that need. And, yet it is precisely its unwillingness to accept the connection between those two hard realities which enables the administration to persist in its request for reduced Federal dollars for the antipoverty program.

Federal dollar cuts planned for CSA, especially when combined with increased local share requirements, will mean major layoffs in big city CAA's. Notices of job termination are going out to employees as early as June 1 of this year

so that fiscal year 1976 CAA budgets can be balanced. Though most local governments would like to see increased dollars flow to CAP's, they simply cannot generate funds to assist under present circumstances. As a result, those CAA's which will be able to meet the required increase in local share in fiscal year 1976 will do so through larger "in-kind" contributions. Thus, even if program levels (ostensibly) remain the same in some CAP areas during fiscal year 1976, the coupling of reduced Federal dollars with the impact of inflation will result in a substantial, actual loss in CAP services to the poor and increased unemployment beginning this summer when the nation can least afford either.

In the face of the rhetoric which has issued from all quarters calling upon the public and private sectors to take steps to relieve the current economic crisis, it seems inappropriate for me to be requesting only the scraps from our enormous Federal budget. In a bow to current "political realities", we ask only the $420 million which would maintain current Federal dollar contribution. These very limited dollars are for a program which is a proven mechanism for linking needs and resources, which should, in fact, expand that role, as well as its role as an advocate and ombudsman for the poor. To do justice to the needs of the Nation's poor, we should be here calling for massive Federal dollar increases to our program which is currently unable, because of limited resources, to serve millions of Americans who could clearly benefit from the multiple service we now offer and from the full range we wish to offer.

It is interesting to note that in this time of burgeoning unemployment more and more CAP beneficiaries do not fall in the category of the chronically indigent. The following report from the Baltimore County CAA is not atypical:

"More than four factories laid off or closed down this year. Many who are referred to community nutrition at CAP for emergency assistance and help with their first month's purchase of food stamps are these 'new poor.' The time lag between the last grocery trip and the first unemployment check is long enough for the family to go hungry a month or more."

The myth that poverty programs deplete rather than benefit the nonpoor is additionally belied by the most recent statistics, giving evidence that the training, employment and sustenance of the poor nourishes the life of all economic sectors.

For example, CAA's employ over 185,000 people, of whom 51 percent were poor and on welfare prior to their employment in the agencies. They are now working at an average annual salary of under $5,500, contributing to what former Director Alvin Arnett has called the "lowest overhead in the business." Due to the policy of community participation and to the successful recruitment of employees from the community, not only is overhead low, but returns to the community are high. In addition to the obvious benefits of employment, CSA estimates that each salary of $5,500 has generated about $13,000 at the community level. A source of economic health and community calm which should be nurtured, not diminished by the Federal dollar prioritizing and spending process.

In order to serve as we are mandated by the law you have written and approved, CAAs must be able to innovate and to address recognized needs in a meaningful manner. In line with this clear mandate, the forum would request the following:

(1) That the committee provide adequate administrative funding for CSA. For 3 years we have been operating without a training and technical assistance capability. This, coupled with short-term funding and the uncertainties of our very existence, have made long-term planning and technical development impossible. No industry could even survive under these conditions. We aspire to growth and improvement. This requires knowledgeable and sufficient staff support at the national and regional levels. The CSA Union has suggested a floor requirement of 1,500 personnel to satisfy the most basic administrative needs of the Agency. We would also urge funding of the evaluation component as written in our authorizing legislation. You and we need to measure the impact of other Federal legislation and programs on the poor and this is an excellent available vehicle for doing so.

(2) That a sufficient dollar amount to win an administrative commitment to the research and demonstration component of the Agency be included in the appropriation. Food coops, consumer unions and fuel stamp test projects are examples of the relevant efforts that CSA's R. & D. moneys have produced in the past. We all sense the need for new ideas and new directions, but somewhere in this vast bureaucracy, someone must be directed and funded to dare to innovate,

to dare to fail. We suggest CSA has done it, can do it, and must do it if the people are to be served.

(3) That the energy section of the legislation be funded to an amount compatible with the current national need. You have all been informed of CSA's winterizing and crisis relief programing. CAAs know how to do the job. They need the dollars to do it right. The $250 million cost excess on the M–60 Sheridan tank would have winterized most of the homes of the poor and elderly in this country. We do not request these dollars for frills, but for energy conservation which would benefit all, economic survival for the poor who now choose between food and fuel, and for the health of the sick and aged who may freeze in the dark.

(4) That Community Nutrition continue to be earmarked and fully funded. An example of that has been accomplished by Community Nutrition dollars is the neighbors-in-need program in Seattle, Washington. Neighbors-in-need has established food banks, tapped community volunteers, marshaled churches and other resources and is presently building a statewide coalition against hunger. In last year's report, NIN had 1,200 volunteers, 330 churches and 68 food banks that answered an average of 65,000 food requests per month. The Seattle experience can be replicated in other parts of the country.

(5) Fund at $50 million the community partnership provision of our authorizing legislation. This offers dollars available beyond our basic funding to stimulate opportunities for greater involvement with and commitment from State government, business and other groups which may not, to date, have had a financial alliance with CAA's. This could enable Community Action to build stronger bridges of both economic sharing and human understanding between the more and less affluent sectors of society.

(6) Increase the funding for community development corporations (CDC's) to $80 million. CDC's have pioneered the concept of self help community economic development and have recorded significant achievements in the fields of housing, health, manpower training and social services. This is a program which should be the signpost to the new economic direction this country must take to move free of our current economic bind.

(7) Continue funding for State economic opportunity offices. SEOO's are the linkages for facilitating such programs as community partnership and interstate fuel stamp programs. They are also a valuable resource for Federal and local authorities in the implementation of the New Federalism.

(8) Provides moneys for the senior opportunities and services to stimulate innovative programing for the aged and encourage coalition activities with other senior citizen interest groups.

In testimony before the Senate Committee on Labor and Welfare which was deliberating the future of our authorizing legislation at this time last year, I said:

"The overriding sentiment of the forum throughout our deliberations has been that the Federal Government must continue to acknowledge and address the particular problem of poverty in a coordinated and concerted manner; and that whatever bill finally emerges from the Congress, it must be one which guarantees that the Federal commitment to the poor not be reduced or buried."

This would still be the urgent message of the Community Action world to you. This is not a time to pit need against need; but to acknowledge resources such as ours where they exist and by sufficient funding to enable them to fulfill their capacity—each to join with others in the struggle to find a way forward for us all.

COMMUNITY DESIGN CENTERS

LETTERS AND STATEMENT FROM CONGRESSMAN LES AUCOIN, OREGON

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., May 22, 1975.

Hon. DANIEL J. FLOOD,
Chairman, Appropriations Subcommittee on Labor-HEW,
Washington, D.C.

DEAR MR. CHAIRMAN: I would like to take this opportunity to express my support for section 226 of the Community Services Act of 1974.

The Community Design Center in Portland, Oreg., is an excellent example of a project using this program to provide very useful and much needed services to

the community. The Portland Community Design Center functions as a nonprofit, tax-exempt organization. It was developed by the Oregon Human Resources Council in September, 1971, and is a community-oriented resource center providing free professional services in architecture, planning, and community development to community groups and individuals who otherwise might not have access to such services.

The goal of the CDC is to reduce the number of low-income individuals and groups who are unable to receive architectural and planning services. Toward this end, the Portland CDC seeks to respond to community needs and desires as defined and evaluated by the community. The CDC does not initiate projects, but rather acts to aid the community in finding, analyzing, and implementing solutions to their environmental concerns.

I think the value of this program has been proven many times over, and I would like to ask that information concerning this be made part of the committee's official record. I am enclosing a copy of a letter I received from Mr. David A. Pugh of the architectural firm of Skidmore, Owings and Merrill. Mr. Pugh gives examples of the proven value of this program; he sets forth reasons it should be continued; and he provides background information on the Community Design Center.

I hope the committee will give careful consideration to this invaluable part of the Community Services Act.

With best wishes,

Sincerely,

LES AUCOIN,
Member of Congress.

Enclosures.

SKIDMORE, OWINGS AND MERRILL,

Portland, Oreg., May 20, 1975.

Subject: Money for community design centers for fiscal year 1976 under section 226.

Hon. LES AUCOIN,
Cannon House Office Building,
Washington, D.C.

DEAR REPRESENTATIVE AUCOIN: I understand that the House and Senate Appropriations Subcommittees on Labor, Health, Education, and Welfare will soon write appropriations bills for fiscal year 1976 budgets.

I seek your support for funding through section 226 (Design and Planning Assistance) of the Community Services Act of 1974 (Public Law 93-644). Portland's Community Design Center will benefit as one of the recipients.

Developed by the Oregon Human Resources Council in September, 1971, The Portland Community Design Center functions as a nonprofit, tax-exempt organization. It is a community-oriented resource center providing free professional services in architecture, planning, and community development to community groups and low-income individuals who, otherwise, could not afford such services.

Since January, 1972, when the Community Design Center accepted its first project, it has worked on over 30 projects. Some of those who have received assistance include: The Fred Hampson Free Peoples Clinic. The Everett Street Drop-in Center, the Highland Community Center playground, the Sunnyside neighborhood model block, and the Portland bicycle paths task force study.

The goal of the CDC is to significantly reduce the number of low-income individuals and groups unable to receive architectural and planning services. In realizing its goal, the Portland CDC seeks to respond to community needs and desires as defined and evaluated by the community. Thus, the CDC does not initiate projects, but rather acts to aid the community in finding, analyzing, and implementing solutions to their environmental problems.

Basically, the CDC is an architectural "legal aid". It does not compete with paid professionals for clients, but seeks instead to provide professional services for those to whom, for financial reasons, these services would be denied.

The Portland Community Design Center is staffed by volunteer architects, planners and others in the building industry from the Portland area, VISTA volunteer architects, and community volunteers. As a nonprofit, tax-exempt corporation, it is funded through community donations and grants.

The Community Design Center offers technical assistance in such areas as building and site design, remodeling, surveys, feasibility studies, zoning investigations and research into new concepts of building.

The Community Design Center has been financed entirely through private community membership programs and is in desperate need of additional funding to maintain the momentum of the program already established and to expand the degree of assistance to the community.

I would appreciate your interest and support of funding for the Portland Community Design Center.

Sincerely yours,

DAVID A. PUGH,
Skidmore, Owings and Merrill.

PORTLAND COMMUNITY DESIGN CENTER,
Portland, Oreg.

What is the Community Design Center?

Portland's Community Design Center is a community-oriented resource center providing free services in architecture, planning and community development to neighborhood groups and low-income individuals who otherwise could not afford such services.

It is one of three programs developed by the Oregon Human Resources Council, a nonprofit, tax-exempt organization. The Community Design Center was established by the HRC board of directors in 1971 and was organized, with the help of the Portland chapter of the American Institute of Architects, in 1972.

The other programs of the Oregon Human Resources Council are the housing task force, which focuses on the quality of the city's housing, and the minority education committee, which provides information for those who are interested in entering architectural fields.

How is the Community Design Center staffed?

The CDC is staffed by volunteer architects, planners and others in the building industry from the Portland area, VISTA volunteer architects, and community volunteers. The CDC presently has five full-time VISTA volunteers, and is under the volunteer directorship of a professional Portland architect.

What does the center do?

The program seeks to respond to community needs and desires as defined by the community. Thus, the CDC does not initiate projects, but acts to aid Portland's neighborhoods in finding, analyzing, and implementing solutions to their problems.

Basically an architectural "legal aid," it does not compete with and does not take work away from paid professionals. Rather, CDC works to fill in the voids, by becoming involved with citizens and nonpolitical groups not served by professional planners and architects or in urban renewal areas.

The Community Design Center offers technical assistance in such areas as building and site design, remodeling, surveys, feasibility in low-income housing. Additionally, CDC helps provide community representatives with the technical background they require to deal with the specific needs of local neighborhoods, helps citizens evaluate programs relating to renovating our neighborhoods, and develops community support for comprehensive planning.

How is the Community Design Center funded?

As a nonprofit, tax-exempt organization, the CDC must rely entirely on community donations and grants for funding.

How effective is the CDC?

Organized in February 1972, the Portland CDC quietly attended to some 10 projects in its first 8 months of work, including the rehabilitation of existing homes and buildings for what is now the Sunnyside Neighborhood Model Block. By the end of its first year, the Community Design Center was responding to a dozen calls a week from citizens seeking information and help. In 1973 the center completed a total of 18 community projects.

The year 1974 has seen the mailing of a new CDC brochure to more than 200 Portland services and neighborhood associations, an increase of the VISTA staff from one to five full-time volunteers, and the move of the CDC office from the Dekum Building to a larger workshop center in a renovated storefront on S.E.

Grand Avenue. Sixteen different architectural, engineering, construction and building supply firms in Portland have donated some $6,000 worth of materials and labor to help the CDC staff remodel and equip the new center.

Twenty-five projects have so far been accepted by the Community Design Center this year. Among them are Eliot Neighborhood Model Block—housing rehabilitation; Sunnyside Neighborhood—children's playground design; Blanchet House drop-in center—correct fire code violations; Dolph Park Neighborhood—neighborhood traffic study; Portland Recycling Team—site design; North Portland neighborhood—community center remodeling; Northwest Pilot project—future plan for model block in northwest Portland.

Perhaps the best judge of the CDC's potential and effectiveness is the community it serves. David Cox, Community Coordinator for the North Portland Citizen's Committee, had this to say:

". . . the CDC has been of great assistance in consultation on zoning, planning, and architectural problems, and in putting together a neighborhood survey to pinpoint neighborhood environmental problems and concerns.

"Community organizations such as ours have little resources; the CDC provides a vital resource which might not otherwise be available."

What are the current needs and goals of the CDC?

Next year, the Community Design Center hopes to broaden its exposure and effectiveness in providing services to the community by starting a self-help information and referral library for low-income homeowners—covering such topics as remodeling, building codes, and how to read plans; acquiring a full-time director and assistant; increasing the volunteers staff to handle what is certain to be an increased project workload; and acquiring the funds to develop a more realistic and dependable budget.

Fact Sheet

DESIGN AND PLANNING ASSISTANCE IN POVERTY AREAS

Background

To constructively participate in the development of their communities, low-income residents must have access to design and planning assistance. Since these people usually cannot afford the services of private architectural, planning, and design professionals, they are often unable to initiate community development projects or to take part in private and public programs intended to make physical improvements in their communities.

Community Design Centers respond to the needs of low-income residents by providing access to design and planning services. Community Design Centers are nonprofit, community-based organizations established to provide free professional services related to architecture, planning and other design fields, to individuals and community groups who could not otherwise afford such services. A price objective is to provide the technical assistance necessary to translate neighborhood and community goals into good design programs.

The first design center was the Architects Renewal Committee of Harlem, started in 1964. Since that time, Community Design Centers have existed in 47 States. Currently there are 80 Community Design Centers serving urban and rural client groups in 40 States.

Legislative history

As part of its efforts to eradicate poverty, the Office of Economic Opportunity, under title II, section 232 (research and pilot programs) of the Economic Opportunity Act of 1964 (Public Law 88–452) granted research and demonstration funds to four community-based architectural and planning workshops—more commonly known as Community Design Centers. One demonstration Community Design Center was initially funded in 1967 under section 232 and several other demonstration centers were funded through June 1974. Since June 1974, only one demonstration Community Design Center has continued to receive section 232 funding.

The Economic Opportunity Act Amendments of 1972 (Public Law 92–424) authorized a new program, section 226 (Design and Planning Assistance), under which organizations such as Community Design Centers are eligible for funding. Section 226(d) continues the pilot demonstration projects established in section 232 of the 1964 act. The Community Services Act of 1974 (Public Law 93–644) retains section 226. Up to this time, earmarked funds for the design and planning assistance program have not been appropriated.

The American Institute of Architects

The American Institute of Architects and its component chapters are committed to the existence of Community Design Centers. At its national convention in May 1973, the AIA reaffirmed its support for design and, planning assistance programs and specifically for the vital role Community Design Centers play in providing community-based design and planning technical assistance to low-income communities throughout the nation. Many Community Design Centers have historically been supported by local AIA chapters. These centers represent one of the means of public involvement to which the Institute is committed. Through the specific involvement of practicing architects with these centers, low-income citizens are afforded the same kinds of professional services as have been traditionally available to middle and upper income groups.

Recommendations

Aside from OEO funding of demonstration Community Design Centers, no satisfactory source of daily operating revenues has been found. In the absence of federal funding, Community Design Centers have had to rely on the sporadic support of local foundations and private contributions, and their programs have suffered accordingly.

The American Institute of Architects recommends that $15 million be appropriated for the Community Services Administration's Design and Planning Assistance program (section 226) for fiscal year 1976. This recommendation is based on Senate Report 93–1292, which accompanied S.4178, the Labor and Public Welfare Committee-reported Headstart, Economic Opportunity and Community Partnership Act of 1974. In its projection of the program's funding, the committee suggested $10 million in fiscal year 1975, $15 million in fiscal year 1976, and $20 million in fiscal year 1977 for section 226, Design and Planning Assistance.

Proposed allocation of funds—fiscal year 1976

65 Community design centers at $75,000	$4, 875, 000
40 Community design centers at 100,000	2, 000, 000
20 Community design centers at 150,000	3, 000, 000
Administrative costs for 145 community design centers	1, 125, 000
Total program costs	15, 000, 000
Projected inkind professional contributions	45, 000, 000
Total value of design and planning services delivered to low-income communities	60. 000. 000

Projected employment impact

Professional positions	640
Nonprofessional positions	360
ISTA's and other full-time volunteers	1, 450
Drafting and other trainees	500
Total people employed	2, 950

Program cost per job; $5,000.

Minimum budget for a community design center

Salaries and wages:	
1 executive director	$16, 000
1 architectural director	12, 000
1 staff planner	12, 000
1 secretary	7, 200
4 VISTA volunteers	-----
30 volunteer professionals	-----
taxes and fringe benefits at 15 percent	7, 000
	54, 200

Nonpersonnel:	
Space costs (1,200 ft.²)	$3,000
Equipment	2,000
Consumable supplies	1,200
Travel	800
Telephone	1,200
Postage	500
Copying and reproduction	900
Library materials	300
Insurance	300
Conferences and seminars	400
	10,600
Fiscal and administrative services at 8 percent	5,200
Total	70,000

Budget for a community design center serving a large multi county or metropolitan area

Salaries and wages:	
1 executive director	18,000
1 architectural director	14,000
1 urban planner	13,200
1 landscape architect	11,400
1 interior designer	11,400
2 community workers at $9,000	18,000
1 secretary/office manager	8,400
1 clerk/typist (half time)	3,600
12 VISTA volunteers	------
100 volunteer professionals	------
Taxes and Fringe Benefits	14,700
Total	112,700
Nonpersonnel costs:	
Space costs (3,000 square feet)	7,500
Equipment	3,000
Consumable supplies	3,000
Travel	2,600
Telephone	2,600
Postage	1,800
Copying and reproduction	3,000
Library materials	500
Conferences and seminars	1,500
Insurance	700
	26,200
Fiscal and administrative services at 8 percent	11,100
Total	150,000

ALBINA NIGHT CLINIC,
Portland, Oreg., February 21, 1975.

THOMAS GILLESPIE,
Director, Community Design Center
Portland, Oreg.

DEAR MR. GILLESPIE: We completed the major portion of our construction work about the 1st of February. The plans you drew up for us worked beautifully. We are very grateful for the work you did in helping to make our new location livable. Our clients seem to like the new clinic and we have received many favorable comments from our attorneys and staff personnel.

Thank you very much, Tom, for your swift and expert assistance. We hope things go well for you in the coming year. If our clinic is any indication of your work, you're doing a very good job. Thanks again.

Very truly yours,

PAT REGAN,
Legal Intern.
JAY FOLBERG,
Civil Clinical Director,
Northwestern School of Law.

DEPARTMENT OF HUMAN SERVICES,
Portland, Oreg., February 27, 1975.

MR. DON MACGILLIVRAY,
Project Coordinator,
Community Design Center.

DEAR DON: At last it's a print!

Our staff wants to thank you for your help in designing our logo. You succeeded in getting the idea of professionalism and appeal to youth that we wanted for our letterhead.

Again, our thanks.

Sincerely,

PAT KLING,
Administrative Assistant,
JANIS Project.

PORTLAND ACTION COMMITTEES TOGETHER, INC.,
Portland, Oreg., November 13, 1974.

MS. CHERIE MACGILLVRAY,
Community Design Center,
Portland, Oreg.

DEAR CHERIE: Thank you so much for the beautiful maps you prepared for the coalition on such short notice. Many thanks and compliments to you and the Community Design Center.

For an encore, we request blown up maps of the target areas with lots and houses indicated. Enclosed please find target areas for HAND, SMILE, and Richmond. I shall send or deliver the target areas for Sunnyside, Brooklyn, Kerns, and Buckman as they are chosen.

Also, we would like a large map of the Southeast with the target areas of each of the neighborhoods indicated and eight 8½ x 11" copies of the same.

Again, if you run into any problems or questions, please contact me.

Many thanks,

DAWN ROBBINS,
Community Worker, UYA.

3 Enclosures.

NORTH PORTLAND CITIZEN'S COMMITTEE,
Portland, Oreg., September 10, 1973.

To Whom It May Concern:

The Portland Community Design Center has been working with our organization over the last year. Through Mr. Bob Evanson, the CDC has been of great assistance in consultation on zoning, planning and architectural problems and in putting together a neighborhood survey to pin-point neighborhood environmental problems and concerns.

Community organizations such as ours have little resources; the CDC provides a vital resource which might not otherwise be available.

Sincerely,

DAVID COX,
Community Coordinator,
North Portland Citizen's Committee.

PORTLAND, OREG., *September 5, 1973.*

Community Design Center,
Portland, Oreg.

To Whom It May Concern:

On behalf of the residents of Schrunk Riverview Tower I would like to thank the Community Design Center for their help and advice in decorating the communal dining area and outside patio.

Although they have not been able to complete the outside area, the residents plan to have it ready to enjoy by Spring, 1974.

Thank you again for the time and effort you spent to make this elderly residence a bit nicer.

Sincerely,

ALICE L. DOYLE,
Assistant North Area Director.

HIGHLAND COMMUNITY CENTER,
Portland, Oreg., September 6, 1973.

DEAR SIRS: We of the Highland Community Center, and the Model Cities Neighborhood would like to express our sincerest appreciation for the beautiful engineering job done on the basketball court at the Yaun Boys Home.

Your recognition of the need for this recreational facility and your ready acceptance of the task proves indeed that people do care about other people.

Thank you again and best wishes for the continuance of your fine services.

T. N. NOFFA Jr.,
Executive Director.

LEGAL AID SERVICE,
Portland, Oreg., September 5, 1973.

Mr. BOB EVENSON,
Portland Community Design Center,
Portland, Oreg.

DEAR MR. EVENSON: On behalf of Multnomah County Bar Association Legal Aid Service, I would like to sincerely thank you and the CDC for the invaluable assistance you provided for the Fred Hampton People's Free Health Clinic.

The pamphlet which you published was very helpful in publicizing the clinic's services, and has been extremely instrumental in the expansion of the medical and dental services which the clinic provides to the community. The complete set of architectural plans and blueprints which the CDC drew up make the needs of the clinic known, and resulted in the clinic's being able to move to an office much more suitable to its needs.

The services which CDC has provided—the booklet, the plans, and the advice—would all have been otherwise unavailable were it not for CDC. To groups such as the health clinic, which rely almost entirely on voluntary in-kind contributions, the work of the CDC is invaluable. The actual cost of the services which CDC contributes would far exceed most community organizations' ability to pay. Were it not for CDC, these groups would be precluded from utilizing architectural services which help the groups better serve the community.

Again, I would like to thank you and the Portland CDC for the invaluable service you have provided.

Sincerely,

CHARLIE HARRIS,
Attorney.

EPISCOPAL LAYMEN'S MISSION SOCIETY,
Portland, Oreg., March 14, 1974.

DEAR MR. EVENSON: Hearty congratulations on your move to new quarters on Grand Avenue. For the reasons stated in your March letter, we can readily understand the greater convenience of your present location.

How very fortunate for Portland that your specialized work is available to the community and with the added boon of being free to community groups and low-income individuals.

We wish you continued success in your undertaking and ask God's blessing on each of your volunteers.

Faithfully,

C. T. ABBOTT,
Executive Director.

NORTHWEST PILOT PROJECT,
Portland, Oreg., September 4, 1973.

COMMUNITY DESIGN CENTER,
Portland, Oreg.

DEAR SIR: Jerry Goldsby made a genuine contribution toward our efforts to provide more adequate space for group activities for the aged, blind, and disabled in our community. He offered his services in advising and helping the owner of the Campbell Hotel enlarge a room in the basement of the hotel for such activities.

There are too many environmental barriers in our community for the aged, blind, and disabled. It is encouraging to know that there are architects who are concerned and actually make the effort to help remove such barriers within a residential hotel where many of our aged, blind, and disabled citizens of low income live.

Sincerely yours,

PETER H. PAULSON,
Director, Northwest Pilot Project.

WILLAMETTE COMMUNITY DESIGN CENTER

GOALS

WCDC is a public service organization that provides free or low-cost architectural and planning services to the community. It is sponsored by the Human Resources Council, a nonprofit, tax-exempt organization created to involve architects and related professionals in community activities and services.

SERVICES

WCDC is a resource for helping to define and evaluate community needs in the manmade environment. It aids the community in analyzing and implementing solutions to environmental problems. Services include project development, programing, preliminary studies, research, planning, design, working drawings, construction administration, and educational seminars.

STAFF

WCDC is staffed by an architect/director, project designers, VISTA volunteers, university students, and professional and community volunteers. The design center emphasizes the combination of the abilities and resources of design professionals and user groups in the resolution of their problems.

CLIENTELE

WCDC is available to low-income individuals, nonprofit organizations, citizens' and neighborhood groups, public service associations, and others without adequate resources, and incapable of hiring appropriate professional consultants.

CDC HOTLINE

(May–June 1975 Portland community design center)

MAY:

14, 17, 20: Portland Opera
Salome

16 and 17: Science Fiction Film Festival omsl, 10:00 p.m. 8 hr. $5.00
18–22: National A.I.A. Convention, Atlanta, Georgia.
22 and 29: "Bill of Rights" Historical Society Brown Bag lunch
24: O.M.S.I. Star Party to view lunar eclipse—free parking lot.
27: AIA Chapter Meeting Art Museum $3.00

JUNE:

4: CDC Beer Get Together, 4:30. Please Come!
8–14: Rose Festival

11–13: AIA Seismic Lab
15: Fathers Day

KBOO Radio station is currently looking for a space to lease or rent. Once they locate, we expect to be assisting with the design for the remodeling.

The design of the Immaculate Heart playground and play structure is complete thanks to the efforts of volunteers Dan Glennon and Steve Lebwohl. We will be building a model and doing construction drawings in order to break ground in mid-June.

Remodeling plans done by Alex Pierce for the Hollywood Senior Center are complete and are being reviewed by the senior center staff.

Volunteers Dan Wheeler and Cleve Motley are designing interior graphics to brighten the hallways and classrooms of the Sunnyside Methodist Church. The church also offers itself as a community center, so many southeast residents will be participating in carrying out the design plans.

Teachers and parents of children at the Lutheran Church of the Resurrection preschool on NE 132nd participated in an idea brainstorming session to design a playground for the school. After CDC volunteer Steve Lebwohl helped to stimulate ideas by showing slides of playgrounds and play structures, as well as discussing playground concepts, the group was able to come up with their own design. Steve Dotterer has volunteered to work with the school's design committee to formalize the plans.

The Bishop Peterson Child Development Center in the Albina neighborhood has requested help from the CDC for design of a new play structure. Jeff Kirsch has volunteered his talents and any other interested people are encouraged to participate in the designs.

If the Ondine Women's Residence is purchased, 13 handicapped women will be displaced. They have a suitable residence available but are looking for sources of funding. The women need CDC help to compose a funding proposal to present to the public as well as private sources involved.

Centenary–Wilbur Church now has a plan for their parking lot, but we're looking for volunteer assistance for interior remodeling.

Morrison Family Service Center is a new project looking for assistance with the redesign of their waiting area and help with their acoustical problems. Larry Mentrom has begun working with them.

Rick Fowler has been working with the Grant Park neighborhood association's traffic committee. They now have a neighborhood traffic plan which will be presented to the neighborhood and then to the city for approval.

CDC volunteers, staff, board members and clients were able to spend an afternoon together at our first beer get together on April 30. We'll all get another chance to talk to each other and share information and ideas on Wednesday, June 4 at 4:30. The beer will be here, at the eastern foot of the Morrison Bridge.

Volunteer hours: To help us record project hours, please keep track of your monthly hours starting from January 1975. It's a necessity when applying for grants.

Rehabilitation Services

Statement of James Smittkamp, in behalf of the National Paraplegia Foundation

Mr. Chairman, I am grateful to you and the members of this subcommittee for the privilege of presenting a statement for the record in behalf of the National Paraplegia Foundation and the paraplegics and quadriplegics of the United States.

I am James Smittkamp, executive director emeritus of the National Paraplegia Foundation, the only organizational voice for 125,000 American paraplegics and quadriplegics. I was executive director of NPF for approximately 10 years. I have been a paraplegic for 30 years as a result of a World War II combat incurred injury to my spinal cord. I have observed care of spinal cord injured persons as a patient in a variety of Army hospitals, a VA hospital, two university affiliated hospitals, and an indepedent hospital. As NPF director I had daily experience with the problems of individual paraplegics and with the aggregate problems of 125,000 paraplegics. (We use the term "paraplegic" to indicate both

the conditions of paraplegia and quadriplegia.) And as well be evident, I have consulted with several people of varied expertise in the preparation of this statement. I believe I have good knowledge of paraplegia and the need for improved care and research.

To be clear on the subject, paraplegia is paralysis of a person from about his waist down from injury or some diseases of the spinal cord. Quadriplegia is paralysis of a person from the neck down from similar damage at a higher level of the cord.

Traumatic damage to the cord does not simply result in an inability to move affected parts of the body voluntarily or to feel such external stimuli as heat, cold, touch, pin pricks, et cetera. The pleasures or comforts of such stimuli are gone together with the body's warning system that the stimuli are excessive to the point of danger and damage. This leads to possible burns, pressure sores, and frostbite because the paraplegic is unaware that he's in trouble. The processes of elimination no longer function normally and this leads to dangerous urinary infections at worst and social embarrassment at best. Normal sex function is usually lost. In addition to these severe physiological problems, the psychological impact is enormous. One's sense of manhood or womanhood is disturbed. Frustration, anger, guilt, depression can lead to personal defeat. In short, the total personal impact is enormous and is more serious with the higher levels of injury and resulting paralysis.

The numbers of persons so afflicted are not particularly impressive when considered by themselves. The prevalance of paraplegia has been variously estimated at 100,000 to 400,000. Dr. Byron Hamilton, of the Midwest Regional Spinal Cord Injury Center, suggests that the conservative figure of 125,000 is reasonably defensible and I concur. Dr. Hamilton also states that available data indicate new cases occur annually at a rate of 24 to 35 per million population. Using the conservtive end of this range, there would be approximately 5,000 new cases per year.

Aside from obvious human considerations, these modest numbers probably don't mean much until the financial cost is calculated. Mr. David Barrie, former chief rehabilitation examiner for the Liberty Mutual Insurance Co., and now a private consultant in paraplegic matters, estimates that, at today's prices, the total lifetime—age 29 at onset, surviving 33 years—direct costs for a paraplegic are about $170,000. For a quadriplegic—age 29 at onset, surviving 25 years—similar costs are nearly $400,000. If lost wages are added, total cost for a paraplegic is about $470,000 and over $700,000 for a quadriplegic. Assuming that paraplegia and quadriplegia occur at about the same rate, we are adding potential costs of $3 billion per year with each new annual crop of spinal cord injuries. It would appear prudent to make some investments of money towards programs that might reduce this financial burden—and help some people in the process.

Basic and clinical research directed to reduction of paralysis after injury and, eventually, to a complete cure must be part of the approach to the problem. I am neither scientist nor clinician but I am aware of a new optimism by both that newly available lab tools and techniques are making the search into the mysteries of the spinal cord easier and more productive. The National Institute of Neurological and Communicative Diseases and Stroke is currently supporting five clinical research centers and related research in at least two other facilities.

Mr. Chairman, we urge that you and your subcommittee at least support these existing projects and that you support the level of spinal cord financing suggested by the director of NINCDS and endorsed by Mr. O'Neill, the minortiy leader. It is almost certain that any knowledge gained through these spinal cord and central nervous system research efforts would accrue to improvement in the care of some 5 million neurologically impaired Americans.

In spite of the most intense programs in safety devices and practices, spinal cord injury is not 100 percent preventable. Thus, even when a cure for paralysis resulting from cord injury is found, it will have to be applied in a clinical facility. Therefore facilities are needed in which to effect cures when possible, but also to provide the best possible care for spinal cord injured persons now to minimize disability and ensure the best possibility of using remaining abilities to the utmost. There is good evidence that systemized care combining specialized acute treatment facilities with equally specialized rehabilitation can reduce the

usual complications that accompany paraplegia and reduce both treatment time and hospital costs. Again quoting Dr. Byron Hamilton, the Midwest Regional Spinal Cord Injury Center has effected a 30- to 35-day reduction in initial hospital stay, a $5,000 to $6,000 reduction in costs, and a 50 percent reduction in the usual complications of urinary infections and pressure sores as opposed to patients not treated in a special center.

There are now 10 HEW-SRS designated spinal cord injury centers. Dr. John Young, director of the spinal injury center at the Good Samaritan Hospital in Phoenix has estimated that a good center can serve a population of 3 to 5 million. That would suggest that the country needs about 50 such centers.

Mr. Chairman, we urge that you and your subcommittee continue support of the 10 existing centers and, because the human and dollar benefits have been proven, that you extend the network of systems at a rate which would cover the Nation with centers at the earliest feasible date. If each of the 5,000 new paraplegics each year had access to systemized care, the initial hospitalization cost would be reduced by $30 million (5,000 cases at a savings of $6,000 each). It would be an investment that could save money and improve the lives of persons paralyzed by injuries to their spinal cords, a financial investment that pays both financial and human dividends.

Mr. Chairman, the Subcommittee on Appropriations for Labor and HEW has been both generous and foresighted over the several years I have had the pleasure of either appearing before you or observing the presentations of others. We, the spinal cord injured persons of the country and those of us who are professionally concerned with paraplegics are most grateful for your enlightened and humanistic support, and we are confident that you will continue and increase that support within the limitations you are confronted with in the context of your larger concerns and the financial capability of our country.

Thank you for the privilege of attaching this statement to your record.

Rehabilitation Services

Statement of Dr. William Berenberg

Medicine and Engineering: A Potent Combination in Rehabilitation

Mr. Chairman and members of the committee, it is a privilege to testify again this year on the vital importance of increasing funds for research technology within the overall budget of the Rehabilitation Services Administration.

As you well know, the President in 1974 pocket vetoed the rehabilitation services administration bill. However, the pocket veto didn't last very long. The House passed a similar bill by the overwhelming margin of 398 to 7, and the other body passed it by a vote of 90 to one.

For fiscal 1976, the Rehabilitation Act of 1974 authorizes $32 million for rehabilitation research. Of the amount authorized for research, a minimum of $8 million is specifically allocated for rehabilitation engineering centers. I am therefore somewhat mystified at the administration's request for only $20 million in fiscal 1976 for all phases of rehabilitation research. This is the identical request that the previous administration made in fiscal 1973 and in fiscal 1974 and is $12 million under the amount appropriated for fiscal 1972.

Mr. Chairman, I respectfully submit that this recommendation does not square with the following statement from the President's fiscal 1976 budget mandating first priority for the Rehabilitation Services Administration to an accelerated effort combining medicine and engineering in the alleviation of the plight of the severely handicapped. I quote from the President's budget: "Developing new technology to serve the needs of the severely disabled * * * by developing Rehabilitation engineering centers devoted to research."

I think the committee would be interested to know how the rehabilitation-engineering concept came about. As far back as 1966, at the request of the then-Vocational Rehabilitation Administration, the Committee on Prosthetics Research and Development of the prestigious National Academy of Sciences was asked to study the entire area of the severely handicapped and develop recommendations for a concerted attack on the problem.

Four years later the Academy committee did a post mortem on its original findings and came to the following conclusion: "The method of funding research by relatively small grants has been effective, but it appears that the time has come when support of special centers devoted to integrated research-engineering programs seems desirable."

This appraisal led the Academy to the forthright conclusion that what was desperately needed in this country was a network of rehabilitation-engineering centers "to carry out integrated programs of research, development, evaluation and education in rehabilitation-engineering * * *. The center should be in a clinical setting with a substantial case load, and it should have a strong teaching affiliation with both medical and engineering schools."

The 1971 Academy report was accepted with enthusiasm, not only by the vocational rehabilitation people, but by top officials concerned with this problem in the National Aeronautics and Space Administration, the Veterans' Administration and a host of professional medical organizations.

Despite all of these accolades, progress has been agonizingly slow. The 1971 Academy survey projected a level of funding at $1 million per center, since each of these centers would be highly specialized units with full-time medical and engineering staffs dedicated to the rather difficult problem of applying the newest advances in technology to the most severely handicapped people—the blind, paraplegics, hemiplegics, cerebral palsied, spinal cord victims and thousands of additional people with crippling handicaps.

Furthermore, the rehabilitation-engineering center concept was down at the low end of the totem pole of rehabilitation. For example, for the past eight years the program has been assigned to just one person, and he doesn't even have a full-time secretary. After numerous pleas for additional staff, he has decided to go off to Egypt to set up a model rehabilitation engineering center for Mr. Sadat.

As a result of these developments, or lack of developments, the first rehabilitation engineering centers came into being in fiscal 1974. They were not financed at a million dollars, as the following five centers—the only ones in the country—will show:

Grantee	Fiscal year—	
	1974	1975
Rancho Los Amigos Hospital, Downey, Calif	$500,000	$600,000
Moss Rehabilitation Hospital, Philadelphia, Pa	500,000	600,000
Texas A. & M. Research Foundation, College Station, Tex	500,000	600,000
Harvard School of Medicine, Cambridge, Mass	350,000	500,000
Northwestern University, Evanston, Ill	350,000	500,000

The Rehabilitation Services Administration intended to fund at least three new centers last year, and it so stated before the House legislative committee having jurisdiction over the area. These centers are:

(1) The University of Virginia, Charlottesville, Va., "Rehabilitation Engineering Center" (technology for application in spinal cord injured).

(2) Institute of Medical Science, San Francisco, Calif., "San Francisco Rehabilitation Engineering Center" (sensory disabilities—blind and deaf).

(3) University of Iowa, Iowa City, Iowa, "Rehabilitation Engineering Center" (problems of the human spine).

In the current fiscal year, two more research engineering center applications have been recommended for approval and could begin immediately if funds were available. They are:

(1) University of Tennessee, Knoxville, Tenn., "Rehabilitation Engineering Center for Appalachian People" (rehabilitation engineering service delivery systems).

(2) Case Western Reserve University, Cleveland, Ohio, "Rehabilitation Engineering Center" (standards for internal and external prosthetic and orthotics system).

In addition, several exciting applications are being reviewed at the present time. One Center application comes from a consortium composed of Wichita

State University, United Cerebral Palsy of Kansas and the University of Kansas Medical School. Its primary goal is the development of techniques for returning to the mainstream of American life thousands of handicapped who were previously regarded as "unemployable." A second application from the University of Florida is being reviewed, and there are a number of others which time does not permit me to list.

Needless to say, we have to upgrade the skills of many people in this difficult area of research-engineering. Much of the technology works, but it is not being applied to handicapped people because they aren't enough bodies around who know how to do it. Only in a fairly large center can you have the experts needed to train the doctors, the physiotherapists, the nurses, and so on in these new techniques.

You may remember, Mr. Chairman, that when I testified before this committee a year ago, I had with me a blind professor from the University of West Virginia who demonstrated the use of the Optacon, an electronic device which was a byproduct of the NASA program. This is just one of many frontiers, because for all these years, the blind have had to depend upon the use of braille, which is really the learning of a highly complex new language and which limits the readers to only those volumes which have been translated into braille.

In testifying before the Senate Appropriations Subcommittee last year, Mr. Leonard Goldenson, chairman of the board of the United Cerebral Palsy Association, cited a number of examples of space technology which could be applied to the handicapped if we forged the necessary union between the engineer and the doctor. For example, he hold the committee that NASA had developed a lunar walker originally in their space program because they felt man could not walk on the lunar surface. They did not need this particular technology, but it is still available—it is just not widely used. Mr. Goldenson journeyed to the Ames Space Center and saw a young boy of twelve get out of his wheelchair and use this lunar walker to move upstairs, downstairs, through mud, over rocks, through sand and shallow water. As Mr. Goldenson testified:

"We immediately felt that if, through research, this could be put into a miniature form for a handicapped person, we could free millions of handicapped and elderly people who had become immobile, get them out of their bedrooms and into society."

In this year of our Lord 1975, you may ask, "What is the cost-benefit ratio in putting a few million dollars into intensive rehabilitation engineering centers for the handicapped?"

Right here at George Washington University, Dr. Thomas R. Shwarles took 27 severely spinal-injured patients who were confined to their homes. By the application of medical and engineering technology, he has made these people contributors to the gross national product of our country. He calculated the cost-benefit ratio, the benefits over a 5-year period divided by the cost actually spent on this training and for equipment. The country and the Government got back $56.00 for every dollar spent. These are real cases. They are in business now and are not only able to survive a competitive economy, but we can readily appreciate the difference it makes in their psychological well-being.

As Doctor Schwarles pointed out: "To serve the millions of such handicapped persons throughout the nation is a great challenge to Government at all levels."

We therefore, Mr. Chairman, recommend as an absolute minimum the $32 million for research in the Rehabilitation Services Administration so overwhelmingly voted by the Congress less than a year ago.

Work Incentive Program

STATEMENT OF EDWARD T. WEAVER, EXECUTIVE DIRECTOR, AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. Chairman, I am Edward T. Weaver, executive director of the American Public Welfare Association, the national membership organization in the field of public welfare.

53-100 O - 75 - 62

I appreciate this opportunity to submit testimony to your distinguished committee. I will present the concerns of our association about two specific elements of the proposed budget for the Department of Health, Education, and Welfare for fiscal year 1976—child-welfare services and the child care and supportive services component of the work incentive program. I will not address the concerns of our association—and they are many—related to proposed legislative changes which would result in budget reductions. I understand that your committee appropriately confines itself to appropriations under existing law. Therefore, our assumption is that the committee will restore to the appropriations estimates the reductions associated with proposed legislative changes.

The concerns which I express reflect discussions over the past several months with the National Councils of State and Local Public Welfare Administrators. These bodies are constituent members within our association. The councils include in their membership the administrators of every State and territory and of about 1,700 local jurisdictions. These are the officials who carry, among their other duties, the administrative responsibilities for cash assistance, social services, and medical assistance programs of the Department of Health, Education, and Welfare at the State and local levels. Individually, and through the national councils, they have under continuing review and discussion the issues and problems surrounding Federal budgeting for public assistance programs.

1. TITLE IV–B CHILD-WELFARE SERVICES

The administration proposes budget authority of $46.0 million for title IV–B child-welfare services in fiscal year 1976. The fiscal year 1975 appropriation was $50 million. The administration proposed a rescission of $4 million of the fiscal year 1975 appropriation. We commend Congress for rejecting this rescission proposal. As $46 million was totally inadequate for fiscal year 1975, it also is totally inadequate for fiscal year 1976.

The legislative objective of the child-welfare services program is to establish, extend, and strengthen child-welfare services through Federal financial participation in State and local programs. The goal of these programs can be seen as providing every child an opportunity to live with his or her parents in a home environment that will enable that child to develop—to the extent of his physical and mental ability—into a self-realized, adult contributor to society. This goal might be approached through strengthening the capabilities of families to provide shelter, care, guidance, and supervision for their children. In tandem, social research, demonstrations, and staff training are essential.

A basic issue which must be addressed at the outset is whether an expanded child-welfare services program—or any unique child-welfare services program—is necessary in light of the title XX social services program which will be in effect during fiscal year 1976. We believe the answer to this question is very strongly in the affirmative. There are three primary reasons for our strong conviction:

First, the title IV–B program can effectively provide funds to public agencies, thus giving them the capability to act as an advocate or guardian for all children who have needs that cannot be met, or problems which cannot be solved, by the family or a parent acting alone. As implemented by the Department of Health, Education, and Welfare, title XX services such as protective services to children are severely limited for the universal population, and generally require an income determination before anything substantially in excess of information and referral is provided.

Second, the title IV–B program can most effectively target services on children. Child-welfare services are not forced to compete with all other service demands within the State.

Third, title IV–B provides a direct avenue for research, demonstration, and training with respect to the provision of child-welfare services. If this Nation holds that its children are its future, a program such as title IV–B is essential. Therefore, an expanded child-welfare services program is necessary.

Congress has authorized appropriations which could provide the base for achieving the title IV–B goal. It has regularly increased these authorizations,

most recently in 1972. The fiscal year 1975 authorization was $226 million; the fiscal year 1976 authorization, $246 million; and the fiscal year 1977 and subsequent years authorization, $266 million. Actual appropriations have languished far behind—at $46.0 million from fiscal year 1967 to fiscal year 1973 and at $50 million in fiscal year 1974 and fiscal year 1975. In both of the latter years, actions were taken to withhold the additional $4 million. In fiscal year 1976, the $46 million proposed would amount to only about 9 percent of the total Federal, State, and local spending for child-welfare services programs.

Inadequate funding has produced a myriad of barriers to achievement of the title IV–B program legislative objective.

Each State and local child-welfare services program must attempt to assess needs, develop and evaluate pilot programs, expand successful programs, develop management and program information systems, and set up mechanisms to coordinate their programs with other services. Without adequate funds, agencies must cut corners. When corners are cut, program effectiveness suffers.

Each agency must attempt to educate the public on social hazards which impede wholesome child development, and specifically on the resources available in the community to help avoid and correct them. The education process is difficult and costly. It cannot be adequately performed within most existing budgets.

Necessary program information cannot be gained or disseminated within most existing budgetary frameworks. The Federal Government has elected to provide little assistance in this area. Direct program assistance to build the capacity of States to operate existing programs is not generally available.

Utilization of demonstration project findings may be precluded by the lack of sufficient funds to meet the "front-end" cost of program change.

In addition, the lack of Federal involvement—partly budget related—places State and local agencies in the inefficient position of frequently covering the ground which a neighboring jurisdiction has previously covered in efforts to find more cost-effective methods of services provision.

A $46 million limit in fiscal year 1976 will place an additional burden on the States. Section 220.40 of Title 45 of the Code of Federal Regulations requires provision of child-welfare services in all political subdivisions of a State by July 1, 1975. If a State is to meet this requirement in anything more than name, additional Federal outlays are essential.

In order to achieve the objective established for the title IV–B child-welfare services program, we strongly urge the committee to appropriate a minimum of $100 million, or double the fiscal year 1975 appropriation, for child-welfare services grants to the States in fiscal year 1976. This should be viewed as an incremental step toward appropriation of the full amount of the Federal authorization in future fiscal years. The recommendation is a realistic assessment of the fact that States could not gear-up to expend the full authorization, a five-fold increase over previous years, in 1 fiscal year.

The recommended increase is justified by the benefits it can produce. The benefits which can be derived include:

An increase in agency capacity to assess State and local needs for services; to identify target groups; to provide comprehensive information and referral services; and to develop program information systems that will further the program-planning-evaluation and accountability requirement of the State or local agency concerned;

An expansion of demonstration project capabilities, dissemination of findings, and utilization of information obtained;

Extension of needed child-welfare services to communities not presently benefitting from such services; and

Additional staff development and training in this important area.

To further attempt to insure the accrual of these benefits, we recommend that the committee encourage the Department of Health, Education, and Welfare, through its committee report, to (1) undertake a vigorous advocacy and leader-

ship role for child-welfare services; (2) resume the practice of developing State plans jointly with the States; (3) utilize section 426 research, demonstration, and training funds in conjunction with the formula grant program to strengthen State and local child-welfare services programs, consulting with the States as to their needs; (4) consolidate program responsibility within HEW; (5) provide basic national information exchange services; and (6) staff regional offices with sufficient program specialists to provide ongoing guidance and technical assistance to the States.

2. THE WORK INCENTIVE PROGRAM

While the proposed budget for HEW in fiscal year 1976 indicates an increase in budget authority for the work incentive program, the child care and supportive services component of the program continues to be severely underfunded.

Before proceeding, we commend the Appropriations Committee and the Congress for enactment of the fiscal year 1975 suplemental appropriation for child care and supportive services, which also allows for reimbursement of unmatched fiscal year 1974 expenditures. If this measure is not vetoed by the President, the additional funds provided will be of substantial assistance to the States.

The fiscal year 1976 proposed budget provided $97 million for WIN child care and supportive services. This is $27 million more than the budget authority granted by Congress in the fiscal year 1975 budget. However:

Approximately $23.5 million was carried in to fiscal year 1975 from fiscal year 1974; and

Congress, as was noted above, recently enacted a provision for a supplemental appropriation of $35 million for child care and supportive services in WIN.

Therefore, the fiscal year 1975 total program level for child care and supportive services will be about $128.5 million, if the President does not veto the supplemental appropriation.

The $128.5 million program level for fiscal year 1975 is expected to leave a maximum carry-in to fiscal year 1976 of $8 million. With $8 million in carry-in to fiscal year 1976, the program level for child care and supportive services would be at a maximum of $105 million—or $23.5 million below the expected fiscal year 1975 program level.

Expenditures for child care and supportive services have been increasing. In fiscal year 1974, expenditures reached $114.9 million. In fiscal year 1975, expenditures are constrained by an allocation formula, imposed after the start of the fiscal year, but are expected to reach a minimum of $120.5 million. We have estimated that Federal funds totaling over $152 million would be required to operate the child care and supportive services component of the WIN program in fiscal year 1975 without a cut back in planned services. Table 1 provides the base for this estimate.[1] Thus, a maximum program level of $105 million in fiscal year 1976 is totally inadequate.

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[1] The calculation of $152 million was made in the following manner and with the following data, which is aggregated from table 1:

49 States, fiscal year 1974 (actual, as available)	$109, 891, 310
49 States, fiscal year 1975 (projected)	145, 780, 155
Total fiscal year 1974 expenditures (as available)	114, 884, 664

$$\text{Estimated fiscal year 1975 program level} = \frac{\text{49 States, fiscal year 1974}}{\text{49 States, fiscal year 1975}} = \frac{\text{FY 1974 Total}}{\text{Unknown}}$$

$$= \frac{\$109,891,310}{\$145,780,155} = \frac{\$114,884,664}{X}$$

$$= \$152,400,000$$

This logic assumes that the 5 jurisdictions for which data is not available follow, on the average, the trend of the 49 jurisdictions for which data is available. Results are not sensitive to changes in this assumption. For example, if each of the unknown jurisdictions increased at a rate of 10 percent above the average, the estimated total would be approximately 0.2 percent less than the "actual" total.

Table 1 — Page One

State	FY 1974 Expenditures[1]	FY 1975 Projected Expenditures	FY 1975 1st Quarter Expenditures	Semi-Annual Allocation	Annual Allocation
Alabama	$ 1,500,553	$ 3,144,600*	$ 441,500	$ 644,750	$ 1,215,332
Alaska	485,394	977,957*	262,719	210,968	431,096
Arizona	1,123,392	1,224,765	325,804	432,554	1,039,171
Arkansas	762,938	865,800*	207,438	303,305	676,151
California	5,562,905	9,443,964*	1,519,052	2,251,161	6,479,045
Colorado	1,324,437	1,223,362*	415,465	553,802	1,202,995
Connecticut	1,436,077	1,680,300*	370,110	638,614	1,238,065
Delaware	490,369		130,688	194,045	364,966
District of Columbia	2,035,037	2,210,085*	599,049	784,837	1,617,688
Florida	3,078,435	6,461,387*	807,579	1,209,158	2,307,565
Georgia	3,758,314	6,172,677*	1,062,376	1,910,333	2,793,831
Guam	29,382	63,917*	4,427	12,590	52,697
Hawaii	319,319	417,380*	80,277	134,299	337,097
Idaho	796,185	1,762,683*	206,016	322,058	601,300
Illinois	2,653,273	3,202,000	767,595	1,051,547	2,528,415
Indiana	948,975	1,116,265	268,883	439,295	783,597
Iowa	1,129,174		302,651	447,194	945,416
Kansas	1,033,531	1,480,703	175,016	301,237	765,125
Kentucky	1,619,736	1,725,879*	382,704	664,605	1,184,646
Louisiana	1,241,435	1,852,358*	462,315	490,994	975,438
Maine	758,238	1,196,582*	198,786	308,003	632,614
Maryland	2,821,388	3,281,587*	754,080	1,043,713	2,237,571
Massachusetts	1,702,205	4,559,630*	455,077	646,112	1,719,431
Michigan	14,881,682	18,384,930*	3,950,287	5,753,153	10,521,908
Minnesota	1,871,107	2,284,545*	476,631	822,628	1,589,968
Mississippi	537,732	748,271*	147,435	212,568	589,305
Missouri	2,247,089	3,031,266	575,872	949,430	1,791,944

*Indicates figure taken from approved State operational plan.

1/ This figure is data as of Dec. 26, 1974. It employs some unadjusted 4th quarter information. Previous data (Nov. 20, 1974) indicated expenditures of $116,410,838.

State	FY 1974 Expenditures	FY 1975 Projected Expenditures	FY 1975 1st Quarter Expenditures	Semi-Annual Allocation	Annual Allocation
Montana	555,986	648,000	127,532	229,598	474,895
Nebraska	553,309	702,000	170,084	229,644	456,198
Nevada	55,269	152,017	17,241	19,981	102,953
New Hampshire	166,139	760,211*	45,805	68,371	155,639
New Jersey	9,316,552	12,330,000	3,067,227	3,295,636	6,284,690
New Mexico	426,531	473,692*	84,170	181,462	376,962
New York	17,221,285	18,135,000	2,010,425 1/	7,460,778	13,053,504
North Carolina	1,279,043	3,897,927*	523,260	469,384	1,354,505
North Dakota	248,477	285,302*	80,061	105,996	223,553
Ohio	2,127,382		869,113	852,195	2,265,392
Oklahoma	916,659	1,003,918*	220,035	393,351	804,834
Oregon	3,373,763	3,703,653*	998,996	1,411,172	2,561,328
Pennsylvania	2,501,585	3,200,000	800,266	1,128,353	2,611,836
Puerto Rico	1,212,873		276,809	514,294	1,250,230
Rhode Island	928,850	1,244,336*	197,145	367,092	689,559
South Carolina	1,430,853	2,567,966*	349,254	549,363	960,850
South Dakota	357,309	472,553*	79,444	145,656	292,487
Tennessee	1,539,478	1,583,791*	413,283	624,970	1,229,633
Texas	3,624,471	4,403,662*	1,152,018	1,437,378	2,920,541
Utah	975,885	841,500*	318,611	318,611	1,183,835
Vermont	763,482	837,000*	255,344	328,313	557,908
Virgin Islands	33,556		21,488	9,177	43,666
Virginia	1,682,281	1,760,386*	494,732	698,468	1,330,208
Washington	1,925,972	2,067,246*	495,633	1,094,257	1,763,536
West Virginia	1,587,101	1,952,702	386,519	693,256	1,470,007
Wisconsin	3,788,368	4,050,000	642,070	1,550,553	3,174,084
Wyoming	143,094	194,400*	50,808	50,808	133,430
Total	$114,884,934		$29,494,726	$47,168,970	$94,349,000

1/This figure may be substantially understated. See Table 6, footnote 1.
* Indicates figure taken from approved State operational plan

We recommend that a minimum of $152.0 million be appropriated for WIN child care and supportive services in fiscal year 1976. This estimate is based on the assumption that States have been cutting programs back during the second half of fiscal year 1975 to meet, as best they can, constraints established by the Department of Health, Education, and Welfare. The $152.0 million level would allow programs to be expanded to the levels originally anticipated by the end of fiscal year 1976. This recommendation is based on our belief that the child care and supportive services component must be fully funded if the training and incentives component of the program is going to continue to grow and WIN is to enroll additional persons. (The training and incentives program level in fiscal year 1975 was about $268 million; with about $275 million proposed for fiscal year 1976).

3. ADDITIONAL CONSIDERATIONS IN THE FISCAL YEAR 1976 BUDGET

There are several additional considerations which should be addressed in the proposed fiscal year 1976 budget for the Department of Health, Education, and Welfare.

First, the economic assumptions employed in the administration's estimates may be unrealistic. Recovery from the present economic climate is likely to be slow and painful. This may result in additional expenditures for aid to families with dependent children. These additional expenditures could be in the area of $400 to $500 million for fiscal year 1976.

Second, States are contesting liability for supplemental payments made erroneously by the Federal Government for the States and liability for State supplementary payments made by the State based on erroneous Federal information in the supplemental security income program. We strongly believe that the States should not be held liable for these payments. Settlement of this issue to the satisfaction of the States may raise estimated Federal expenditures by $100 million in fiscal year 1976.

Finally, the proposed budget reflects almost no increase in social services outlays in fiscal year 1976, even when the impact of proposed legislation is added back into outlays. Despite the establishment of title XX which envisions expanded social services programs, the administration's proposed budget indicates only a $56 million increase in outlays. We believe, at a minimum, the fiscal year 1976 budget should adjust fiscal year 1975 outlays for inflation to achieve current service levels, to the extent possible, in fiscal year 1976. A major problem here is, of course, the fact that some States are expected to be at their State ceilings in fiscal year 1975. Without redistribution of unused social services appropriations or an increase in the $2.5 billion Federal ceiling, States at their ceilings will be faced with reductions in real levels of service in fiscal year 1976. This is a subject which must ultimately be addressed by the Congress.

The funding in each of the above cases is essentially open-ended, in the case of social services—open-ended up to a ceiling which the majority of the States have not reached. Therefore, we raise the above considerations in the spirit of comments on the structuring of the most reasonable initial appropriations bill.

We sincerely appreciate the opportunity to present our concerns and recommendations to the committee. Thank you.

EMPLOYMENT SERVICES

LETTER AND STATEMENT OF MR. DEAN PHILLIPS, LEGISLATIVE COORDINATOR, UNITED VETERANS COMMITTEE OF COLORADO

UNITED VETERANS COMMITTEE OF COLORADO,
Denver, Colo., May 20, 1975.

HON. DANIEL J. FLOOD,
Chairman, House Appropriations Subcommittee,
Washington, D.C.

DEAR CONGRESSMAN FLOOD: I write you today in the name of the United Veterans Committee of Colorado (UVC) which is made up of the Colorado

Departments of: The American Legion, Veterans of Foreign Wars, Disabled American Veterans, American GI Forum, Colorado Association of Collegiate Veterans and Veterans of World War I, Inc.

It is our understanding that in a few days your subcommittee will end its hearings concerning the employment service fiscal year 1976 budget. I implore you and your committee members to grant a budget of at least $562,100,000 to finance 31,035 employment service positions.

The administration has requested $493,600,000 for 27,300 positions which is not acceptable to us in light of the mandate given the employment service by Congress in Public Law 92-540 and Public Law 93-508.

As you are aware, section 2007(a)(1), Public Law 92-540 which was signed into law October 24, 1972 charges the U.S. Department of Labor and State agencies of the employment service with the following responsibilities:

"* * * Each eligible veteran, especially those veterans who have been recently discharged or released from active duty * * * shall promptly be placed in a satisfactory job or job training opportunity or receive some other specific form of assistance designed to enhance his employment prospects substantially, such individual job development or employment counseling services."

Despite the strong language of Public Law 92-540, The Nixon administration requested a $1.4 billion slash in the fiscal year 1974 budget for the U.S. Department of Labor which funds the Employment Service. In testimony June 28 1973 before the U.S. Senate Appropriations Subcomittee, Secretary of Labor Peter Brennan agreed to the proposed slash.

The result has been very poor service to veterans for the employment service due to the lack of staff to provide the specific services mandated by Public Law 92-540.

On April 26, 1974 Colorado veterans filed a civil action (74-F-383) against the U.S. Department of Labor and the Colorado Employment Service for their failure to provide services mandated under Public Law 92-540.

Since that time the Denver Federal District Court judge has denied plaintiffs' motions to dismiss our case and set a pretrial date of June 11, 1975. Last month the Colorado Employment Service filed a cross-claim against the U.S. Department of Labor claiming lack of sufficient funding.

Department of Labor data indicates that for April 1975 the unemployment rate for 20- to 24-year-old Vietnam era veterans was 22.8 percent and for minority Veterans that age during the first quarter of 1975, the unemployment rate was 30.3 percent.

Information from the Interstate Conference of Employment Security Agencies, Inc. (ICESA) indicates that while in 1967 the ratio of ES staff to the labor force was 1 to 2,527, for fiscal year 1976 the ratio is 1 to 3,432. ICESA figures also indicates that the 1967 ratio of ES staff to unemployed was 1 to 97 while for 1976 it is 1 to 275.

I am enclosing an affidavit I wrote January 1975 and request that you include it with other testimony heard by your committee.

Sincerely,

DEAN K. PHILLIPS,
Legislative Coordinator,
United Veterans Committee of Colorado.

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLORADO

DEAN K. PHILLIPS, Colorado Association of Collegiate Veterans and BOB CASSIDY, Plaintiffs,	)	
v.	)	CIVIL ACTION
PETER J. BRENNAN, WILLIAM H. KOLBERG, SAMUEL R. MARTINEZ, JAMES SHAFFER, JOHN HURLEY, and WILLIAM M. SULLIVAN, Defendants.	)	No. 74 F-383

Dean K. Phillips, being first on oath duly sworn, deposes and says that:

I. He is the Co-Chairman of the Legislative Committee of the United Veterans of Colorado (UVC) and served as Executive Secretary of that organization from October 1972 until March 1974.

He served on the Colorado Governor's Jobs for Veterans Task Force from November 1971 to June 1974 and Co-Chaired the Legislative Committee of that body from January 1972 until June 1974 when the Task Force was phased out by former President Nixon.

He has served as member of the Board of Directors of the National Association of Concerned Veterans (NACV) since March 1974 and was Colorado State Coordinator for NACV from August 1972 until March 1974.

He has served as Vice Chairman of the Legislative Committee of the American Legion, Department of Colorado since June 1973.

He was appointed by Governor John Vanderhoof to the seven-member Colorado Board of Veterans' Affairs on March 11, 1974 and was elected to the position of Vice-Chairman by that Board on April 25, 1974.

II. In my opinion, the Colorado Employment Service (CES) and the U.S. Department of Labor (DOL) have failed to comply with Title V, Public Law 92-540 which was signed into law on October 24, 1972.

I will now quote individual sections of Title V and proceed to comment on DOL and CES noncompliance with these sections.

Section 2007. Administrative controls; annual report

"(a) The Secretary of Labor shall establish administrative controls for the following purposes:

"(1) To insure that each eligible veteran, especially those veterans who have been recently discharged or released from active duty, who requests assistance under this chapter shall promptly be placed in a satisfactory job or job training opportunity or receive some other specific form of assistance designed to enhance his employment prospects substantially, such as individual job development or employment counseling services.

"(2) To determine whether or not the employment service agencies in each State have committed the necessary staff to insure that the provisions of this chapter are carried out; and to arrange for necessary corrective action where staff resources have been determined by the Secretary of Labor to be inadequate.

"(b) The Secretary of Labor shall report annually to the Congress on the success of the Department of Labor and its affiliated State employment service agencies in carrying out the provisions of this chapter. The report shall include, by State, the number of recently discharged or released eligible veterans, veterans with service-connected disabilities, and other eligible veterans who requested assistance through the public employment service and, of these, the number placed in suitable employment or job training opportunities or who were otherwise assisted, with separate reference to occupational training under appropriate Federal law. The report shall also include any determination by the Secretary under section 2004 or 2006 of this title and a statement of the reasons for such determination.

To the best of my knowledge, no such "Annual Report" has yet been filed to the Congress by the Secretary of Labor. However, the Secretary of Labor did file a report with the Congress on March 26, 1974 which covered only the first four months of FY 1974-(July-September 1973).

On April 22, 1974, the Director of the Colorado Division of Employment sent the above mentioned quarterly report, which for some reason was entitled "Secretary of Labor's Annual Report to the Congress on Veterans Services"; with a cover memo. I have enclosed both items for your inspection. (Enclosures #1 and #2)

As you can see, the Director of the Colorado Division of Employment stated in his memo that Colorado ranked: (1) seventh in number of veteran applicants available to the offices of the Division, (2) first in the number of recently separated veterans available to local offices, (3) second in the number of disabled veterans available to the agency, (4) seventh in the number of veterans placed in jobs, (5) first in the number of disabled veterans placed in jobs, (6) sixth in the number of veterans enrolled in job training, (7) third in the number of recently separated veterans enrolled, (8) second in the number of disabled veterans enrolled in job training, (9) seventh in providing veterans with other services, (10) second in the number of recently separated veterans receiving other services, and (11) second in the number of disabled veterans receiving such services.

These claims were, of course, based on the DOL quarterly report.

As data came in for the entire FY 1974, it became clear that the situation in Colorado was not nearly as good for veterans as the Director of the Colorado Division indicated in his memo of April 22, 1974.

I am enclosing for your inspection a "Statistical Review of Services Provided Veterans" for the period ending June 30, 1974. (Enclosure #3.) This report is for the State of Colorado and indicates that 83,717 veterans filed applications for employment assistance at various offices of the Colorado Division of Employment during FY 1974.

However, as you can see from section #8, 41,761 of the 83,717 applications were "inactivated with no service." Thus 50% of the Colorado veterans filing applications received no "job placement, counseling, job training opportunity, or some other specific form of assistance designed to enhance his employment prospects substantially." These services are required under section 2007 (a) of PL 92-540.

I am also enclosing for your inspection an item entitled "Employment Service Performance, by State, Fiscal Year 1974." These two pages of tables compare the services of the 50 States and include renewal applications in addition to new applications filed by veterans for employment assistance. (Enclosure #4.)

As you can see, Colorado ranks:

(1) 36th out of 50 States in the placement of Vietnam Era Veterans on jobs

(2) 27th out of 50 States in the placement of Handicapped Veterans on jobs

(3) 33rd out of 50 States in percentage of individual veterans placed on jobs after counseling

(4) 34th out of 50 States in percentage of total veterans (renewal applications and new applications) placed in jobs

Because of the failure of the Secretary of Labor to file an accurate annual report, his failure to determine whether or not the employment service agencies in each State have committed the necessary staff to insure the provisions of Title V are carried out, and his failure to take the "necessary corrective action" where these resources

are inadequate, the Congress ammended Section 2007 (2) through the passage of Public Law 93-508 in December 1974. This ammendment reads:

> (b) The Secretary of Labor shall establish definitive performance standards for determining compliance by the State public employment service agencies with the provisions of this chapter and chapter 42 of this title. A full report as to the extent and reasons for any noncompliance by any such State agency during any fiscal year, together with the agency's plan for corrective action during the succeeding year, shall be included in the annual report of the Secretary of Labor required by subsection (c) of this section.

The record is clear that in FY 1973, veterans received less than adequate services from DOL State agencies. I submit a letter dated September 11, 1973 from Alfred M. Zuck, Associate Manpower Administrator for Financial and Management Information Systems (Enclosure #5) answering an inquiry from Norman D. Hartnett, National Director of Employment for the Disabled American Veterans.

Mr. Zuck indicates that during FY 1973; 3,469,000 Veterans filed applications for employment assistance with DOL State agencies. Only 17.7% were placed on jobs and only 6.4% received counseling. In addition, according to Mr. Zuck, only 1.6% were enrolled in training. In his footnote, Mr. Zuck admits that " ... only 14.7% of all Vietnam-Era disabled ... " veterans were counseled.

A General Accounting Office (GAO) preliminary report submitted by Mr. Gregory J. Ahart on April 30, 1974 (Enclosure #6) stated on page #9 that:

> "Available statistics for the employment service offices we visited showed that during fiscal year 1973, from about 2 percent of the veterans' applications in one office to more than 50 percent in another were transferred from active to inactive status with no service recorded other than the initial interview when the application was prepared. The majority of offices we visited fell above 25 percent."

Despite the alarming lack of services documented in Mr. Zuck's letter, Labor Secretary James D. Hodgson allegedly reported to President Nixon in January 1973 that unemployment of Vietnam Era

Veterans "in effect no longer constitutes a national problem."

The following article was printed in the EVENING STAR on January 15, 1973 and was reprinted on February 12, 1974 in U.S. Senate Committee Print No. 26, page 785.

(From THE EVENING STAR, January 15, 1973)

VETERANS' JOBLESS RATE "NO LONGER A PROBLEM"

Labor Secretary James D. Hodgson told President Nixon yesterday the administration's campaign to find jobs for returning GIs had been so successful that unemployment among Vietnam-war-era veterans "in effect no longer constitutes a national problem."

The jobless rate among veterans aged 20 to 29 has been cut in half since reaching a peak of 11 percent two years ago. Their unemployment rate fell to 5.5 percent in December, only slightly higher than the 5.2 percent rate for the entire civilian work force.

In a report to the President, Hodgson said the reduced jobless rate for veterans stems from an improved labor market in an expanding economy, and from coordinating the efforts of government, business and veterans' organizations under the Jobs for Veterans program.

Hodgson said he expects the employment situation of veterans to improve even more during the first six months of 1973 "because of the decreasing number of ex-servicemen expected to return to civilian life this year and the improvement in the overall employment outlook for all Americans."

Under the Jobs for Veterans program, the government gave priority to ex-servicemen for public jobs and job training, and joined business leaders in promoting the hiring of veterans by private employers.

Hodgson said last month was the first time in nearly three years that the unemployment rate for Vietnam-war-era veterans had been under 6 percent. He noted that the unemployment rate for non-veteran men in the same age bracket was 6.5 percent.

Section 2006. Estimate of funds for administration; authorization of appropriations

"(a) The Secretary of Labor shall estimate the funds necessary for the proper and efficient administration of this chapter. Such estimated sums shall include the annual amounts necessary for salaries, rents, printing and binding, travel, and communications. Sums thus estimated shall be included as a special item in the annual budget for the Department of Labor. Estimated funds necessary for proper counseling, placement, and training services to veterans provided by the various State public employment service agencies shall be separately identified in the budgets of those agencies as approved by the Department of Labor.

"(b) There are authorized to be appropriated such sums as may be necessary for the proper and efficient administration of this chapter.

"(c) In the event that the regular appropriations Act making appropriations for administrative expenses for the Department of Labor with respect to any fiscal year does not specify an amount for the purposes specified in subsection (b) of this section for that fiscal year, then of the amounts appropriated in such Act there shall be available only for the purposes specified in subsection (b) of this section such amount as was set forth in the budget estimate submitted pursuant to subsection (a) of this section.

"(d) Any funds made available pursuant to subsections (b) and (c) of this section shall not be available for any purpose other than those specified in such subsections, except with the approval of the Secretary of Labor based on a demonstrated lack of need for such funds for such purposes.

In June 1973, Labor Secretary Peter Brennan offered key testimony concerning the FY 1974 DOL budget.

At the time of his testimony, Mr. Brennan had at his disposal statistics documenting the less than adequate performance of DOL State agencies for the major part of FY 1973 as well as his responsibilities under Title V of Public Law 92-540 (signed into Law on October 24, 1972).

Since the DOL sets priorities for and funds the State Employment Services, Secretary Brennan's comments were particularly critical when they were voiced on June 28, 1973 in Hearings before a Subcommittee of the U.S. Senate Committee on Appropriations on H.R. 8877, pages 2409-2410 (Enclosure #7). Mr. Brennan agreed "completely" to a DOL budget cut of $1.4 billion for FY 1974 which is 35% less than the FY 1973 budget. He cited the justification for the drastic cut as " ... the improving economic situation." To quote the Secretary directly:

"Mr. Chairman, I would now like to describe the highlights of the Department's 1974 budget. We will be glad to talk in more detail during the question and answer period and in subsequent testimony.

Our total budget request for 1974 is a little over $3 billion, a decrease of $1.4 billion from the 1973 operating level. The $3 billion for 1974 consists of approximately

$22 billion in general revenue appropriations, and $844 million in trust fund authorizations.

The $1.4 billion decrease from 1973 is primarily due to the improving economic situation. Unemployment is declining and it is expected to be in the neighborhood of 4.5 percent by the end of this year. Therefore, we anticipate a lower level of unemployment compensation payments for Federal workers and ex-servicemen, as well as fewer payments for extended unemployment benefits."

In my opinion, this budget cut hurt the DOL State agencies in their efforts to comply with Title V of Public Law 92-540 both directly and indirectly. The State agencies often had to terminate some local office personnel that had been serving Veterans and also diverted the duties of other personnel to non-veteran related functions.

It is important to note that the Comprehensive Education and Training Act of 1973 (CETA) was not to become operational until FY 1975 and that the $1.4 billion DOL budget cut mentioned here is for FY 1974.

It is hoped that a considerable portion of Emergency Employment Act monies (I understand Region VIII will receive over $40 million) and CETA Title VI monies will go to both hire Vietnam-Era Veterans and staff DOL State agencies at a sufficient level to provide better services to Veterans.

Section 2003. Assignment of veterans' employment representative

"The Secretary of Labor shall assign to each State a representative of the Veterans' Employment Service to serve as the veterans' employment representative, and shall further assign to each State one assistant veterans' employment representative per each 250,000 veterans of the State veterans population, and such additional assistant veterans' employment representatives as he shall determine, based on the data collected pursuant to section 2007 of this title, to be necessary to assist the veterans' employment representative to carry out effectively in that State the purposes of this chapter. Each veterans' employment representative and assistant veterans' employment representative shall be an eligible veteran who at the time of appointment shall have been a bona fide resident of the State for at least two years and who shall be appointed in accordance with the provisions of title 5, United States Code, governing appointments in the competitive service and shall be paid in accordance with the provisions of

chapter 51 of sub-chapter III of chapter 53 of such title, relating to classification and general schedule pay rates. Each such veterans' employment representative and assistant veterans' employment representative shall be attached to the staff of the public employment service in the State to which they have been assigned. They shall be administratively responsible to the Secretary of Labor for the execution of the Secretary's veterans' counseling and placement policies through the public employment service and in cooperation with manpower and training programs administered by the Secretary in the State. In cooperation with the public employment service staff and the staffs of each such other program in the State, the veterans' employment representative and his assistants shall --

"(1) be functionally responsible for the supervision of the registration of eligible veterans in local employment offices for suitable types of employment and training and for counseling and placement of eligible veterans in employment and job training programs;

"(2) engage in job development and job advancement activities for eligible veterans, including maximum coordination with appropriate officials of the Veterans' Administration in that agency's carrying out of its responsibilities under subchapter IV of chapter 3 of this title and in the conduct of job fairs, job marts, and other special programs to match eligible veterans with appropriate job and job training opportunities;

"(3) assist in securing and maintaining current information as to the various types of available employment and training opportunities, including maximum use of electronic data processing and telecommunications systems and the matching of an eligible veteran's particular qualifications with an available job or on-job training or apprenticeship opportunity which is commensurate with those qualifications;

"(4) promote the interest of employers and labor unions in employing eligible veterans and in conducting on-job training and apprenticeship programs for such veterans;

"(5) maintain regular contact with employers, labor unions, training programs and veterans' organizations with a view to keeping them advised of eligible veterans available for employment and training and to keeping eligible veterans advised of opportunities for employment and training; and

"(6) assist in every possible way in improving working conditions and the advancement of employment of eligible veterans.

At the time of the passage of Public Law 92-540 (October 1972), the formula in Section 2003 required the hiring of an additional 68 Assistant Veterans' Employment Representatives (AVER's). Not until a year later was the first AVER hired (according to the GAO review); and as of April 23, 1974, only 42 of the 68 AVER's had been hired. In my opinion, this delay shows a lack of good faith on the part of DOL.

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Section 2004. Employees of local offices

"Except as may be determined by the Secretary of Labor based on a demonstrated lack of need for such services, there shall be assigned by the administrative head of the employment service in each State one or more employees, preferable eligible veterans, on the staffs of local employment service offices, whose services shall be fully devoted to discharging the duties prescribed for the veterans' employment representative and his assistants.

According to page #10 of Mr. Ahart's enclosed GAO statement:

"At some locations included in our review, local employment service offices did not have full-time representatives as required by the criteria. State and local employment service officials generally attributed the lack of full-time local representatives to insufficient funds."

It is my belief that many Colorado local office VER's are only titular and spend a great majority of their time in areas of responsibility other than Veterans' services. It is my understanding that the Trinidad local office manager also holds the title of local VER for Walsenburg, Colorado which is approximately 40 miles away. I further understand that the Montrose local office manager holds the title of local VER for Gunnison which is approximately 50 miles away.

A formal request for monthly reports of the Colorado State Veterans Employment Representative (SVER) on "Level of Accomplishment and Standards of Performance for Veterans by Division of Employment Local Offices" should prove most enlightening and should document noncompliance with Section 2004 of Title V, P.L. 92-540 and C.S.L. 209-73.

III. It has come to my attention that employers interested in hiring both veterans and non-veterans alike file job orders on a continuing basis with DOL State agencies.

It is my understanding that an alarming number of these job orders are cancelled by employers. Officials and employees of the Colorado Employment Service (CES) have been quoted as stating that

employers have become frustrated in not having their job orders filled promptly by the CES and have canceled the orders and gone elsewhere.

An official of the CES admitted to me in March 1974 that the Denver local office alone had been averaging more than 1,000 job order cancellations per month by employers.

Another CES official, Mr. Bruce Crabb, was quoted in the July 17, 1974 CERVI'S ROCKY MOUNTAIN JOURNAL as claiming that during the eleven-month period between July 1, 1973 to Juné 1, 1974; employers canceled 51,412 or 44% of the total job orders filed with the CES for that time period.

The "life" of a job order is rather short according to some manpower specialists -- perhaps 48 hours. Since Colorado is one of the five fastest growing states in the country, I would hope that DOL would provide the CES with a computer (preferably an IBM-370) that would enable an incoming individual job order to be "brushed" against all applicants on file in less than 30 seconds.

It is my understanding that presently individual file search time runs as high as 15 minutes in Colorado since this is presently a manual operation in the CES. Utah has had a computer for nearly five years and I hope that DOL and OMB would consider establishing a regional computer in Denver for Region VIII.

I further understand that Title III of CETA provides monies for computer matching.

IV. A 38-page section of the Kirschner Associates Report entitled "National Evaluation of Manpower Services for Veterans" for the U.S. Department of Labor -- Report MEL -73-03 under contract number 43-1-007-35 is also enclosed (Enclosure #8).

As you can see, the copy was stamped for some reason "NOT FOR RELEASE SINCE OCTOBER 1, 1972." This is, of course, the same month Public Law 92-540 was signed into law.

As stated in the Report Summary, its purpose was:

1. To identify and describe the nature and extent of manpower services available to veterans,
2. To assess the relevance and quality of manpower services for veterans,
3. To assess the effectiveness of the delivery system for manpower services to veterans, and
4. To evaluate the management and administration of manpower services for veterans.

The scope of the Kirschner Report was national and included "an examination of a sample of 26 local employment service offices in all regions of the country." Field research was conducted between December 1971 and April 1972.

The conclusions include the following observations:

(1) The organizational and administrative arrangements are rather complex for the delivery of manpower services to veterans through the Federal-State Employment Service system. The VES, responsible for insuring that preferential services for veterans are provided by the system, occupies a unique position in that it has no formal authority for delivery of the services at any level or point in the system. The primary function of VES is to evaluate the performance and results of the system's outputs as related to veterans services; yet, VES, as part of USES, is part of the system. Therefore, objective evaluation by VES is subjected first to interpretation by the system itself.

Despite the intensive efforts of VES, services to veterans by State ES agencies and their local offices are very uneven, and the same variability is evident in the commitment to serving veterans by State and local ES offices. Without specific arrangements to either or both strengthen the role of VES or the ES structure for serving veterans, the sporadic nature of manpower services to veterans can be expected to continue.

(2) Currently, there is often a considerable lag between the time the newly returning veteran returns home and the time he is contacted, if he is contacted at all, by the ES.

(3) It also appears from the findings of this evaluation that if preferential treatment for veterans is to be continuous and intensive, the position and role of the LVER needs strengthening. This could be accomplished readily by having full-time LVERs in all full-functioning ES local offices, and by either giving the LVER line authority over other ES staff who serve veterans or by federalizing the LVER position.

The ES system for delivering manpower services to veterans has been hampered both by lack of clear direction from the Manpower Administration and by lack of implementation at the state and local levels.

(4) It is evident that we do not have a comprehensive policy or set of policies designed to deal with the employment problems of returning veterans, particularly during periods when those problems are the most pressing -- near the end of major military actions. Great effort is expended by the military services to assure the transition of recruits from civilian to military life. Relatively little effort is expended, however, to assure the transition in the reverse direction; since, of course, military missions and goals necessarily are the first concern of the military establishment.

There has been insufficient effort following all recent wars to attend to these major problem areas:

-- The decline in aggregate demand that tends to accompany the winding down or demobilization period;

-- The conversion of military skills to related civilian skills;

-- The removal of institutional and personal barriers that confront many returning veterans seeking employment; and

-- The lack of significant incentives for employers to hire veterans over non-veterans.

Although improvements can be made, it is unreasonable to expect the Federal-State Employment Service system to solve these problems; in large part, it cannot even address them.

V. The 100 member President's Jobs for Veterans Task Force, which never met in its entirety, was formed in October 1970.

On April 1, 1971; Colorado Governor John A. Love announced the formation of the 42 member Colorado Governor's Jobs for Veterans Task Force. Ironically, none of the original 42 members was a Vietnam-Era Veteran. I was appointed by the Governor on November 4, 1971.

As I remember the mission of the Task Force, there were five "phases".

(1) Phase I -- "Organization"

(2) Phase II -- Set up tools such as a monthly reporting system which developed into "Scoreboard" and the development of 25 Mayors' Task Forces

(3) Phase III - Publicize the Task Force to encourage "employer motivation"

(4) Phase IV - Analyze the statistics on Vietnam-Era Veterans still unemployed to determine their needs.

(5) Phase V - Locate individual veterans on file with the CES and give them manpower services.

An examination of "Scoreboard" as published by the CES from July 1971 through December 1971 indicated a highly confusing and what I considered to be a highly misleading reporting system on "Veteran Job Placements." I am enclosing the aforementioned "SCOREBOARDS" for your inspection (Enclosure #9).

Often, 50% of "veteran non-agricultural (job) placements" were "short-time" -- for three days or less duration. For example, the July 1971 "SCOREBOARD" reports that during that month; 1,672 veteran job placements were made by the CES (column #14). However, column #15 indicates that 800 of these 1,672 placements were "short-time" -- for three days or less duration.

These 800 "placements" were transactions and did <u>not</u> indicate that 800 <u>individual veterans</u> were placed on short-time jobs in July. Column #13, as I understand it, reports that <u>237 individual veterans</u> were placed on the 800 short-time jobs during July. Thus each of the 237 veterans was placed on four short-time jobs during that month.

The public was led to believe, by inference, that for the month of July; the CES placed 1,672 veterans on jobs. Often, the public and the Press assumed that these 1,672 jobs were career-type jobs.

Beginning January 1972, the CES system was revised and "individual veterans placed" were no longer reported. However, transactions were of course still published.

The Phase IV Survey was conducted by the CES during the spring of 1973 and indicated that a considerable percent of Colorado veterans registering with the CES for employment assistance were "disadvantaged", "under-educated", and "minority" veterans. The Survey indicated that the unemployment rate for these veterans was increasing.

The Phase V segment was introduced by the National Alliance of Businessmen (NABs) during the summer of 1973 and called for a Phase V Committee to be lead by the Director of the CES. It is my understanding that the Phase V Committee only met twice and that the plan was not fully carried out.

The "Phase V Program Plan" (Enclosure #10) interpreted the results of Phase IV:

> "Analysis of current Phase IV data also discloses that the veteran unemployment problem, as a whole, is diminishing. At the same time, however, the rate of unemployment among disadvantaged veterans -- those who lack skill and education including many who are members of minority groups -- shows a marked increase.
>
> It is apparent that the veteran who is seeking employment and lacks the training and skill to meet normal employer specifications needs special help. Without such help, he is likely to remain outside the labor force relegated to the ranks of the chronically unemployed."

A memo to me in my capacity as Co-Chairman of the Task Force Legislative Committee from the Denver local office CES manager (Enclosure #11), indicates that as of September 12, 1973; the Denver local office had 1,705 veterans registered for employment assistance. The memo indicates that 41.4% of these veterans had "less than high school completed" and that 37.1% were "disabled".

VI. These results were no surprise to me as upon my return from a year (1967-1968) in Vietnam with the 101st Airborne Division, I conducted research in order to document what I had observed in Vietnam.

Nearly 60% of draft age males avoided military service through the Student Draft Deferment. Those that could not afford college were left to face other alternatives among which were enlistment or the draft.

Black Americans enlisted and re-enlisted in the Armed Forces at a much higher rate than their peers. "Studies Prepared for the President's Commission on an All-Volunteer Armed Force" printed in 1970 (Library of Congress Catalog Number 72-610221) concluded that:

> "The major differences between black and white groups of enlisted men are in civilian pay alternatives and in draft motivation. The re-enlistment rate for whites is approximately two-thirds the rate for blacks. Since black earnings expectations are approximately one-third poorer, a civilian pay elasticity of unity explains differences of this magnitude. If relative incomes of whites and blacks narrow (in civilian life), the relative weight of blacks in the force should approach the relative weight of blacks in the eligible population."

DOL report "Social and Economic Conditions of Negroes in the United States", BLS Report No. 332, printed in October 1967; reported that Blacks made up only 9% of the U.S. Armed Forces but took 15% of the combat deaths in Vietnam. Other reports indicate Black casualty rates as high as 22.4%.

Professor Ralph Guzman of the University of California at Santa Cruz reported very high casualty rates for Mexican-Americans serving in Vietnam between 1961 and 1969.

By 1970, the ARMED FORCES JOURNAL (June 7, 1971) reported that only 2.5% of the U.S. Army's enlistees asked for infantry.

Thus much of the combat burden had fallen upon the shoulders of the draftee. "The Nader Report on the Vietnam Veteran and the Veterans Administration" (published in January 1973) reports that in 1969 and 1970, 60% of U.S. dead in Vietnam were draftees.

A Pentagon breakdown by age indicates that between January 1961 and January 1969, the average age at death was 20.2 years.

The Veterans Administration reported that the percentage of Vietnam Veterans suffering loss of legs and feet to be 300% more than World War II Veterans and 70% higher than Korean Veterans. This was reflected in the Denver local CES office manager's 37.1% disabled figure for registered veterans.

The lack of formal education and job training in the CES memo (41.4% had less than a high school degree) was reflected in the Nader Report on "Project 100,000". Under this program, previously ineligible men in "Mental Group IV" were permitted to enter the military. Nader reports that 10% of this group of hundreds of thousands were either killed or received other-than-honorable discharges.

The April 1974 "Manpower Report of the President" indicated that the average unemployment rate for minority veterans was "nearly double" the rates for non-veterans of these ages (24-34).

The relative youth of America's Vietnam-Era Veterans that returned to the civilian work force is reflected in 1972 Veterans Administration statistics. Vietnam-Era Veterans were nearly three years younger than their World War II counterparts at their time of discharge from active duty.

Thus while a cross-section of 29 million American Veterans, or the 370,000 Veterans in Colorado, would not be predominately minority, young, disadvantaged or under-educated; a cross-section of those that served during 1965-1973 in Vietnam would, in my opinion, tend to be minority, young, disadvantaged and under-educated.

It is to these recently discharged Veterans that Section 2007 of Public Law 92-540 applies: " ... each eligible Veteran, ESPECIALLY THOSE VETERANS WHO HAVE BEEN RECENTLY DISCHARGED OR RELEASED FROM ACTIVE DUTY ... ".

* I understand recent DOL statistics indicate that the unemployment rate for Vietnam-Era Veterans, ages 20-24, is 15.3% for December 1974 -- more than twice the national average.

VII. As Executive Secretary of the United Veterans Committee of Colorado (UVC), I voiced my concerns to the Secretary of Labor in a certified letter mailed March 6, 1974 (Enclosure #12). I included a copy of the January 1974 SCOREBOARD which indicated that the number of Veterans registered with the CES had increased from 8,503 in July 1971 to 21,264 in January 1974.

After receiving no answer of any sort for more than six weeks, CACV, Bob Cassidy and I filed Civil Action 74-383 in Denver Federal District Court on April 26, 1974.

On April 30, 1974, I testified on this matter before a Subcommittee of the U.S. Senate Committee on Veterans Affairs.

On May 6, 1974, I received a response from DOL to my letter (Enclosure #13). I do not feel the DOL response addressed my concerns directly.

A DOL letter dated May 4, 1974 (Enclosure #14) answered Colorado Congressman Donald G. Brotzman's inquiry concerning an appropriate DOL response to my letter. The DOL response to Congressman Brotzman included a copy of their answer to me and the explanation:

> "As requested, enclosed is a copy of Benjamin L. Brown's reply to Mr. Phillips. Please note that the Secretary is taking the necessary steps to insure that the provisions of the Act are implemented."

I see no evidence to support the above statement in the DOL response to me.

* For April 1975 DOL reports an unemployment rate for 20-24 year old Vietnam Era Veterans of 22.8% compared to 14.5% for their non-veteran peers 20-24 years of age. For minority Veterans that age it was 30.3%

VIII. A further and more recent blow to the morale of returning Vietnam-Era Veterans was dealt (perhaps unintentionally) by President Ford in his October 1974 Veterans Day Speech when he gave the impression that he would order Federal agencies to hire 70,000 Vietnam-Era Veterans before July 1, 1975.

The President gave the impression to many Americans that 70,000 jobs would be reserved for Vietnam-Era Veterans -- above and beyond normal hiring procedures.

However, the facts indicate that during FY 1974, Federal agencies; through normal hiring procedures, hired 112,000 Vietnam-Era Veterans.

The confusion caused by President Ford's Veterans Day promise perhaps precipitated the drafting of "Fact Sheet on the 70,000 Federal Jobs for Vietnam-Era Veterans" for DOL (Enclosure #15) which reads in part:

> "The 70,000 jobs figure was based on a careful analysis of overall Federal hiring. They were not special or specific jobs for veterans only, but a portion of the total number of civilian jobs that would be filled in Federal offices during a specified period.
>
> If veterans apply for those jobs they are automatically in competition with everyone else who applies, veteran or non-veteran."

State of Colo
Co of Jefferson Dean K. Phillips appeared before me this 14th day of January 1975.

X. Dean K Phillips

John M Crouch
Notary Public
My Comm expires
7-9-77

STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

MAY 20, 1975.

On behalf of our thousands of members who work in State employment services offices across the country, the American Federation of State, County, and Municipal Employees submits this statement on the proposed fiscal year 1976 appropriations for the employment service.

The President's fiscal year 1976 budget request of $494 million for 27,300 employment service staff positions continues a recent trend of, in effect, strangling the employment service by slowly reducing staffing levels each year. This year's request is roughly $10 million less than Congress made available last year; would fund fewer positions than even last year's Presidential request; and would result in 3,700 fewer employment service positions than available last year.

To demonstrate more concretely what this request would mean, consider briefly what happened last year and would happen this year to the employment service in Pennsylvania. Due to national staff reductions and Department of Labor distributional methods, Pennsylvania lost 150 ES positions last year. The Wilkes-Barre office lost three positions which was a 9 percent reduction in staff. If the President's budget request is left unchanged this year, Pennsylvania will lose another 190 positions, and the Wilkes-Barre office will lose another 2, assuming staff cuts are made equally for all offices in the State with some adjustment for office size. In 2 years Pennsylvania would have lost about 340 ES staff positions and the Wilkes-Barre office would have lost about 5—down from 34 positions 2 years ago to 29 this coming year.

In the face of this decline in staff capacity, however, the number of unemployment insurance claimants, who in Pennsylvania must register with the employment service for work, has risen dramatically. UI claimants stood at 408,000 the week of March 18, 1975 compared to 185,000 for the comparable week in 1974. This was a 45 percent increase in the number of people flowing through employment service offices.

Clearly, the President's fiscal year 1976 proposal is not only grossly inadequate but also insensitive during this time of high unemployment. It would reduce the employment service's capacity to help the growing number of unemployed. It also would eliminate needed jobs from the labor market, if not result in actual layoffs of personnel.

AFSCME believes that rather than reduce employment service staffing levels this year, the Congress should increase them. We strongly urge this subcommittee to appropriate at least $578,889,000 to fund at least 31,960 employment service jobs (at a national average cost of $18,113 per man-year, which includes both salaries and overhead items).

Our request would provide 1,000 more ES positions than Congress made available for fiscal year 1975; 3,260 more ES positions than were filled last November according to Department of Labor estimates; and 4,660 more ES positions than the President has requested for fiscal year 1976. It would be about $85.3 million more than the administration has requested for fiscal year 1976 and, about $75 million more than Congress made available for fiscal year 1975.

We do not believe our request is extravagant. Rather we feel it is quite reasonable and can be justified on the following grounds:

1. The workload of the employment service has increased substantially in the last year. Many States require UI claimants to register for work as a condition for receiving benefits. With high unemployment (8.9 percent nationally) and with formerly ineligible people receiving unemployment insurance benefits through the special unemployment assistance program, many more people are requiring help in finding jobs. The ratio of ES staff to unemployed is a projected 1 to 275 in 1976 compared to 1 to 97 in 1967. It does not make sense to cut staff when unemployment and work applications are rising dramatically. The AFSCME request would help meet the increased workload.

2. Except for fiscal year 1973, ES staff has gradually declined during the last 5 years. Most of the cuts have been absorbed by attrition, a less painful way to reduce staff from the individual employee's standpoint, but a no less harmful way from the standpoint of the overall functioning and effectiveness of the employment service.

Despite this trend, at no time during the last 10 years, except for fiscal year 1975, has ES staff positions fallen below 30,000. (It would not be below 30,000 in fiscal year 1975 if the Department of Labor had released all the funds Congress appropriated.) The President's budget request is, therefore, a 10-year low in terms of staff capacity and would continue the recent trend to reduces ES staff positions. The AFSCME request would arrest this recent trend and attempt to rebuild some of the staff capacity lost in recent years.

3. It would not be difficult to absorb these additional jobs. For example, the roughly 250 additional positions Pennsylvania would receive (again assuming $18,113 per position) would prevent the State from losing additional staff positions this year, but the State still would not regain all the positions lost last year. Assuming the 250 jobs in Pennsylvania were spread equally among the approximately 100 ES officies in the State, each office would gain about 2+ staff positions.

4. The ratio of ES staff to the labor force has declined significantly in the last 10 years. In 1967, it was 1 to 2,527; in the coming year, it would be roughly 1 to 3,432. In other words, there are relatively fewer ES staff to pentrate a larger labor force and labor market. To raise ES staff levels so that the ratio next year would be the same as it was 10 years ago would require adding about 9,970 additional ES positions to the President's fiscal year 1976 request at a cost of $180.6 million more than the President's request. The AFSCME request is considerably less than this.

For these reasons, we urgently request the subcommittee to give favorable consideration to increasing the President's Employment Service request by at least $85.3 million to improve the capability of the Employment Service during this period of high unemployment.

Employment Services

STATEMENT OF AUSTIN E. KERBY, DIRECTOR FOR ECONOMICS, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, the American Legion has traditionally supported adequate funds for the Department of Labor to operate and carry on an effective job counseling, placement, and training program for veterans, as well as other programs designed to support and improve the veteran's economic capabilities.

Resolution No. 81 of our 1974 National Convention specifically requests, "a substantial increase in the amount of funds specificallly designated for service to veterans for the U.S. Department of Labor, the Manpower Administration, the Veterans Employment Service and the State Employment Services to adequately staff the program of services to veterans to assure that the provisions of title 38, United State Code, as amended, are fully implemented and administered."

This support is for an "effective program" and in 1974, we could not testify for the Department of Labor budget request because of their failure to adequately implement the provisions of Public Law 92-540 as intended by Congress. The above mentioned Resolution No. 81 was approved after the Manpower Administration proceeded to implement these provisions of title 38, United State Code. The American Legion, however, has some reservations about the effectiveness of the Manpower Administration policies to "strengthen the employment services to veterans." We understand that the requested amount of $5.275 million includes moneys for the salary of 10 Regional Veterans Employment Representatives (RVER's). The American Legion has continuously opposed this regionalization of the Veterans Employment Service by the appointment of these RVER's in each of the 10 regional offices. We disagree with the statement of the Department of Labor that this will improve the veterans employment program, but believe it will lose its effectiveness. It will impose a new supervisory level which will interfere with the direct supervision of the Director of the Veterans Employment Service over the State VER's. The moneys for these RVER positions could be far better used in staff at the national headquarters, which has been undermanned for some time.

The need for an effective veterans employment program, and the unfortunate lack of it, is demonstrated by Bureau of Labor Statistics figures which show, as

of April 30, 1975, nearly 600,000 jobless Vietnam veterans and a 22.8 percent unemployment rate for those veterans in the 20 to 24 age group, which is 8.3 percent above that of nonveterans in the same age group. It was statistics of this kind that prompted legislation to improve employment services to veterans, and we must not forget the nearly 600,000 unemployed veterans of earlier wars whose unemployment problems are complicated by the "older worker" barrier and physical handicaps.

In spite of the exceptionally high level of service to veterans as intended by Congress in the provisions of chapters 41 and 42, title 38, United States Code, during the first half of fiscal year 1975, the Department of Labor provided veterans with 50 percent less job training and 5 percent less job placement than nonveterans. We have been assured by officials of the Manpower Administration that corrective action is underway, including establishment of definitive performance standards for job placement and other services for veterans as required by section 2007 of title 38, United States Code, as amended. We expect these definitive performance standards will be published soon in the Federal Register for public comment.

The American Legion respectfully requests that the amount of $5.275 million for the salaries and expenses of the Veterans Employment Service as requested by the Department of Labor be approved by the subcommittee, with the proviso on the RVERs which we have already made. The Veterans Employment Service is an urgently needed activity and, while we have some reservations about the way in which the Manpower Administration is carrying out its responsibilities to veterans, we believe the Veterans Employment Service must have adequate working moneys to operate an effective program. We have been working with the Manpower Administration, Department of Labor, on all their programs affecting veterans and shall continue to do so with the aim of assisting all veterans.

We understand the Department of Labor's budget request includes $5.4 million for the Department's participation in the Veterans Outreach program, which will include the amount of $1,515,000 for 60 positions in USVAC centers, $2,375,000 for work with community veterans organizations, and $1,510,000 for publicity. We have no specific mandate for these programs, but the American Legion favors any program to benefit veterans.

In general terms, with respect to the total Department of Labor budget request for manpower services, we understand that the administration's appropriation request will cut employment service positions in the States by 2,125 positions below the level approved by Congress for fiscal year 1975 and 2,200 positions below the estimate of fiscal year 1976 as projected by State administrators surveyed by the interstate conference of employment security agencies. According to this ICESA survey, the employment service agencies should have an increase in personnel to 31,035 positions to adequately serve the national interest and the special needs of veterans and other groups.

Section 2006, title 38, United States Code, stipulates clearly that the State agencies and the Department of Labor are to identify all funds for salaries, rents, and other expenses necessary to provide the job counseling, training, and placement service for veterans in the local employment offices as intended by Congress. This section also provides that these funds shall not be available for any other purpose unless the Secretary of Labor can show a demonstrated lack of need. However, too many States have had to cut back veterans employment services because of lack of funds. Apparently, the Department of Labor has insufficiently estimated the cost of such services, or they are ignoring the requirements of the law that the funds appropriated for this purpose must be used only for those services. For instance, in Illinois 230 employment service personnel were laid off because of lack of funds, including 14 disabled veterans who were especially qualified to assist other veterans. This is a twofold loss; veterans lose much needed employment assistance and another veteran becomes jobless.

While we do not wish to speak in terms of required dollar increases, we do hereby urge that adequate appropriations be made available to the several States for required local veterans employment representatives to insure the uninterrupted delivery of effective employment services to veterans as required by law. Mr. Chairman, we would request your careful consideration of this aspect of the Department of Labor's budget request.

Another matter we would briefly refer to is the veterans reemployment rights program. The American Legion has long advocated reemployment rights benefits

for those persons who serve their country in active military service or in performance of reserve training. Therefore, the American Legion at its 1974 national convention, consistent with its traditional support of a strong national defense, and an adequate military reserve program, adopted Resolution No. 308. The Department of Labor has requested $2.509 million for the veterans reemployment rights program. The American Legion supports the approval of this amount as fair and reasonable for the purpose of carrying out this important veterans program.

Before concluding our statement, the American Legion would like to take this opportunity to endorse the programs of the President's Committee on Employment of the Handicapped, including its sponsorship of the national policy for barrier-free environment, which has been endorsed by the American Legion.

I thank you for this opportunity to express the views of the American Legion. And may I again urge you to act favorably upon the fiscal year 1976 budget request of the U.S. Department of Labor for those programs in that Department intended to place the veterans in gainful employment so that they may resume a normal life in society after service to their country.

STATEMENT OF AUSTIN E. KERBY, DIRECTOR FOR ECONOMICS, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, the American Legion has traditionally supported adequate funds for the Department of Labor to operate and carry on an effective job counseling, placement, and training program for veterans, as well as other programs designed to support and improve the veteran's economic capabilities.

Resolution No. 81 of our 1974 national convention specifically request—

A substantial increase in the amount of funds specifically designated for service to veterans for the U.S. Department of Labor, the Manpower Administration, the Veterans Employment Service, and the State employment services to adequately staff the program of services to veterans and to assure that the provisions of title 38, United States Code, as amended, are fully implemente and administered.

This support is for an effective program and in 1974, we could not testify for the Department of Labor budget request because of their failure to adequately implement the provisions of Public Law 92-540 as intended by Congress. The above mentioned Resoultion No. 81 was approved after the Manpower Administration proceeded to implement these provisions of title 38, United States Code. The American Legion, however, has some reservations about the effectiveness of the Manpower Administration policies to strengthen the employment services to veterans. We understand that the requested amount of $5.275 million includes moneys for the salary of 10 regional veterans employment representatives (RVER's). The American Legion has continuously opposed this regionalization of the Veterans Employment Service by the appointment of these RVER's in each of the 10 regional offices. We disagree with the statement of the Department of Labor that this will improve the veterans employment program, but believe it will lose its effectiveness. It will impose a new supervisory level which will interefere with the direct supervision of the Director of the Veterans Employment Service over the State VER's. The moneys for these RVER positions could be far better used in staff at the national headquarters, which has been undermanned for some time.

The need for an effective veterans employment program, and the unfortunate lack of it, is demonstrated by Bureau of Labor Statistics figures which show, as of April 30, 1975, nearly 600,000 jobless Vietnam veterans and a 22.8 percent unemployment rate for those veterans in the 20 to 24 age group, which is 8.3 percent above that of nonveterans in the same age group. It was statistics of this kind that prompted legislation to improve employment services to veterans, and we must not forget the nearly 600,000 unemployed veterans of earlier wars whose unemployment problems are complicated by the older worker barrier and physical handicaps.

In spite of the exceptionally high level of service to veterans as intended by Congress in the provisions of chapters 41 and 42, title 38, United States Code, during the first half of fiscal year 1975 ,the Departmentof Labor provided veterans with 50 percent less job training and 5 percent less job placement than nonveterans. We have been assured by officials of the Manpower Administration that corrective action is underway, including establishment of definitive performance

standards for job placement and other services for veterans as required by section 2007 of title 38, United States Code, as amended. We expect these definitive performance standards will be published soon in the Federal Register for public comment.

The American Legion respectfully requests that the amount of $5.275 million for the salaries and expenses of the Veterans Employment Service as requested by the Department of Labor be approved by the subcommittee, with the proviso on the RVER's which we have already made. The Veterans Employment Service is an urgently needed activity and, while we have some reservations about the way in which the Manpower Administration is carrying out its responsibilities to veterans, we believe the Veterans Employment Service must have adequate working moneys to operate an effective program. We have been working with the Manpower Administration, Department of Labor, on all their programs affecting veterans and shall continue to do so with the aim of assisting all veterans.

We understand the Department of Labor's budget request includes $5.4 million for the Department's participation in the veterans outreach program, which wil include the amount of $1,515,000 for 60 positions in USVAC centers, $2,375,000 for work with community veterans organizations, and $1,510,000 for publicity. We have no specific mandate for these programs, but the American Legion favors any program to benefit veterans.

In general terms, with respect to the total Department of Labor budget request for Manpower services, we understand that the administration's appropriation request will cut employment service positions in the States by 2,125 positions below the level approved by Congress for fiscal year 1975 and 2,200 positions below the estimate of fiscal year 1976 as projected by State administrators surveyed by the Interstate Conference of Employment Security Agencies. According to this ICESA survey, the employment service agencies should have an increase in personnel to 31,035 positions to adequately serve the national interest and the special needs of veterans and other groups.

Section 2006, title 38, United States Code, stipulates clearly that the State agencies and the Department of Labor are to identify all funds for salaries, rents, and other expenses necessary to provide the job counseling, training, and placement service for veterans in the local employment offices as intended by Congress. This section also provides that these funds shall not be available for any other purpose unless the Secretary of Labor can show a demonstrated lack of need. However, too many States have had to cut back veterans employment services because of lack of funds. Apparently, the Department of Labor has insufficiently estimated the cost of such services, or they are ignoring the requirements of the law that the funds appropriated for this purpose must be used only for those services. For instances, in Illinois 230 employment service personnel were laid off because of lack of funds, including fourteen disabled veterans who were especially qualified to assist other veterans. This is a two-fold loss; veterans lose much needed employment assistance and another veteran becomes jobless.

While we do not wish to speak in terms of required dollar increases, we do hereby urge that adequate appropriations be made available to the several States for required local veterans employment representatives to insure the uninterrupted delivery of effective employment services to veterans as required by law. Mr. Chairman, we would request your careful consideration of this aspect of the Department of Labor's budget request.

Another matter we would briefly refer to is the veterans reemployment rights program. The American Legion has long advocated reemployment rights benefits for those persons who serve their country in active military service or in performance of reserve training. Therefore, the Ameican Legion at its 1974 National Convention, consistent with its traditional support of a strong national defense, and an adequate military reserve program, adopted Resolution No. 308. The Department of Labor has requested $2.509 million for the veterans reemployment rights program. The American Legion supports the approval of this amount as fair and reasonable for the purpose of carrying out this important veterans program.

Before concluding our statement, the American Legion would like to take this opportunity to endorse the programs of the President's Committee on Employment of the Handicapped, including its sponsorship of the national policy for barrier-free environment, which has been endorsed by the American Legion.

I thank you for this opportunity to express the views of the American Legion. And may I again urge you to act favorably upon the fiscal year 1976 budget request of the United States Department of Labor for those programs in that Department intended to place the veterans in gainful employment so that they may resume a normal life in society after service to their country.

Longshoremen's and Harbor Workers' Compensation Act

Letter from James J. Reynolds, President, American Institute of Merchant Shipping

American Institute of Merchant Shipping,
Washington, D.C., May 19, 1975.

Hon. Daniel J. Flood,
Chairman, Subcommittee on Labor, Health, Education, and Welfare, Committee on Appropriations, Washington, D.C.

Dear Mr. Chairman: The American Institute of Merchant Shipping (AIMS) is the national association representing most of the American-flag steamship industry. Our 34 members own and operate 340 oceangoing vessels of all types in the foreign and domestic trades of the United States. These vessels represent about 70 percent of all active privately owned tonnage registered in this country and aggregate over 8 million deadweight tons.

We have had an opportunity to review a paper issued April 15, 1975, by the Department of Labor which purports to be a justification of its proposal to assess user charges for the costs of administering the Longshoremen's and Harbor Workers' Compensation Act. The proposal is reflected in budget language which is presently being considered by your subcommittee.

While the amount of money involved is not great (about $3.5 million for fiscal year 1976), the principle is an important one. The administration is attempting to pass on to industry (insurance carriers and employers of those covered by the act) expenses incurred by the Labor Department in implementing a statute enacted to serve a public interest. The maritime industry already pays out a considerable amount of money in connection with this act: it pays high insurance premiums; it pays into a special fund (under section 44 of the act) for employee compensation benefits; and it pays general revenue taxes which are allocated to run the Federal Government. The administration is now suggesting that the amount paid by carriers and employers into the special fund be doubled so that it will cover administrative expenses associated with the act.

Questions were raised during your hearings on the Department's budget request as to the statutory authority for this proposed assessment. The agency has now responded with the following: first, a statement reflecting the policy of the Office of Management and Budget to make identifiable recipients of Government services pay for measurable benefits received; and, second, a draft legislative proposal (which has not been formally transmitted to Congress) to amend the Longshoremen's and Harbor Workers' Compensation Act to give the Labor Department authority to do what it is seeking to do through the appropriations process.

We urge you to reject the proposed user charges on the ground that compensation received by employees covered by the Longshoremen's and Harbor Workers' Compensation Act cannot properly be construed as a direct monetary benefit to industry. Further, the administration of the Act is a matter of public policy affecting a wide range of people and should therefore be supported from general revenues. Finally, we have a deep philosophical objection to user charges in a situation such as this where a complex law is being administered by persons not having responsibility for keeping costs down.

We suggest that the Labor Department in effect conceded the absence of statutory authority to assess user charges by recommending the submission of draft legislation to authorize this approach.

Sincerely,

James J. Reynolds,
President.

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LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT

LETTER FROM ANDRE MAISONPIERRE, VICE PRESIDENT, AMERICAN MUTUAL INSURANCE ALLIANCE

AMERICAN MUTUAL INSURANCE ALLIANCE,
Washington, D.C., May 2, 1975.

HON. DANIEL J. FLOOD,
Chairman, Subcommittee on Labor, Health, Education, and Welfare, House Committee on Appropriations, Washington, D.C.

DEAR MR. CHAIRMAN: Proposed changes in funding the administration of the Longshoremen' and Harbor Workers' Compensation Act through user charges of the industry.

The American Mutual Insurance Alliance is the national association representing mutual property and casualty insurance companies. Its member companies write workers compensation insurance in all 50 States and the District of Columbia. Some of the Nation's largest workers compensation insurers are members of the American Mutual Insurance Alliance.

We urge your committee to reject the Department of Labor's proposal that the Longshoremen's and Harbor Workers' Compensation Act be amended to provide that the cost of its administration be charged to the business community. We believe that any change in funding, the administrative costs of the Longshoremen's and Harbor Workers' Compensation Act should be made only after full hearings and examination by those congressional committees which have jurisdiction over the administration and management of the act—the House and Senate Labor Committees. We do not believe that switching the funding for the administration of the act from the general tax base to the affected industries can be viewed as "technical amendments." Such a change is substantial and will bring about a marked increase in the cost of doing business for the companies affected—an increase which will ultimately be passed on to the consuming public.

On the merits of the proposed change, we believe that the Department of Labor's proposal is not in the public interest. Few, if any, Labor Department programs are funded through user charges; neither the National Labor Relation Act, nor the Occupational Health and Safety Act, nor many other Labor Department programs applicable to the business community are paid for through user charges. All of these programs derive their funds through general appropriation, from the Federal tax base.

The Department of Labor alleges that the services provided by the Employment Standards Administration in administering the Longshoremen's and Harbor Workers' Compensation Act accrue to the covered employers only, and thus should be paid for directly by those employers. This assumption is erroneous and demonstrates a failure to understand and appreciate the pervasive role contemplated by Congress in the application of the act and in its administration. Administrative responsibilities implementing the Longshoremen's and Harbor Workers' Compensation Act go considerably beyond the adjudication of disputes arising between employers, employees, and insurance carriers. The fact that the Employment Standards Administration has failed to recognize its total responsibilities in administering the act should not be used as an excuse to tax a specific industry for implementation of the law.

It is true that the Employment Standards Administration has been unable to provide community services required under the 1972 amendments of the Longshoremen's and Harbor Workers' Compensation Act. But this failure has been due primarily to lack of adequate funds. In turn, the Employment Standards Administration has not received adequate funding because it has failed to acquire sufficient visibility within the structure of the Department of Labor to warrant increased funding. Perhaps this may be due, in part, to the narrowness of the scope in which the administration has viewed its responsibilities under the act. We firmly believe that the administration of the Longshoremen's and Harbor Workers' Compensation Act should be upgraded within the structure of the Department of Labor and should be provided with a sufficient budget from general revenues to allow for proper implementation of the act, as expected by Congress.

We urge rejection of the Department of Labor's proposal to change the funding and administration of the Longshoremen's and Harbor Workers' Compensation Act, by imposing a user tax on the industry. We would appreciate your making this letter a part of the record.

Sincerely,

ANDRE MAISONPIERRE,
Vice President.

STATEMENT OF GEZA J. JAKO, M.D.

Mr. Chairman and distinguished members of the House Appropriations Subcommittee on Health, Education, and Welfare, my name is Geza J. Jako, M.D., professor of otolaryngology at Boston University School of Medicine, with offices at 169 East Emerson Street, Melrose, Mass. I appear on behalf of the Association for Research in Otolarynogology, as chairm an of the Committee on Governmental Relations, which committee includes the president of ARO, Jack Vernon, Ph. D., professor at the University of Oregon Medical School; and Merle Lawrence, Ph. D., director of the Kresge Hearing Research Institute, Ann Arbor, Mich.

The Association for Research in Otolaryngology was formed last year by a large number of physicians, researchers, and scientists working in otolaryngology (ear, nose, and throat).

We appreciate the wisdom of your committee in its appropriations report of last year: "Since more than 20 million Americans have handicapping disorders of this (hearing and speech) type, this area of the institute's responsibility should receive additional attention" (H. Rept. 93–1140, p. 22, by Mr. Flood).

Accordingly, we recommend a modest increase in the appropriations for NINCDS for communicative disorders from $16,840,000 in fiscal 1975 to $20 million in 1976, instead of the proposed reduction in the HEW 1976 budget to $14,318,000.

We are confident the new and eminent director of NINCDS, Dr. Donald B. Tower, will carry out the intent of Congress, and we are pleased with his appointment of an otolaryngologist, Dr. Wesley H. Bradley, to head the extramural research program for communicative disorders.

Greater support is needed of investigations into the prevention of deafness, and damaging effects such as noise, ototoxic drugs, aging process, genetic effects, viral diseases, and the like. Deafness is one of the most frequent and debilitating maladies suffered by modern mankind, and the incidence is increasing.

We also recommend increased support of research on diseased mucosal membranes of ear, nose, sinuses, and throat. Other prominent areas for increased research include voice research and diseases of the larynx, papilloma, and benign and malignant tumors.

Considerable success has already been attained in the private development for clinical use of a carbon dioxide surgical laser, and also of electrodes for intracochlear implantation. The greater resources of Government should be increasingly focussed on the whole field of biomedical engineering as applied to otolaryngology and the communicative sciences.

We feel that both Congress and the Institute are emphasizing communicative disorders, and the new change in name of the Institute to "National Institute of Neurological and Communicative Disorders and Stroke" should symbolize this joint increase in emphasis, for which the following specifics are recommended:

COMMUNICATIVE DISORDERS—NINCDS, 1976

[In thousands of dollars]

	1975 actual appropriations	1976 reductions proposed by HEW	1976 recommendations of ARO
Hearing and equilibrium	10,493	9,389	12,700
Speech and language	2,592	2,849	3,500
Research career programs	214	250	300
Research training programs	3,541	1,830	3,500
Total	16,840	14,318	20,000

We thank you, Mr. Chairman and your fellow subcommittee members, for your continued emphasis on increased appropriations in keeping our country's research on communicative disorders at the highest levels.

Emergency Medical Services

STATEMENT OF LANGDON PARKER MARVIN, JR.

Mr. Chairman and distinguished members of the Appropriations Subcommittee, my name is Langdon Parker Marvin, Jr., of 5530 Wisconsin Avenue, Suite 840, Washington, D.C. 20015.

Your committee report last year dealt wisely in the emergency medical services: "For emergency medical services, the bill provides $37 million, an increase of $10 million over the budget and the 1974 appropriation. The emergency medical services systems program provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of emergency health care in an appropriate geographical area. The Federal share will provide 50 percent of the grants or contracts obligations for "establishing and initial operation" and "expansion and improvement" activities. The committee believes the additional funds are necessary in order to take a further step in the development of self-supporting area wide emergency medical services systems which will be accessible to virtually all of the Nation's citizens" (H. Rept. 93–1140, p. 17, by Mr. Flood).

For fiscal 1976, the third and final year under Public Law 93–154 (until it is extended), the President's budget proposes an unwise reduction of $12 million below the 1975 level of appropriations.

This dangerous reduction is proposed when there is already a backlog of some $70 million in EMS applications from all over the country.

It is conceded that fully-developed nationwide emergency medical services can save in a single year more American lives that were lost in the whole Vietnam War.

Therefore, it is recommended that no less than the present level of $37 million including the full authorization of $5 million for research, be appropriated for emergency medical services for 1976.

So doing would provided $22 million for EMS more than the administration requested for the 2 years 1975 and 1976.

Occupational Safety and Health Review Commission

LETTER AND STATEMENT OF ANDREW BIEMILLER, DEPARTMENT OF LEGISLATION, AFL–CIO

Department of Labor

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

June 2, 1975.

Hon. Daniel Flood,
Chairman, Subcommittee on Labor-HEW Appropriations, House Committee on Appropriations, Washington, D.C.

Dear Mr. Chairman: Herewith are the recommendations of the American Federation of Labor and Congress of Industrial Organizations with regard to the implementation of the Occupational Safety and Health Act of 1970 by the Departments of Labor and of Health, Education, and Welfare and the Occupational Safety and Health Review Commission for fiscal year 1976.

I respectfully request that these recommendations be included in the record of your subcommittee's hearings on the Labor-HEW appropriations bill for fiscal year 1976, and that they be given serious consideration.

As you know, the AFL–CIO has appeared before your subcommittee each year since Public Law 91–596 went into effect in 1971, urging that adequate financial resources be placed at the disposal of the three Federal agencies delegated by the Congress to administer the act. Our interest and concern is no less this year. The fact that we did not appear before your subcommittee was due to an inadvertency.

Sincerely yours,

Andrew J. Biemiller, *Director.*

We particularly wish to call your attention to the rapidly deteriorating State plans program of the Department of Labor's Occupational Safety and Health Administration. Where last year there were 25 States with approved OSHA plans, there are now only 20, representing less than 25 percent of all covered employees, and with the distinct possibility that more of such States will drop out, either by withdrawal by the Governor, or by refusal of the State legislature to appropriate funds to carry forward the State effort for the next fiscal year.

Now that the States of New Jersey, New York, Illinois, Wisconsin, and Colorado have discontinued their programs under sec. 18(b) of the act, it is imperative that a greatly increased effort be made to supply additional enforcement personnel to the States whose plans are no longer in operation and to augment enforcement personnel in the other States federally preempted, as well.

Our recommendations, we hope, will be of assistance to you in reprograming funds recommended by the President's fiscal year 1976 budget for State plans into an increased Federal enforcement effort, so that these goals will be accomplished.

In view of the increased need for strengthening the OSHA standards development program because of increased emphasis on protecting workers from industrial carcinogens and other toxic materials we are also asking your consideration of additional funds for this function during fiscal year 1976.

Increased Federal implementation efforts in enforcement and standards development can be accomplished by reprograming funds no longer needed for State OSHA programs, and, in addition, provide, should the subcommittee so decide, for an extension of the onsite consultative program under sec. 7(c)(1). We are informed, however, by OSHA, that the $5 million appropriated for this purpose during fiscal 1975, is largely unused by the federally preempted States and most of it will be returned to the Federal treasury.

Department of Health, Education, and Welfare

National Institute for Occupational Safety and Health

Organized labor is strongly urging that your subcommittee appropriate additional monies to enable the National Institute for Occupational Safety and Health to carry out its increasingly important responsibilities assigned to it by the Congress under the act.

In particular, we call attention to the following areas wherein NIOSH needs assistance and needs it badly:

1. The need for laboratory facilities for NIOSH is of the highest magnitude. The present Cincinnati laboratory is a disgrace. It is not only unsafe but is so inadequate that it is dispersed in three different locations. Although funds have been appropriated for architectural line drawings, no money is proposed for actual construction. The design drawings will be completed in November, at which time a site decision must be made and preliminary construction begun during fiscal year 1976, as completion of such facilities will require 5 to 7 years. Without adequate laboratory facilities, including those to provide safe testing of industrial carcinogens, NIOSH cannot recruit technical personnel which it presently lacks. This means also, that in the interim funds must be appropriated for consolidation of the scattered temporary laboratory facilities in Cincinnati, and for an orderly phased construction schedule, which will result in safe and adequate quarters. This omission in the President's fiscal year 1976 budget must be corrected.

2. Once again, we request the committee to reinstitute funds for training grants to capable educational institutions, which program was terminated as of the end of fiscal year 1976. NIOSH estimates a deficit of over 46,000 occupational health professionals needed by government and private industry to design and maintain a healthy work environment. These needed skills range from occupational health and industrial physicians, industrial nurses, industrial hygienists to paraprofessionals. There are only 770 occupational physicians in the country, according to NIOSH, and their median age is 46 years. Only two colleges award degrees in occupational medicine. We recommend additional money to be appropriated to expand the competence of the existing colleges, and to develop curriculum, faculty and a student body in others.

3. The National Cancer Institute estimates that 80 to 90 percent of the nation's 600,000 new cancers each year are environmentally induced mostly in industry and agriculture. Increased money and manpower is necessary for NIOSH in fiscal year 1976 to begin the program of identifying and monitoring industrial carcinogens and to produce at least two criteria documents leading to OSHA standards each year.

Occupational Safety and Health Review Commission

In spite of the anticipated increase in caseload of contested citations, which will increase even more as a result of five States no longer operating plans under sec. 18(b), the President's fiscal year 1976 budget calls for no increase in judges and backup personnel. We request the subcommittee to recommend appropriation of additional money for this purpose.

SUMMARY OF AFL–CIO BUDGET PROPOSALS FOR OSHA FISCAL YEAR 1976

Occupational Safety and Health Administration

1. Reprogram $30 million from the $48.5 million fiscal year 1976 budget request for State programs as follows:
   a. $25,500,000 to provide 1,060 additional safety inspectors, industrial hygienists, and backup personnel;
   b. $3 million for sec. 7(c)(1) contracts with preempted States for onsite compliance personnel;
   c. $500,000 for additional Bureau of Labor Statistics personnel needed for expansion of OSHA statistical programs; and
   d. $1 million for expansion of development and promulgation of occupational safety and health standards.

National Institute for Occupational Safety and Health

	Millions
Additional funds should be recommended for appropriation, as follows:	
1. Reactivation of manpower training grant program	$9.5
2. Consolidation of temporary laboratory facilities and start of construction of permanent laboratory	3.3
3. Research grant program	3.3
4. Industrial carcinogens program	2.7
Total	18.8

Occupational Safety and Health Review Commission

1. $250,000 additional funds for new law judge activities and administration.

ADMINISTRATION'S BUDGET FOR HEALTH MAINTENANCE ORGANIZATION

A major innovation of the administration was to promote the development of HMOs as a strategy to restrain the rapid escalation in health care costs. HMOs have demonstrated the capability of delivering comprehensive health services of high quality at less cost than can the fragmaneted fee-for-service system. HMOs also cut the need for expensive hospital beds by almost one-half.

The development of HMOs thhoughout the country would also lead to healthy competition between two delivery systems which would indirectly restrain the escalation in physician fees and hospital charges.

Unfortunately, the administration has not included enough in its budget to carry forward the projects already under way.

The attached table indicates that $33 million would be required for planning and development grants for those HMOs for which feasibility grants have already been determined should be funded. A budget of $33,000,000 in grant funds would mean no new starts, and the HMO program would, in effect, be phased out.

To keep the HMO movement growing an additional $15 million would be required for a moderate number of new starts. The minimum budget, including staffing, would require an appropriation of $51.5 million.

HMO program requirements—for effective action in fiscal year 1976[1]

[Dollar amounts in millions]

1. Grant funds:	
A. To continue grants funded in fiscal year 1975 at the authorized levels	$33
B. To permit a moderate number of new starts in fiscal year 1976 (50 feasibility, 14 planning, 13 development)	15
Rural carryover from 1975	−3
New funds	45

[1] With travel, supplies, fringes, etc., this will require approximately $4,000,000.

	Millions
Grants (new funds)	45.0
Operations	6.5
Staff and expenses	(4.0)
Contracts	(2.5)
	51.5

2. Contract support funds:	
A. Assistance to program (audit, financial analysis, actuarial analysis, marketing, legal)	1
B. Specialized technical assistance to projects (medical, financial, systems, marketing)	1
C. Education through provider, purchaser, consumer organizations	.5
Total	2.5
3. Program Operations:	
Development staff (central and regional)	125
Quality compliance staff	25
Total	150

Health Programs

STATEMENT OF CONGRESSWOMAN BELLA S. ABZUG

Mr. Chairman, I want to thank you for the opportunity to testify this morning on needed appropriation for health and welfare programs. I am confining my remarks to the general problems created by the administration's position on funding health programs and to certain programs of the Health Services Administration, particularly, neighborhood health centers, family planning service, and material and child health programs.

In general terms, the administration is asking that HEW programs assume over 45 percent of total reductions proposed in the fiscal year 1976 budget though HEW is only one-third of the total budget. If the administration's budget were implemented, minimal health care would become a luxury for those hardest hit by our near depression. Basic research and manpower development to prepare a systematic national health insurance would come to a virtual standstill.

Any effort to offset the cuts by State or local governments would place an unmanageable burden on these diminishing resources. The proposed cuts could require an additional $950 million of State outlay to continue these programs because the administration is proposing to reduce Federal matching rates from 75 percent to 65 percent.

On top of the change in matching rates, the Federal medicaid reimbursement share is proposed to be reduced from 50 percent to 40 percent. A State such as Massachusetts—which the Governor has described as "flat broke"—would have to absorb over $22 million; California over $125 million; New York, nearly $325 million. The cost to New York City alone, itself on the verge of financial insolvency, would be $142.8 million if the medicaid matching share is reduced as proposed. Clearly, the States cannot rely on the medicare and medicaid systems to preserve these programs.

The administration's rationale for shifting the burden of the program is as nonsensical as the proposal. In March of this year Congressman Fred Richmond, and 25 of his colleagues including myself, wrote to the President protesting, specifically, the 20 percent cuts in neighborhood health centers. I would like to spend a few minutes shortly detailing the effects of these cuts, but I think the President's answer has broader overtones. In it, Presidential Assistant Vernon C. Loen, writing for the administration, stated, "We believe financial programs—medicare and medicaid and, eventually, national health insurance—should be the Federal Government's principal vehicles for financing the delivery of health services." Programs funded under narrow categorical program authorities, he argues, provide services without the needs and eligibility tests of the financing programs, implying that they are piecemeal and selective rather than standardized to national needs.

This position is simply not based in reality. Medicare and medicaid serve a highly select group of people. National health insurance, which would serve a broad, general population, does not now exist. It will still not be geared up and operational, even if Congress acts at breakneck speed, by the time fiscal year 1976 funds are used up. Indeed, the House Budget Committee, in its report on the first concurrent budget resolution, states that, "* * * it does not appear to the committee that enactment of a national health insurance program would have a significant impact on fiscal year 1976 outlays."

The administration reasons further that singling out of certain health care delivery mechanisms from all other types of delivery mechanisms, services, populations, groups, or diseases, as categorical grants do, is poor program design. It adds that, "Many other equally deserving delivery mechanisms, services, groups, and diseases are left out." The administration reasons, in effect, that since categorical grants tend to single out needy populations and diseases and exclude others, we should rely on a system which tends to support none of these programs! The logic boggles my mind.

The substantive loss of medical care as provided by the neighborhood health center program for thousands of people who cannot go elsewhere must be understood.

During the 1960's, a commitment was made by the Congress to support actively social welfare programs and thereby attempt to wage a war on poverty. Out of the fervor of the 1960's came direct health services programs, such as neighborhood health centers, community mental health centers, migrant health centers, and family planning services. Special programs including maternal and child health care, comprehensive and community based family planning services, drug abuse and alcoholism treatment, and lead poisoning and venereal disease prevention are godchildren of this commitment. Although the administration would like to rely on third-party payment plans to support such services, these types of programs are never featured components of any third-party payment plan—certainly not the administration's national health insurance proposal. Further, neighborhood health centers were developed across the country to provide comprehensive, family-oriented ambulatory care to indigent populations in medically underserved areas. They are not special programs for special needs as are many of the categorical grants the administration so dislikes.

Now, in 1975, when neighborhood health centers serve more patients at less cost per visit than other service systems and when the centers are practicing the kind of preventive medicine which results in less utilization of costly hospital beds, President Ford has proposed that the program be slashed by 25 percent to a funding level of $155 million.

The impact of the $40,080,000 reduction in community health center funded under section 314(e) of the Public Health Service Act of fiscal year 1975 will be: First, a total of 68 community health center projects currently being supported will be discontinued; second, the number of persons served will be reduced by between 300,000 to 400,000 from a base of about 1½ million; and third, approximately 3,000 to 4,000 employees on project staffs will become unemployed. Of persons served and employed in community health centers, 90 percent are medically underserved minorities that are most susceptible to the loss of jobs in periods of unemployment and economic uncertainty.

The impact of these possible closings is more insidious because of the nature of the current relationship between community health centers to other health delivery resources. As we already know, the emergency rooms and outpatient departments at both the municipal and voluntary hospitals are severely overburdened. In New York City, the situation is so serious that voluntary hospitals are turning away patients with five or more unpaid visits and the municipal hospitals are holding strictly to their catchment areas. In my district, I have spent many hours in recent weeks trying to save Delafield Hospital, a 183-bed facility in upper Manhattan, which is one of four city hospitals threatened with closing altogether. Sixty blocks south of that the Midwest Side Neighborhood Health Center is threatened as one of the three centers which may be forced to close and its backup, St. Lukes Hospital, has already closed its doors to the poor who are not covered by any third-party payment plan or have gone beyond their visit debt limit. This health center alone serves 22,000 people in my district.

The increasing number of unemployed (increasing at a rate of 12,000 a month in New York City) who are concentrated in areas served by neighborhood health centers, and who do not have health insurance presently, are now forced to use publicly financed systems. These people can, under the present circumstances, either break the backs of the outpatient and emergency services of the hospitals or have no medical care at all with the loss of the neighborhood health centers.

I would like now to say just a few words about the appropriation for family planning project grants contained in the administration proposal. Expenditures for these programs have totaled approximately $100 million for each of the last 2 years. The administration would cut back funding for these title X programs to $79 million on the assumption that medicaid and title IV–A funds will offset this reduction in program grants.

I strongly oppose the proposed cut of $21 million for these projects, and feel that the administration's rationale for this 20 percent reduction is, at best, questionable. In the absence of reliable recordkeeping procedures for documenting family planning expenditures under medicaid and title IV–A, the administration's estimate that these programs will provide $104.2 million for family planning is highly speculative. Additionally, a recent GAO report, "Improving Federally Assisted Family Planning Programs" concluded that many family planning service projects lack the technical expertise to effectively utilize reimbursement mechanisms, or encounter other barriers in their attempts to obtain full third-party payments. The report faulted HEW for failing to provide the necessary technical assistance and guidelines to aid these projects in obtaining reimbursement for services provided. Even where individual projects are capable of taking the necessary steps to claim payments from third parties, they are often unable to do so successfully as a result of administrative difficulties posed by the State agencies with which they must deal.

To expect the States to assume the cost of these services is an equally unrealistic proposal, in light of the fiscal crisis which these entities are undergoing at the present time.

For all of these reasons, I urge you to reject the proposed reduction in family planning project grants. More, rather than less, money is needed for these programs if they are to achieve the goal of providing crucial family planning services to all those who desire them. I would recommend a figure of approximately $150 million for these programs—a realistic sum, which was included in the health revenue sharing and health service bill vetoed by President Ford last year. Promises and speculation are insufficient guarantees that the Nation's family planning needs will be met.

I urge you also to reject any reduction in funds for contraceptive research under title X. Again, the importance of this research cannot be stressed enough. The sum of $60 million, again what was included in last year's health revenue sharing bill, would be far more adequate than the President's $41.9 million request, and I urge you to consider this figure in your deliberations.

Several other programs are glaring examples of the poor choice of cuts which the administration has chosen to make. The maternal and child health services have been reduced from $294.8 million to $211.4 million, compared to an authorization level of fully $349.5 million. The success of the program though may be measured by the decline in hospital admissions for children served. In 1968 7.7 percent of children needed hospitalization; in 1974 it was 2.4 percent, and the average per capita cost declined from $201 to $130 in the same time period. In the face of the great success of the program and the fact that only 1 of every 22 eligible children are currently served, the President has chosen to cut drastically essential funds to operate the program.

Further, Congress has mandated since 1972 that the States provide at least one program in each of five areas—maternal and infant care, children and youth care, regional newborn intensive care, family planning, and dental care; 209 projects now exist throughout the country, but another 163 are needed to meet the legal mandate. Yet, the administration instead chooses to cut the program by 21 percent when the law requires an increase of 50 percent.

I strongly urge the committee that a full $340 million be funded for the package of maternal and child health programs. The history of program success and the demonstrated need suggest nothing less.

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