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# Senate Hearings

*Before the Committee on Appropriations*

# Departments of Labor and Health, Education, and Welfare and Related Agencies Appropriations

DOCUMENTS

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*Fiscal Year* 1978

95*th* CONGRESS, FIRST SESSION

H.R. 7555

PART 4 (Pages 2503–3441)
NONDEPARTMENTAL WITNESSES

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1978

## HEARINGS

BEFORE A

## SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

ON

## H.R. 7555

AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1978, AND FOR OTHER PURPOSES

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Printed for the use of the Committee on Appropriations

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**PART 4 (Pages 2503–3441)**

**Nondepartmental Witnesses**



U.S. GOVERNMENT PRINTING OFFICE

84-877 O WASHINGTON : 1977

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# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1978

MONDAY, APRIL 4, 1977

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
*Washington, D.C.*

The subcommittee met at 10 a.m., in room S–128, the Capitol, Hon. Thomas F. Eagleton presiding.

Present: Senators Eagleton and Brooke.

## NONDEPARTMENTAL WITNESSES

### WOMEN EMPLOYED

**STATEMENTS OF:**

**NANCY KREITER, RESEARCH DIRECTOR, WOMEN EMPLOYED**
**RUTH KOBELL, NATIONAL FARMERS UNION**
**JOHN CROSIER, PRESIDENT, INTERSTATE CONFERENCE OF EMPLOYMENT SECURITY AGENCIES, AND ADMINISTRATOR OF MASSACHUSETTS EMPLOYMENT SECURITY DEPARTMENT**
**MR. KERBY, AMERICAN LEGION**

### INTRODUCTION OF WITNESSES

Senator EAGLETON. Good morning. The Labor/HEW Subcommittee of the Appropriations Committee will be in session.

This morning we will hear from public witnesses concerning the appropriations for the Department of Labor and related agencies.

In total we have seven groups of witnesses. We will try as best we can to limit their presentation to 15 minutes. To accommodate that schedule that means a prepared statement will have to be a little short, if time is to be allowed for the asking of questions.

I think the questions are great so I would like to ask them. If we can, we would like to move along.

The first set of witnesses are as follows: Nancy Kreiter, research director, Women Employed; Ruth Kobell, National Farmers Union; John Crosier, president, Interstate Conference of Employment Security Agencies, and administrator of Massachusetts Employment Security Department; and Mr. Kerby, American Legion.

Ms. Kreiter, I assume you will lead off.

Ms. KREITER. Thank you. The testimony I will give this morning summarizes the much longer document I have submitted for members of the subcommittee.

I am representing Women Employed, an organization of working women in Chicago's downtown area. Our members work at all levels of employment in insurance companies, banks, retail stores, law offices, for the government and in all types of corporations.

Over the past 4 years Women Employed has been very active in the affirmative action arena. Today I would like to discuss one of the agencies under the Department of Labor, the Office of Federal Contract Compliance Programs—OFCCP.

The OFCCP has overall responsibility for reviewing Federal contractors and enforcing Executive Order 11246 which bans discrimination in employment by Federal contractors.

In turn, OFCCP has designated numerous compliance agencies like Treasury, Defense, HEW, et cetera, to oversee various industries.

The question which now must be posed is: How effectively has the taxpayers' money been utilized in the fight against employment discrimination?

In its budget justification 3 years ago, OFCCP promised that it would assume the full role of a lead agency, supplying necessary direction and leadership for insuring enforcement of the Executive order. OFCCP further stated that it would implement compliance review monitoring and take steps to assure consistent application of guidelines.

These goals have not been achieved and at this point a major overhaul of the Federal contract compliance program is necessary if any progress in eliminating discrimination is to be made.

Although OFCCP has overall responsibility, it ends up merely persuading, cajoling and suggesting policies to 30 autonomous agencies——

Senator EAGLETON. I have induced you to move along expeditiously. You are moving a little too fast for me. Is the OFCCP—the jurisdiction of that division, is it any kind of discrimination in contract compliance?

Ms. KREITER. Minorities.

Senator EAGLETON. In a burst of wisdom, didn't we add aging, in terms of the scope of the contract compliance. Do we delegate that to the Labor Department or leave that to the Commissioner on Aging?

Ms. KREITER. No, it is our department also.

Senator EAGLETON. Do we have anything else in the supplemental? Just 10 positions on aging. OK.

Ms. KREITER. Each with their own hierarchies of authority and diverse approaches to enforcement.

As a result, the Federal contract compliance effort is characterized not by a record of enforcement, but with chaotically different handbooks, procedures, rules, and guidelines.

In essence, vast sources of funds have been funneled into an immense and complex structure marked by application of inconsistent standards, counterproductive procedures and unabiding confusion.

Such a diffused structure plagued by diverse standards and procedures causes insurmountable administrative hurdles for OFCCP.

In effect OFCCP may offer advice, but agencies may heed or ignore it. Overriding OFCCP guidelines is a common practice. For OFCCP, the structure presents a maze of layers which dictates time being

spent on everything except aggressive pursuit of equal employment opportunity.

Senator EAGLETON. What enforcement authority is given to that Office if they find in fact there has been discrimination of some type?

Ms. KREITER. Disbarment from contracts, cancellations.

Senator EAGLETON. Cancellations of contracts or disbarment from future contracts?

Ms. KREITER. Right.

Senator EAGLETON. You are not talking about employment in private sector as such?

Ms. KREITER. Yes.

Senator EAGLETON. It is only connected with the Federal contract; we have the EEOC that has jurisdiction with respect to discrimination, regardless whether a company has a contract or not, they can proceed against United States Steel or whatever.

Ms. KREITER. Right.

Not surprisingly, the OFCCP has also come under extensive criticism for its failure to utilize the enforcement apparatus created to implement the Executive order.

The GAO and congressional committees have thoroughly documented this situation. Women Employed's experiences certainly support such views.

It is generally agreed that the regulations have become burdensome because of their piecemeal nature and emphasis on a myriad of procedural details which result in time-consuming paperwork and administrative debates rather than the elimination of discrimination.

Efforts to clarify and simplify regulations certainly are mandated. However, any revamping should strive to fortify, not erode the already impotent enforcement stance which has characterized the contract compliance program.

A further problem relates to the budget for this program. Over the past 10 years the staff and budget for Federal contract compliance activities has grown from 228 positions with less than $5 million to over 1,600 positions and over $40 million.

Senator EAGLETON. Wait a minute. Is that 10 years?

Two hundred and twenty eight positions at what price?

Ms. KREITER. $5 million.

Senator EAGLETON. Up to 1,600 positions at $40 million? When was OFCCP created?

Ms. KREITER. The Executive order was in 1965.

Senator EAGLETON. 1960 what?

Ms. KREITER. Five.

Since no line-item budget exists for OFCCP, there is no way to assess OFCCP use of funds. This means that there is no financial accountability built into the contract compliance program.

In addition, there are vast disparities in the resources allocated by the separate agencies to their compliance programs, and staffs and budget bear little relation to the size of agency workloads. This means there was no compliance program.

Senator EAGLETON. You said on a minimal it has gone from $5 million to $40 million?

Ms. KREITER. Very minimal. There is no classification breakout at all. The $40 million is the entire contract compliance program which includes the agencies' budgets that are thrown in there.

Actually OFCCP's part is about $4.6 million.

Senator EAGLETON. What else?

Ms. KREITER. HEW, the entire program.

Senator EAGLETON. Is one item? In whose budget?

Ms. KREITER. No, the only thing in the Labor budget is the $4.6 million.

Senator EAGLETON. The $40 million includes not only OFCCP but includes compliance divisions?

Ms. KREITER. OFCCP oversees the entire contract compliance program. That $40 million is what the agency has allocated in addition to what OFCCP uses.

Senator EAGLETON. Why don't we get a breakdown, then?

Ms. KREITER. That was one of my recommendations.

Senator EAGLETON. Have them submit for the record, for my interest, too, the breakdown of how much money is spent.

I think we ought to have it on each Department, shouldn't we, how much is allocated to each Department, HEW, Treasury, Labor.

Since no line-item budget exists for OFCCP, there is no way to assess OFCCP use of funds. This means that there is no financial accountability built into the contract compliance program. In addition, there are vast disparities in the resources allocated by the separate agencies to their compliance programs, and staffs and budgets bear little relation to the size of agency workloads.

Senator EAGLETON. Do you have any idea on the 17 to 11? What are the 17 departments?

Ms. KREITER. Department of Agriculture will no longer be in charge of contract compliance. I don't recall what agency, but perhaps ERDA or something like that will do it, taking 6 of the agencies, consolidating their efforts into the 11 remaining.

Senator EAGLETON. I guess I understand that. There is today in the Department of Agriculture a section of that Department called Contract Conformance for Equal Opportunity, or whatever, and it is being administered today by that Department, separate from OFCCP.

Ms. KREITER. Subject to oversight by OFCCP.

Senator EAGLETON. So they are collapsing eight of those. So OFCCP not only will have oversight jurisdiction, but presumably in that department will have enforcement?

Ms. KREITER. The enforcement would go to another 1 of the 11 agencies. I guess what I am proposing is that OFCCP should have that responsibility for all of them. There should not be separate agencies.

Senator EAGLETON. Let's get a list of the 17, then.

Ms. KREITER. I have attached that. Page 18 of the larger one.

Senator EAGLETON. Appendix No. 1?

Ms. KREITER. Right.

Senator EAGLETON. Are these the 17——

Ms. KREITER. Right.

Senator EAGLETON [continuing]. That exist today. EPA doesn't have one today. DOD doesn't have one, the biggest Department in Government? It's blank.

Ms. KREITER. It's subagency. It's just a major agency. EPA is there.

Senator EAGLETON. I see a blank after it.

Ms. KREITER. Some of the subagencies and others don't. If they don't, then the general department has the responsibility. Others have designated subagencies under them. That is the problem.

We have 60 or 70 agencies, then 13 more subagencies, and when you get down to the bottom line, nobody knows what they are doing. They are all responsible for contract compliance.

Senator EAGLETON. For instance, at DOD I guess there is one top level compliance office.

Ms. KREITER. Right.

Senator EAGLETON. But NASA is broken down into smaller components at these various installations or types of work.

Ms. KREITER. Right.

Senator EAGLETON. On this, this adds up to 17, I take it.

Ms. KREITER. Seventeen for fiscal 1977. Now it is down to 16 and it is going to 11.

Senator EAGLETON. So it will go to 11.

Let's see. For instance, I don't see even—here's USDA. So about six of these guys are going to go out of business and going to be subsumed into OFCCP.

Ms. KREITER. The remaining 11 will take on the responsibility.

Senator EAGLETON. It is your theory or proposal that all of these should be abolished and the whole thing goes to OFCCP?

Ms. KREITER. Right.

Senator EAGLETON. Let's get a comment from the Labor Department on that. This is sort of mind boggling as it is. I can share some of your anxiety.

Go ahead.

Ms. KREITER. The budget ramifications of consolidation are noteworthy. Consolidation of both staff and line responsibilities within the Department of Labor would result in cost savings——

Senator EAGLETON. What would you think of this? Passing for the moment the possibility that the equal opportunity division is in shambles—there is a good case that can be made, it is that way—but assuming we can unscramble it, why don't we go along with all of these and plus OFCCP but give it to EEP, along with the compliance on contract in Government.

Would that be a neat bureaucratic thing to do?

Ms. KREITER. I think in theory it may be a neat bureaucratic thing to do, down the road. Our fear at this time is the timing of the whole thing. We quite agree about the shambles it is in.

I think before any decision is made as to whether anything can be done, an evaluation must be done——

Senator EAGLETON. Based on your knowledge of the 17 agencies, are there some that you think are doing a top flight job in this area, and others doing an inferior job, or is it the thrust of your testimony that they are all doing an inferior job?

Ms. KREITER. Our experience in the Chicago area points out some agencies are doing a better job than others. I have testified both before the Subcommittee on Equal Opportunity and Senator Proxmire's subcommittee about taking the responsibility away from Treasury because of their horrible record.

But both the Department of Defense and ERDA have an excellent record. But that is in the downtown Chicago area, so we don't deal with them.

Senator EAGLETON. Does an individual job applicant have any personal remedy under the Federal contract compliance, or is his or her remedy only within OFCCP?

Ms. KREITER. What we have found, is that the individual charges are really systemic discrimination that is going on, at least for that type of charge.

Senator EAGLETON. These are basic actions. To bar a contract doesn't necessarily get the job for the individual.

Ms. KREITER. That is included in OFCCP regulations.

Senator EAGLETON. To that extent, it is somewhat duplicative of EEOC.

Ms. KREITER. The main difference is the contract and the affirmative action plan.

Senator EAGLETON. Have there been some biggies having their contracts barred, some of the Fortune 500 corporations?

Ms. KREITER. I believe that in the whole history of the program there has only been 11 or 12 disbarments.

Senator EAGLETON. Let's get a list for the record, year by year. If our witness is wrong and there are 50,000 corporations that would be a little bit hard to go through, but if she is right and there are 10 or 11, let's get all of them, whatever they are: Jones Corp. or whatever.

A debarment is a remedy of final choice, that is, I imagine there have been hundreds of cases where corporations have been called in and say, hey, guys, get with it.

Ms. KREITER. Some agencies have a very good record on that. The thing to do before disbarment is the show-cause notice, where they give the company 30 days notice as to why they shouldn't be disbarred.

Very often it's been found very effective in getting them conciliated to institute affirmative action. On the other hand, there are cases like in the Treasury Department where they have been instructed by OFCCP to issue that show-cause notice and then they refuse to even use it.

So the banks know——

Senator EAGLETON. Banks?

Ms. KREITER. Treasury monitors the banks.

Senator EAGLETON. Would you say that the Treasury's approach is the most notorious of the 17 departments? Or one of the most?

Ms. KREITER. One of the most, the most indicative of the problems in the program. It has been documented by a GAO, GSA report.

Senator EAGLETON. What about reverse discrimination in banks? A women's bank has been opened in New York City, they have a woman officer and president and a lot of women officers.

What do we do about that?

Ms. KREITER. My opinion is that reverse discrimination is really no major problem. We are talking about a program of action. We are not asking for quotas, just asking for an equal chance and equal opportunity for women and men. It's been this way for years, anyway.

I don't think in terms of contract compliance that this is a real issue.

The budget ramifications of consolidation are noteworthy. Consolidation of both staff and line responsibilities within the Department of Labor would result in cost savings which should be converted into greater compliance review coverage, increased training and the addition of legal staff who are specialists in equal employment opportunity.

If, indeed, the Wage and Hour Division of the Department of Labor is used for comparison purposes, a 20-percent decrease in administrative overhead is implied. Wage/Hour relies on a straight-line staff system with direct responsibility and control over supervisory levels and overhead.

OFCCP represents a completely decentralized system with increased supervision built into the structure because of the autonomy of the compliance agencies. Thus, nearly 66 percent of the field personnel under Wage/Hour are employment opportunity specialists or compliance officers compared to 46 percent of the field personnel of the compliance agencies—a 20-percent differential relating directly to the increased overhead of a highly decentralized system.

Therefore, Women Employed recommends to this subcommittee that: first, appropriations to OFCCP be contingent upon correction of structural and procedural deficiencies through consolidation and commencement of meaningful regulatory reform; second, OFCCP provide a line-item budget reflecting its operations; and third, the Senate Appropriations Committee examine budgets of the various compliance agencies in order to assess the priority given to equal employment opportunity programs.

Thank you.

Senator EAGLETON. Thank you very much.

May I ask for comments? Don't feel you have to be cautious in your answers.

Have the efforts of the Carter administration in its 2½ months in power, in terms of employment opportunity specifically with respect to women, do you consider what they have done to date fairly satisfactory, very satisfactory, unsatisfactory, what kind of record?

Ms. KREITER. There are two different things.

A lot of people are talking about President Carter's appointments on the one hand. We are talking strictly in the area of equal opportunity programs and what he has done within the Department of Labor.

To date this has been very satisfactory. The appointments are at least favorable in our eyes——

Senator EAGLETON. Talking about the appointments to the OFCCP business?

Ms. KREITER. The indications from him during the campaign on his positions have indicated there will be redresses pursued on equal employment opportunity, and not the benign neglect we saw before.

We are hopeful.

Senator EAGLETON. Is it possible for you to quantify the work of OFCCP along these lines? How much of the effort has been on matters pertaining to race, how much on matters pertaining to sex discrimination, how much dependent on aging discrimination, I am asking for, is much more of their effort on race discrimination than sex?

Ms. KREITER. I know it is broken down in the Department of Labor justifications. They do it by legislative authority.

Senator EAGLETON. We will see what is quantifiable in terms of man-hours, how many person-hours are put in on sex discrimination, race, aging or such others, by category?

Ms. KREITER. I have seen such a list.

Senator EAGLETON. I don't know what it is going to tell me once I look at it. I think it will show that the miniscule percentage goes into aging, and more time is spent on race discrimination than sex.

Ms. KREITER. Probably.

Senator EAGLETON. We will see about that.

PREPARED STATEMENTS

Thank you very, very much. I see you have some written statements to be included in the record.

[The statement follows:]

## STATEMENT OF NANCY KREITER

Women Employed--Who We Are

I am representing an organization of working women in Chicago's downtown area. Our members work at all levels of employment in insurance companies, banks, retail stores, law offices, for the government and in all types of corporations. Women Employed has a two-fold purpose: 1)dealing with employers' discriminatory practices through direct negotiation and, when necessary, by filing charges with government agencies; and 2)monitoring government enforcement activities to ensure that working women's rights are protected. Over the past four years Women Employed has been very active in the affirmative action arena--the enforcement of Executive Order 11246, as amended. We have exposed the discriminatory practices of numerous employers and have worked with nearly every enforcement agency that deals with the Executive Order. We have seen many investigations bungled, and have seen others that resulted in significant improvements for women and minorities. Our experiences have made us well aware of the strengths and weaknesses of the contract compliance program.

Contract Compliance--How Effective Is It?

Executive Order 11246, issued in 1965 and amended in 1967, bans discrimination in employment by federal contractors. In addition, it requires them to take affirmative action to assure equal employment opportunity for women and minorities. The Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) has overall responsibility for reviewing federal contractors and enforcing the Executive Order. In turn, OFCCP has designated numerous compliance

agencies to oversee various industries.

The question which now must be posed is: How effectively has the taxpayers' money been utilized in the fight against employment discrimination? In its budget justification three years ago, OFCCP promised that it would assume the full role of a lead agency, supplying necessary direction and leadership for ensuring enforcement of the Executive Order. OFCCP further stated that it would implement compliance review monitoring and take steps to assure consistent application of guidelines. These goals have not been achieved and at this point a major overhaul of the federal contract compliance program is necessary if any progress in eliminating discrimination is to be made. Two components must be assessed: 1)the bureaucracy which has unfolded over the past ten years and 2)the regulations which have been developed to implement the Executive Order. Both aspects are in total disarray.

In FY 1977, the federal contract compliance program consisted of seventeen agencies, thirteen subagencies, 200 field offices, 1600 compliance personnel, covering over 200,000 contractors with more than 40 million employees, and a budget of over $40 million. (See Appendix I for agency listings). Although OFCCP has overall responsibility, it ends up merely persuading, cajoling and suggesting policies to thirty autonomous agencies, each with their own hierarchies of authority and diverse approaches to enforcement. As a result, the federal contract compliance effort is characterized, not by a record of enforcement, but by chaotically different handbooks, procedures, rules and guidelines.

Structurally, the federal compliance program is unworkable. With OFCCP monitoring their efforts, the vari-

ous compliance agencies are responsible for ongoing enforcement of the Executive Order. In the field, each agency office falls under three hierarchies--the central offices of the agency and OFCCP as well as the regional OFCCP. This creates many layers of non-productive auditors rather than investigators pursuing enforcement. One of the most glaring by-products of such a structure is time delays as decisions get bogged down in Washington, D.C., where contract compliance is one of many programs not necessarily granted top priority. Often OFCCP assumes jurisdiction on cases or intervenes at the hearing stage. Communication with the field offices is invariably severed and significant aspects of the investigation are never followed up.

From the point of view of constituency groups, inexcusable amounts of time and resources are wasted in dealing with the various and confusing layers. For instance, in situations as seemingly simple as Freedom of Information requests, Women Employed in Chicago must contact the central agency staff in Washington, who in turn obtain the information from their Regional office in Chicago, so that it may be sent from Washington to Women Employed back in Chicago! With regard to charges filed and related investigations, Women Employed usually has been forced to turn to OFCCP for intervention after exhausting all possible bureaucratic layers in the specific agencies. Such a structure serves no fruitful purpose and is synonomous with inaction.

Bureaucratic inertia also results from a procedural morass in the enforcement process. The federal contract compliance program has come under severe criticism from the General Accounting Office, civil rights and women's groups and Congressional committees for its inability to

develop procedures that work to reduce discrimination.

There are as many different procedures as there are agencies. In Region V, for example, one agency requires regular detailed progress reports from contractors it has reviewed, employing a full-time compliance officer to do nothing but monitor companies on the basis of the specific data gathered. Yet another agency emphasizes building its files and spending greater amounts of time on-site at companies during compliance reviews with no interim monitoring. While some agencies insist on written documentation of all aspects of their operations, others rely primarily on informal communication and relationships with contractors.

Differences between the agencies in terms of regional authority can also be illustrated. The Treasury Department and ERDA require show-cause notices and sanctions to be issued by the central offices, which means field personnel have the power to determine contractors' compliance, but not their non-compliance, thus increasing the paperwork and delay in the enforcement process. On the other hand, GSA may impose sanctions in the region; however, all hearings are then conducted by the central office which basically thwarts the relationships established in the region. Regional OFCCP offices have absolutely no investigative or enforcement authority, which essentially makes a mockery of their auditing role.

Another complication arises because there is no strong complement of legal counsel within the program. No legal staff is assigned at the field level and attorneys from the Office of the Solicitor of Labor are called in after investigations have already been completed. Thus, decisions reached by compliance officers are later rescinded on the basis of legal opinions.

In theory, OFCCP should be in a position to determine which procedures benefit the program and which actually work contrary to the achievement of equal opportunity. Even when the OFCCP has attempted to intervene to standardize procedures, their direction and guidance has proven extremely deficient. A common complaint of the various compliance agencies is that OFCCP guidelines issued to clarify rules and regulations most often further confuse the issue. In fact, even the regional OFCCP offices have expressed consternation over their inability to obtain meaningful interpretations from the central office. According to the GAO back in 1974, there existed demonstrable need of OFCCP clarification and guidance with regard to such matters as affected class identification and remedies. One year later, the Civil Rights Commission underscored such a finding, again using affected class as a prime example. Yet today, compliance agencies still conduct reviews without addressing this key issue, due to lack of direction. Moreover, policies dealing with such things as availability analysis, plant-to-plant transfers, and "last hired-first fired" syndromes have never been developed.

OFCCP's role in monitoring the work of the compliance agencies in order to guarantee an overall consistent contract compliance program has also been ineffective. Agencies consider OFCCP auditing to be a nuisance which frequently results in a tug of war between OFCCP and agencies' officials. In addition, OFCCP has only monitored five percent of the compliance reviews undertaken and the monitoring occurs only after the review process is well underway and cannot be significantly impacted.

OFCCP has been unable to enforce even a uniform reporting system which could serve as a useful measure of the direction

and progress of the contract compliance program. The quarterly operations reports required from the agencies have proven to be useless. Agencies do not submit information on all reviews and rarely are consistent in complying with OFCCP's standards for format, timeliness and content. In Region V, for example, it is impossible to monitor agency activities since reports submitted for the same quarter are entirely dissimilar. Some indicate reviews completed, others, reviews scheduled. Some are timely, others are retrospective with little usefulness in terms of actual accomplishments.

Contractors are keenly aware of the structural weaknesses and are able to use the fragmentation to their advantage. Since contractors are assigned to compliance agencies on the basis of their standard industrial codes, the possibility exists for two or more agencies to be reviewing the same contractor. This causes duplication of efforts at best, and more probably inconsistent treatment, dissimilar interpretation of the regulations, and differing direction, all of which stall the enforcement process. There may also be an inherent conflict of interest in Executive Order enforcement by agencies which have contractual relationships with firms under their jurisdiction. Women Employed outlined just that situation with regard to Treasury and the banks during testimony before Senator Proxmire and other members of the Senate Committee on Banking, Housing, and Urban Affairs. The Department of Defense falls into the same category.

In essence, vast sources of funds have been funneled into an immense and complex structure marked by application of inconsistent standards, counterproductive procedures and unabiding confusion. Such a diffused structure plagued by divergent standards and procedures causes insurmountable

administrative hurdles for OFCCP. In effect, OFCCP may offer advice, but agencies may heed or ignore it. Overriding OFCCP guidelines is a common practice. For OFCCP, the structure presents a maze of layers which dictates time being spent on everything except aggressive pursuit of equal employment opportunity.

Not surprisingly, the OFCCP has also come under extensive criticism for its failure to utilize the enforcement apparatus created to implement the Executive Order. The GAO and Congressional committees have thoroughly documented this situation.

Women Employed's experiences certainly support such views. (See Appendix II) For example, in 1973, Kraft Foods submitted a six-page affirmative action plan that committed the company to promoting only one woman to a supervisory-level job, sending another six women to a management-training seminar, and hiring 117 women for clerical positions. Kraft also boasted that they subscribed to the Chicago Daily Defender, Chicago's minority newspaper. The Department of Agriculture accepted this affirmative action plan until Women Employed forced them to investigate discriminatory employment practices at Kraft Foods. Some federal contractors get away with even more than Kraft did. CNA Insurance, for example, a company that holds millions of dollars in Medicare contracts, never had an acceptable affirmative action plan until WE pressured the Social Security Administration to review the company. Now CNA, in a creative attempt to avoid compliance with the law, has written an affirmative action plan that is 5000 pages long, reams of paper which defy meaningful evaluation and analyses.

Yet, the very agency charged with ensuring equal opportunity for women and minorities spent thousands of dollars

of taxpayers' money in an attempt to seriously undermine the Executive Order. In the final days of the Ford Administration, his representatives in the Department of Labor published proposed revisions to the affirmative action regulations which rather than clarifying and simplifying existing regulations--their stated purpose--would have effectively gutted the enforcement mechanism altogether.

Testimony and comment received in reaction to the proposed regulations in the fall of 1976 reflected outrage and frustration with efforts to dilute enforcement mechanisms which had never even been exercised. This was the basis for the subsequent defeat of the Department of Labor's proposed revisions. Civil rights and women's organizations across the country were joined by numerous Congressional representatives and Senators including Senators Magnuson, Proxmire, Bayh, Chiles, and Brooke in voicing their opposition to the so-called regulatory reform suggested by the Department of Labor. Comments and testimony submitted by Women Employed (Appendix III) exemplify the concern and drawbacks regarding both the proposed revisions and the existing regulations expressed by the vast majority of those who deal with affirmative action.

It is generally agreed that the regulations have become burdensome because of their piecemeal nature and emphasis on a myriad of procedural details which result in time-consuming paperwork and administrative debates rather than the elimination of discrimination. Efforts to clarify and simplify regulations certainly are mandated. However, any revamping should strive to fortify, not erode the already impotent enforcement stance which has characterized the contract compliance program.

Budgeting

More specifically, in terms of Department of Labor appropriations, several points are in order. Over the past ten years the staff and budget for federal contract compliance activities has grown from 228 positions with less than $5 million to over 1,600 positions and over $40 million. The resources authorized for OFCCP Executive Order implementation in FY 1978 are approximately $4.6 million (of the $40 million), a 2.8% increase over last year. Since the Employment Standards Administration funds OFCCP, OFCCP has no control over its appropriations. Furthermore, since no line-item budget exists for OFCCP, there is no way to assess OFCCP use of funds. This means that there is no financial accountability built into the contract compliance program. Budget analysis is essential in determining the merit of increases or decreases vis a vis the effectiveness of the program. Certainly staff time and resources could have been more efficiently utilized developing affected class and other guidelines in contrast to drafting regulations designed to dismantle the enforcement apparatus.

Another major budgetary problem is that there are vast disparities in the resources allocated by the separate agencies to their compliance programs. (See Appendix IV) Additionally, staffs and budgets bear little relation to the size of agency workloads. Budgetary decisions are completely controlled by the agency's central office with little if any influence coming from the field directors. In some agencies contract compliance is not even a line item. Beyond staffing concerns, travel expenses are the key budget item. Some agencies like ERDA never feel the pinch because other areas outside of contract compliance funnel excess

funds. Yet, other agencies like GSA have been forced to cancel reviews in the face of dwindling travel funds. Contract compliance personnel are in dire need of training to sharpen their skills at the investigative level and thus increase the efficiency of the program. However, allocations for such training are scarce. For example, the Treasury office in Region V received $400 to be applied to training in one year. The minimum per course per person is $200! All in all, budget allowances for OFCCP and the compliance agencies seem to be arbitrary, ill-defined, and inefficiently allocated.

Women and Minorities Are Losing Ground

It is clear to us that federal efforts to end discrimination in employment have not been equal to the task. In fact, women and minorities are losing ground. Statistics show that women now receive fifty-seven per cent of the amount men earn. Twenty-five years ago, female wages were sixty-four per cent of male wages. Women continue to be clustered in the lowest paying jobs and are all too often denied promotion opportunities. Even when adjustments for occupation, education and work experience are taken into account the earnings gap does not close appreciably--perhaps three percentage points. Substantial income differentials are found throughout occupational breakdowns. For example, earnings of females in proportion to males are sixty-five per cent for professionals and technicals, sixty-one per cent for clericals and fifty-eight per cent for service workers. A scant 4.8 per cent of employed women earn between $10,000 and $15,000 versus nearly twenty-two per cent of working men. At the other end of the spectrum, thirty out of every 100 women, but only ten out of every 100 men earn less than $5,000.

The economic status of minority women, because of dual discrimination, is even more depressed than the status of white women. Minority women are relegated to the lowest occupational echelons--fifty-five per cent are working as operatives and service workers compared to twenty per cent of all men. Discrimination at the point of hiring in white collar fields continues to be widespread. Although minority women have made some gains in earnings over the past few years, they still are far from equal to men in wages. The median income of minority women in 1974 was $6611, a mere fifty-four per cent of the income of all men, and seventy-three per cent of the income of minority men.

Consolidation of Program is Needed

Implementation of Executive Order 11246, as amended, has been gravely hampered by a lack of overall leadership and direction, deficient regulations, and assignment of authority to a number of agencies which have issued inconsistent policies and developed uncoordinated programs. Women Employed would conclude that effective use of tax dollars allocated for enforcement of equal opportunity dictates a major overhaul of the contract compliance program. Responsibility and authority for compliance and enforcement is so hopelessly splintered that the program cannot realize its optimum capability unless total accountability for policy and operations is consolidated within a single agency. At this point in time it makes sense for such consolidation to occur within the Department of Labor where the program's history, development and expertise have been carved. The Department's mission is inherently sound, although it has been rendered inoperable by an unwieldy structure and the lack of commitment to equal opportunity during the Nixon-Ford Administrations.

The Department of Labor itself believes that criticisms of enforcement result from problems of coordination, training and duplication which are directly attributable to the multiplicity of agencies with compliance authority. Therefore, the Department of Labor already plans consolidation from seventeen agencies into eleven for FY 1978. The expectation is for increased effectiveness due to a reduction in both the span of control and the needed monitoring function. Certainly, contractors would experience less investigative overlap as well as greater policy consistency. However, total consolidation would be more advantageous than the proposed plans, since in building eleven mammoth agencies, OFCCP risks further loss of influence and leverage. Although under the terms of the Executive Order, compliance agencies are required to abide by the rules, regulations and orders set forth by the Secretary of Labor, reality has reflected quite another picture. It has been shown that the current structure does not allow effective policy and program direction. OFCCP is unable to assure its guidelines are being carried out. Nor can OFCCP obtain timely or sufficient feedback. Accompanied by strong leadership in the Carter Administration, consolidation should lead to a greater concentration on attacking employment discrimination, and thus, a more efficient use of appropriations.

Regulatory reform is a necessary ingredient for the future success of the program. Women Employed recommends simplifying procedures and eliminating paperwork within a framework of strengthened enforcement. To be effective in achieving equal opportunity, affirmative action regulations must provide for:

1) Strict and expedient enforcement mechanisms;
2) Cutting red tape by providing employers with specific criteria for achieving affirmative action which are uniformly enforced;

3)Development and monitoring of goals and timetables not as quotas but as benchmarks in a plan of action; and
4)Government accountability and public disclosure of all aspects of the contract compliance program.

To this end, Women Employed has developed a twenty-four point program depicting the minimum criteria for regulatory reform. (See Appendix V) The prospect of strong enforcement standards in conjunction with an improved consolidated structure holds promise for the true intent of the Executive Order to be achieved--the elimination of employment discrimination.

The budget ramifications of consolidation are noteworthy. Consolidation of both staff and line responsibilities within the Department of Labor would result in cost savings which should be converted into greater compliance review coverage, increased training, and the addition of legal staff who are specialists in equal employment opportunity. This would be realized in three ways. First, management overhead at the headquarters level would be cut since each compliance agency now maintains its own management and program support staff. In the same vein, centralization within the Department of Labor would mean fewer supervisory positions needed in the field offices; instead of regional offices for seventeen compliance agencies, one office in each region with strengthened authority and powers would suffice. Finally, heightened efficiency in operation would occur. The cost per compliance review ranges from approximately $582 for the Small Business Administration to over $7,000 at the Department of Health, Education and Welfare. A single agency would be able to pursue standardized ratios for cost efficiency.

If, indeed, the Wage and Hour Division of the Department of Labor is used for comparison purposes, a twenty per cent decrease in administrative overhead is implied. The fundamental

difference between the operation of Wage/Hour and the Executive Order program lies in the structural levels of supervisory staff. The former relies on a straight line staff system with direct responsibility and control over supervisory levels and overhead. The latter represents a completely decentralized system with increased supervision built into the structure because of the autonomy of the compliance agencies. Thus, nearly sixty-six per cent of the field personnel under Wage/Hour are employment opportunity specialists or compliance officers compared to forty-six per cent of the field personnel of the compliance agencies--a twenty per cent differential relating directly to the increased overhead of a highly decentralized system. This translates into an $8 million savings in administrative overhead based on the current universe of coverage which should be applied to additional staffing, travel, training, etc.

Recommendations

Although the Executive Order was issued in 1965, its implementation has suffered greatly from the not-so-benign neglect experienced under Republican administrations. The established contract compliance program was constructed to have little, if any, impact. Hence, discrimination in employment continues to be widespread. However, the intent of President Johnson's Executive Order can now be carried out by an administration firmly committed to civil rights.

Therefore, Women Employed recommends to this Subcommittee that:

1) Appropriations to OFCCP be contingent upon correction of structural and procedural deficiencies through consolidation and commencement of meaningful regulatory reform;
2) OFCCP provide a line-item budget reflecting its operations; and
3) The Senate Appropriations Committee examine budgets of the various compliance agencies in order to assess the priority given to equal employment opportunity programs.

Contract compliance is only one aspect of federal enforcement efforts to end discrimination. Currently there are twenty-five federal programs covering civil rights enforcement with combined outlays of $467 million. Proposals for consolidating enforcement activities are already being developed. While Women Employed favors streamlining the federal bureaucracy in this arena, we also believe it is critical to examine the steps needed to facilitate consolidation. Presently, there are three schools of thought--1)improving the existing enforcement agencies; 2)consolidating all operations under EEOC; and 3)creating an entirely new superagency. We would argue that the real decision centers around timing. The agencies now responsible for enforcement must demonstrate effectiveness in enforcement before it can be determined what type of consolidation is appropriate. Based on their track records to date, there is certainly no agency capable of administering the entire enforcement effort. In any case, criteria must be devised to ascertain at what point consolidation of one or more agencies should take place.

There are advocates who would move now for consolidation under EEOC. It is our view that elimination of the first step, i.e., making the existing agencies functional, risks inertia for the total enforcement effort. Those of us who represent the women and minorities whom the federal agencies are supposed to protect will be eager to rally behind an overall coordinated and consolidated program if in fact enforcement, and not further bureaucratic entanglement, is the proven effect.

APPENDIX I

Compliance Agencies

| Agency | Subagencies | Total |
|---|---|---|
| Commerce | Maritime Administration(MARAD)<br>Economical Development Administration(EDA) | 2 |
| DOD | | 1 |
| EPA | | 1 |
| ERDA | Government Contractor's and Government Owned Corporations (GOCO's) | 1 |
| GSA | Public Building Services(PBS)<br>Federal Supply Services(FSS) | 2 |
| HEW | Office of Education(OE)<br>Social Security Administration (SSA)<br>Medical Facilities | 3 |
| HUD | | 1 |
| Interior | | 1 |
| Justice | | 1 |
| NASA | Ames Research Center, Flight Research Center, Goddard Space Flight Center, Marshall Flight Center, Kennedy Space Center, Langley Research Center, Johnson Space Center, and Wallops Space Center | 8 |
| SBA | | 1 |
| Treasury | | 1 |
| DOT | U.S. Coast Guard<br>Federal Aviation Administration (FAA)<br>Federal Highway Administration<br>Uban Mass Transit Administration (UMTA) | 4 |
| TVA | | 1 |
| USDA | | 1 |
| VA | | 1 |
| | | 30 |

APPENDIX II

WORKING WOMEN AND AFFIRMATIVE ACTION
WOMEN EMPLOYED'S EXPERIENCE

Women Employed is an organization of working women in Chicago's downtown area. Our membership includes women who work in insurance companies, banks, retail stores, law offices, for the government and in all types of corporations. Women Employed has a two-fold purpose: 1) exposing employers' discriminatory practices and compelling government officials to enforce the law; and 2) pressuring employers to value the work women do in keeping offices running by paying decent wages and treating women with respect.

Over the past three years, Women Employed has been active in analyzing corporations' affirmative action plans, filing charges and dealing with government agencies responsible for enforcing affirmative action requirements. Our activities have also included efforts to improve the enforcement of affirmative action requirements by the Department of Labor's Office of Federal Contract Compliance Programs. Our efforts have led us to the conclusion that the problem in enforcing affirmative action is actually not very complicated. It is simply that the government refuses to use the sanctions it has available. The guidelines and procedures are clear; but government agencies continue to allow corporations to stall in developing adequate affirmative action plans.

The Department of Labor's Office of Federal Contract Compliance Programs has overall responsibility for enforcing Executive Order 11246 (as amended) which requires federal contracts to develop affirmative action plans, plans which are supposed to be approved by the government. The OFCCP has designated numerous agencies to handle various industries. These were the agencies Women Employed initially contacted.

Women Employed went to the Department of Agriculture in 1973 regarding Kraft Foods and discovered that Kraft's affirmative action plan that promised to promote one woman had been accepted by Agriculture. We went to the Social Security Administration regarding the insurance industry and particularly regarding CNA Insurance. We were informed that CNA had never had an approved plan even though they held millions of dollars in government contracts. We went to the Treasury Department with discrimination charges against Chicago's seven largest banks. We learned that these banks had not been reviewed since 1971. We went to the General Services Administration regarding stock brokerages and discovered that no brokerages had ever been reviewed. Federal government securities in brokerages constitute a contractual relationship, yet we were informed that the GSA legal department would have to determine whether a contractual relationship with stock brokerages exists--a legal determination which had never been made since the inception of the federal contract compliance program.

With this information, Women Employed initiated actions to deal with this laxity in the enforcement of affirmative action requirements. After 18 months of pressure by Women Employed, the Department of Agriculture finally required Kraft Foods to establish specific goals and timetables for promoting women and minorities. A year long Women Employed campaign resulted in the Social Security Administration requiring CNA to pay a half million dollars to women who had been discriminated against. But the Social Security Administration then accepted CNA's affirmative action plan on the condition that it be substantially rewritten. CNA is now in court to prevent Women Employed from obtaining a copy of their latest affirmative action plan which obviously leads us to question its acceptability.

The Treasury Department holds the record for the longest Women Employed campaign with, as yet, no demonstrable results. In January 1974, Women Employed requested copies of the most current affirmative action plans for the major banks in Chicago. It took eight months for the Treasury to send

the information--after we appealed twice to higher authorities. Also, in April, Women Employed requested that compliance reviews be conducted at the seven major Loop (downtown) banks. After much pressure, Treasury finally scheduled the reviews for November 1974.

These reviews proved totally inadequate. Eight compliance officers spent only four days examining four major banks with over 10,000 female employees. The other three banks were not dealt with at this time. In February 1975, the Treasury Department informed us that Treasury had accepted affirmative action plans of four banks without answering Women Employed charges.

Women Employed appealed to the Office of Federal Contract Compliance, requesting that they assert jurisdiction. In the spring of 1975, OFCC rejected three of the Treasury-approved affirmative action plans. In June, seven months after the original reviews, Women Employed met with the regional Treasury officials and Alexander White, the Regional Director of the Department of Labor. We requested that show cause notices be issued within thirty days in cases where fully acceptable plans could not be produced by the banks. Although the Treasury official conceded this strategy was certainly feasible, by the Fall of 1975, little had changed and no show cause notices had been issued.

Later in the Fall of 1975, Treasury informed Women Employed that three banks' plans had been accepted by both Treasury and the OFCC, although the Compliance Review Report for one bank indicated the plan was deficient. One bank still had not been reviewed and Treasury had been taken off the review of one bank. The OFCC stepped in to do an affected class study of that bank.

By February 1976, reviews were still being conducted for banks with inadequate affirmative action plans. Two banks finally had plans containing specific goals and programs for dealing with sex and race discrimination. As far as we know, two banks finally have approved 1976 affirmative action plans. In May, the Washington office of the Office of Federal Contract Compliance Programs established a "high impact task force" to examine the banks' affirmative action plans; and Women Employed was assured that settlements would be reached in the next four months.

The experiences Women Employed has had with the compliance agencies led directly to Women Employed efforts to force the Department of Labor's OFCCP to take greater initiative in insuring that affirmative action requirements are enforced. Women Employed launched a campaign in November 1974 to force the Regional Director of the Department of Labor to fulfill his responsibility for enforcement efforts in the region. Numerous meetings, hearings, and information sessions were held. This culminated in April 1976 with Washington OFCCP officials flying to Chicago to negotiate with Women Employed regarding enforcement procedures and the role of the OFCCP.

At the same time, Women Employed is now focusing attention on the efforts to dismantle affirmative action requirements. Currently the guidelines are being reviewed in Washington with proposed revisions scheduled to come out this summer. We are concerned that any new revisions not water down affirmative action requirements. We know that a special Higher Education Advisory Committee is working on concrete measures to exempt universities from some of the existing requirements. If universities receive exempt status, other industries and corporations are certain to follow.

The limited successes Women Employed has had in the past three years convince us that affirmative action can work. At the present time, the enforcement process only responds to enormous sustained pressure. Results at CNA, Kraft Foods, and a few of the banks demonstrate that perseverance pays off. However, the huge resources and continued vigilance of public

interest groups should not be necessary just to force the agencies to carry out their responsibilities.

Unquestionably, affirmative action is necessary to remedy past discrimination and discriminatory practices which continue to exist. The Women Employed program for 1976 includes continuing to document discrimination by employers and seeking enforcement of the law by government agencies. At the same time, it is becoming increasingly apparent that we must also take action to preserve the hard fought gains we have made, and prevent the corporations from dismantling affirmative action requirements.

May 28, 1976

APPENDIX III

November 9, 1976

Mr. Lawrence Lorber
Director, OFCCP
New Labor Building
200 Constitution Ave. N.W.
Washington, D.C. 20210

Dear Mr. Lorber:

The following comments are being submitted to you in response to the proposed revisions and redesignation of the regulations in 41 CFR, Parts 60-1 through 60-60, as published in the Federal Register, September 17, 1976.

Recent Department of Labor statistics indicate that sex and race discrimination are widespread in this country. The facts show that the vast majority of women and minorities still face unequal pay, occupational segregation and dead-end jobs. The facts show that the economic status of women workers is actually deteriorating. In 1974, the median income of women was 57% of the median wage of men--a decrease from nearly 64% in 1955.

These facts demonstrate the need for concerted action to eliminate discrimination. Executive Order 11246, issued in 1965 and amended in 1967, provides for such action. Furthermore, the Executive Order requires federal contractors not only to eliminate employment discrimination, but also to take affirmative action to ensure equal opportunity.

At least 250,000 companies are recipients of government contracts. In fiscal 1974, non-construction contracts alone amounted to over $50 billion. Fully one third of the labor force is dependent on federal procurement expenditures for their jobs. The potential impact of the Executive Order is obviously enormous.

These proposed revisions should be considered in light of the extensive criticism of the OFCCP which has occurred over the last 10 years because of the failure to utilize the enforcement apparatus created to implement the Executive Order. With the continued existence of widespread discrimination, enforcement mechanisms are clearly the key to bringing about equal opportunity. Thus, the most meaningful action at this time should be a strengthening of regulations, not a dilution of the enforcement apparatus.

It is our belief that these proposed revisions will seriously weaken the entire contract compliance program and, in fact, work contrary to the very intent of the Executive Order. The major criticisms we have are outlined below.

COVERAGE

The regulations are watered down by exempting coverage of employers with less than 100 employees and less than $100,000 in contracts. Furthermore, pre-award reviews would only be conducted for contracts of $10 million or more and if there had been no review in the past 24 months. In both cases, the standards have been set totally arbitrarily. No data base which supports such conclusions has been established. Neither have any impact analyses been provided. In fact, the vast majority of pre-award reviews would be eliminated. The concept of targeting major employers is understandable. This approach, however, does not achieve such a goal. Exempting contracts under $10 million from pre-award review makes no sense, since the impact on systemic discrimination does not depend on the amount of the contract, but rather who holds that contract. For example, it is conceivable that a major employer like General Motors could hold contracts totaling less than $10 million.

At the very least, the size of contracts requiring pre-award review should be established on an industry basis. Obviously, such industries as banking and insurance should be treated differently than defense, for example. Furthermore, if the requirement for writing affirmative action programs is going to be raised to a $100,000 cut-off point, those contracts should be measured on a cumulative basis. That is, each contractor/subcontractor having contracts which, in any 12-month period, total or can reasonably be expected to total $100,000 or more, should be required to develop a written affirmative action program. In addition, pre-award reviews for contracts of $1 million should be conducted in cases where outstanding complaints against such contractors exist.

In Section 60-1.5(b)(1) notions of exemption because of national interest and/or convenience are cited. These terms are entirely too vague and must be explicitly defined.

Contrary to provisions in Section 60-1.6(a), contractors should be required to establish local goals, not opt for nationwide ones. Otherwise, there is no allowance for minority or female differentials which may vary from locality to locality.

Finally, we support the elimination of all previous state and local government exemptions, and believe that utilities should also be covered by these regulations.

CONTENTS OF AFFIRMATIVE ACTION COMPLIANCE PROGRAMS

The elimination of Subpart C of the current regulations containing methods, procedures, and specific techniques for achieving non-discrimination and affirmative action results is a massive and serious deletion. In eliminating this subpart, you have decided that all the basic elements of employment practices like selection procedures, transfer and promotion practices, training programs, etc. (60-2.23 of current regulations), need not be examined or regulated. How can any affirmative action program be meaningful without such analyses? Moreover, deletion of 60-2.24 through 2.26 allows for a minimum of effort in developing and executing affirmative action programs. Why should you cease to direct contractors to utilize all procedures that would result in effective programs?

We oppose the adoption of the testing guidelines issued by the Equal Employment Opportunity Coordinating Council. These, too, represent a watering down effort, and in fact are not supported by the EEOC. We specifically take issue with the provision that validation is unnecessary unless adverse impact is demonstrated.

Finally, Section 60-2.13 is not specific enough to be enforceable in any significant manner. Affirmative action programs should thoroughly and explicitly address establishment of training programs, career paths, transfer mechanisms and complaint procedures.

GOALS AND TIMETABLES

In neither Alternative A nor B is there any relationship between the section regarding development of workforce array, and the way goals and timetables are established. We support the development of a workforce array as proposed, which would then logically lead to an examination of job titles and salary grades demonstrating underutilization, rather than a massive lumping of job groups. Job grouping, in fact, allows the contractor to manipulate statistics. It is much more useful to establish goals and timetables based on deficiencies evidenced from the workforce array.

Alternative A makes no sense in terms of its provisions for monitoring progress. It seems to allow for exemption from review on the basis of demonstrating progress in goal achievement over five years. However, how can progress be demonstrated if there is no provision for regular review? Alternative B, on the other hand, although seemingly providing for more regular review, allows the contractor to choose those areas to be monitored. Goals are based on the contractor's estimate of the results of its recruitment, training, and non-discriminatory practices. This self-regulation has never worked in the past and there is no basis to assume that it can work in the future. In any regulations finally adopted, goals and timetables should not be based on the contractor's perception of good faith. The OFCCP must monitor both the establishment and implementation of goals and timetables. Review should be on an annual basis. Furthermore, contractors should be required to establish and document qualifications for all jobs.

We favor the availability analysis described in Alternative A vs. B, but would argue for an additional factor to be considered: the existence of training institutions capable of training persons in the requisite skills. Meaningful goals and timetables cannot be established unless all relevant factors of availability are taken into account. Why should such a factor be overlooked which certainly has a major impact on determining the workforce a contractor can consider?

We believe that the provision for variations in the methods of developing goals to be derived by industry and contract compliance officials serves as a basic escape-clause for contractors. In arguing for the types of variations outlined in Section 60-8.4(a), the contractor is protected from addressing concerns of its employees or civil rights organizations.

Finally, we agree that a program summary would be useful to monitor progress, but such a report only makes sense if statistics are its basis. In these revisions, there is no description of the contents of the program summary. A comparative statistical

analysis is essential. This could be accomplished by contractors submitting an EEO-1 form that compares the current year to the past one.

FILING COMPLAINTS

The OFCCP should have the responsibility for dealing with class action complaints, and a procedure should be developed to facilitate and encourage such charges. If affirmative action isn't working, the OFCCP is supposed to make it work. In fact, class action complaints against contractors should be made a priority, as agreements reached would have widespread effects.

The explicit provision allowing for referral of OFCCP complaints to EEOC constitutes a violation of civil rights, since the remedies prescribed under the Executive Order (debarment) are not covered under Title VII and the EEOC. Any complaints that are referred and then settled by EEOC should eventually be dealt with by OFCCP again in order to gain full remedies and carry out the intent of the Executive Order.

Finally, we do not favor any type of reliance on internal complaint procedures. However, even the optional one you have proposed should provide for a timeframe in which the employer must operate.

ENFORCEMENT

The crux of enforcement is to be strict and expedient. Elimination of the show-cause notice along with pass-over authority would be acceptable if a stronger enforcement mechanism had replaced them. Instead, an expanded system of due process steps for contractors has been provided. Where is the due process for the employee? Looking at the steps outlined in these regulations, any complainant(s) would understand that the enforcement of the Order involves a process so lengthy as to render it ineffective in addressing complaints. Moreover, the likelihood of invoking sanctions becomes almost nil. Thus, the whole purpose and effect of the current show-cause notice have been negated.

First of all, Part 60-1.6(d), in removing the threat of a possible pass-over, removes any motivation for a contractor to 1)initiate an affirmative action program or 2)implement his affirmative action program because he knows that he has nothing immediately to lose and can, in fact, use the new procedures to continue to avoid implementation. The new regulations provide even more opportunities for hearings, mediation, and delay for the employers in a system already wrought with bureaucratic red tape. After three months of compliance review, a notice of deficiencies may be issued. If this is the case, the contractor has an additional 10 days to request the Director to review the situation and possibly prescribe a hearing regarding the validity of the notice. So there is room for more delay. After this point, three more months pass, during which time conciliation conferences occur, in the hopes that a written agreement will emerge. But, if it does not, there must be a documented request to the Director for the use of sanctions. More time elapses as the Director directs the case to either an administrative proceeding or to the Justice Department. In either case, there are more hearings, more efforts to achieve compliance through mediation and negotiation. If all of the above fails to elicit the desired compliance, then finally sanctions may be invoked. In fact,

these regulations rely on the very moral suasion that has meant failure of the program up until now. Any employer should be elated at such an expanded system of justice. Any employee will be totally discouraged from challenging discrimination on the basis of the Executive Order.

We support the notion of due process, but would argue it should be applied to employees as well as contractors. We would propose enforcement procedures that would result in carrying out the intent of the Executive Order in an expedient and judicial manner. A compliance review with a finding of compliance or notice of deficiencies with subsequent written conciliation agreement should be completed within 90 days. If no conciliation agreement is reached, a show-cause notice to the contractor should be issued directing the contractor to appear at an administrative hearing to be convened within 30 days. The administrative law judge should be chosen on a rotating basis from a pre-determined, published panel of administrative law judges in the OFCCP. The administrative hearing would determine whether or not the contractor's affirmative action program is acceptable. Remedies could be prescribed which include, but are not limited to, back pay, wage adjustments, promotions, and training programs. If the contractor fails to agree to remedies prescribed, the Director would invoke sanctions. Finally, if a contractor appeals the decision in the courts, the Director should bar the contractor from any further contracts until the case is resolved.

PUBLIC ACCOUNTABILITY

Any regulations should make the following provisions explicit:

1) The OFCCP will disclose to the public: contents of written affirmative action programs, including goals and timetables, and any other required reports including but not limited to compliance review reports and statistical reports, except as exempted under the Freedom of Information Act.

2) The OFCCP will furnish complainants with monthly written reports addressing the status of the investigation and planned timetable. The complainant will also be notified of OFCCP findings, remedies being sought and final determination at the first point in time such information is established.

3) Enforcement proceedings will be public including but not limited to notice of deficiencies, issuance of show-cause notices, hearing dates, and conciliation agreements. Specific provision should be made for administrative hearings being open to the public.

4) The OFCCP will compile and publish quarterly reports indicating contractors which have been reviewed within the quarter and those scheduled for review during the upcoming quarter.

CONCLUSIONS AND RECOMMENDATIONS

The stated purpose of these revisions has been to streamline and simplify the contract compliance program. The above criticisms make it clear that such a purpose has not been achieved. Streamlining is accomplished by exempting contractors from the program and deleting essential employment guidelines and programs already proven effective in achieving affirmative action. The language of these revisions remains vague rather

than more specific. Such concepts as good faith and reasonability still shape the regulations. Finally, it is extremely disturbing that the notion of non-discrimination has totally supplanted the more meaningful concept of equal opportunity. Such an ommission clearly undermines the very intent of the Executive Order.

For all of the above reasons, Women Employed is calling for the immediate withdrawal of the proposed revisions.

Sincerely,

Jean Hoffenkamp

Jean Hoffenkamp
Chairwoman

The stated purpose of the proposed revisions has been to clarify and simplify the contract compliance program. It is quite easy to demonstrate that such a purpose has not been achieved. Streamlining is accomplished by exempting contractors from the program and deleting essential employment guidelines and measures already proven effective in achieving affirmative action. The language of these revisions remains vague rather than more specific. Such concepts as good faith and reasonability still shape the regulations.

Today, Women Employed calls attention to some of the more blatant examples of sections and concepts which demand clarification before any new regulations can be implemented.

With regard to coverage, I pose the following questions:

What exactly is the effect of raising the required workforce number from 50 to 100 employees and the amount of contracts from $50,000 to $100,000 before a written affirmative action plan must be filed?

In terms of pre-award compliance, what are the standards to be used in determining whether a contractor is making "good faith efforts"? How is this concept any clearer than the current regulations?

Why is the proposed $10 million threshold for pre-award review a more realistic figure than any lower amount? Isn't there a tremendous disparity between the previous $1 million figure and the proposed $10 million that cannot be explained by inflation and which, furthermore eliminates from review many contractors whose employment and promotion practices significantly affect women and minorities?

What is the justification for limiting coverage in terms of written affirmative action plans and pre-award review to non-construction contractors, omitting the construction industry?

In Section 60-1.5(b)(1), notions of exemption because of national interest and/or convenience clarify nothing, but do give the OFCCP broad freedom to use its judgment. Where are the specific, simplified definitions?

Section 60-1.6(a) allows contractors to forego local goals for establishments employing less than 100 persons. Doesn't that totally ignore the variations in the availability of women and minorities which occur from locality to locality? How will the relevant labor area be defined on a nationwide basis?

Section 60-1.6(b) states that within 120 days of commencement of a contract, a written affirmative action plan must be developed. If contracts are not continuous, can the contractor keep waiting another 120 days?

What does the reporting form mentioned in Section 60-1.9(a) look like? How can we comment without a description?

Why have small contractors been completely removed even from reporting requirements?

Why is certification of non-segregated facilities eliminated?

Concerning the contents of affirmative action plans, I ask:

Why has the government abandoned the very goal set forth in the Executive Order---that of achieving equal employment opportunity---and replaced it wholly with a focus on non-discrimination?

Section 60-2.13 is not specific enough to be enforceable in any significant manner. What are the specific guidelines regarding training programs, career paths, transfer mechanisms, or complaint procedures? How can clarity and consistency result if there is no standardization or yardstick for measurement prescribed? Where is the clear-cut government guidance that would create a program which is meaningful, easily evaluated, and effectively monitored?

Which are the industries which fall into the category of being entitled to develop special formats for presentation of data and completion of conciliation agreements? How will this determination be made? Is there room for input by affected employees?

These proposed revisions, instead of setting forth clear-cut criteria for setting goals and timetables, adopt an attitude that contractors should be granted great latitude in tailoring their needs according to their perceptions of good faith. The alternatives proposed are totally confusing. I therefore raise the following issues:

What is the logical and statistical relationship between the workforce array and the manner in which goals and timetables are derived? What are the specific parameters for job grouping? That is, what constitutes "similar characteristics"?

Why are job groups based on similar content, wage rate, or career development in contrast to the current stipulation of content, wage rate, and career development? Doesn't this just allow for statistical lumping that could disguise underutilization?

What is the rationale for excluding the group of Caucasian women from the category of incumbents which must be included in the internal workforce array?

Disparities are to be identified and goals set for job groups in which minorities and women are employed at levels lower than their availability. Why is this not minorities or women?

There are two serious deletions from availability factors to be considered---these are the amount of unemployment and the existence of training institutions capable of training in skills required by the contractor. Where is the analysis which has led to their omission?

Are there limitations placed on timetables for achieving goals? May contractors set goals beyond five years?

What type of monitoring will actually occur? Although it is not made clear in the text of the regulations, the summary explains that in Alternative A contractors with an approved multi-year affirmative action plan would be reviewed only in "exceptional circumstances". What are these circumstances? Is is possible for a contractor to go unmonitored for five years?

Is the intent in Alternative B to enable contractors to avoid setting goals if, in his estimation, they are unwarranted. Such interpretation is entirely conceivable.

Does the OFCCP intend to exempt a contractor from affirmative action requirements in any area not designated by the contractor as a focus job group? That certainly is the effect.

What does the program summary contain? How can we assess it for purposes of comment?

On the subject of filing complaints:

Notwithstanding that an internal complaint procedure is naive and will be non-functional, are employers being given any time-frame in which to address complaints?

What is the rationale for cutting in half the time in which a complaint may be filed with OFCCP when an employee has elected first to exhaust internal review procedures? Why are these complainants being put at a disadvantage?

If OFCCP refers complaints to EEOC, are Executive Order remedies ever going to be addressed, or will full recourse be denied?

In the vital area of enforcement, please clarify:

What consitutes good faith? Why is reliance on the very vague and unsuccessful process of moral suasion not being replaced with strict and expedient enforcement mechanisms?

Does the use of the word "may" throughout Section 60-1.25(a)(2) signify that the OFCCP or agency, at its own discretion, may decide not to institute proceedings even after an investigation

proves that the Order and regulations have been violated? What are the ultimate time limitations in exhausting all enforcement procedures? How long does a contractor have to get in compliance?

Doesn't the concept of "issues of law or fact" represent loose legal jargon versus the clarity supposedly being sought, since issues of fact can be found in any dispute?

Where is the due process for employees? Is a contractor considered awardable after a notice of deficiencies has been issued?

Who conducts the hearing? Is it the compliance agency or the Solicitor of Labor?

How will the administrative law judge be chosen? Will he/she be hand-picked or selected on a rotating basis? Will he/she be from the OFCCP or the Solicitor's office?

What is the priority compliance review selection system referred to?

An affirmative action plan is deemed accepted by the government at the time the appropriate compliance agency accepts the plan unless within 45 days the OFCCP has disapproved. How does this deal with the problem of clearly unacceptable plans which the OFCCP fails to disapprove because the 45 days elapse before OFCCP finishes review?

Do unions have the same due process protection afforded contractors before the Director notifies government agencies of union practices deemed in violation of the civil rights laws and/or regulations?

Sections 60-5.7 and 5.8 appear twice in the regulations. Section 60-5.7 is the same in each instance, but 60-5.8 differs. It is impossible to ascertain which is intended or if they are alternatives upon which to comment.

Finally, public accountability must be addressed:

Exactly which written reports will be made public--the contents of affirmative action plans including goals and timetables? compliance review reports? statistical reports? etc.

How will OFCCP account to a complainant with regard to the status of investigation, the findings, and the remedies being sought?

Are enforcement proceedings public--in particular, notice of deficiencies, hearings, and conciliation agreements?

Which OFCCP administrative reports will be public? What are OFCCP's procedures for monitoring the compliance agencies? Are they more specific than time to time evaluation by the Director as noted in these regulations?

At this time, Women Employed formally requests that you answer each of these questions in writing. There are two reasons for this. First, all of these points obviously need clarification. Second, we are certain that once you have actually attempted to respond to these issues, you will understand and agree with our position that these revisions must be withdrawn.

STATEMENT BY WOMEN EMPLOYED AT PUBLIC HEARINGS ON PROPOSED FEDERAL CONTRACTOR EQUAL EMPLOYMENT OPPORTUNITY REGULATIONS HELD IN CHICAGO, ILL.

DECEMBER 13, 1976

My name is Jan LaBrie. As an officer of Women Employed, I have seen first-hand the pervasive discriminatory employment practices by major employers of women and minorities. Unfortunately, I have also seen the government condone these discriminatory practices through their lax enforcement of affirmative action.

The problem with affirmative action stems, not from poor regulations, but rather from the lack of strict and expedient enforcement of those regulations. The OFCCP and its designated compliance agencies have, in the past, been criticized for not using the enforcement/sanction mechanisms available under the existing regulations and for poor administration of the compliance program (i.e. understaffing, underbudgeting, and insufficient guidance by OFCCP). Rather than addressing those criticisms, through stricter enforcement of regulations, increased staffing, better resource allocation, clearer direction from OFCCP, the Department of Labor has chosen to tailor the revised regulations to more accurately reflect its minimal federal contract compliance posture. Obviously, by limiting both its monitoring and enforcement responsibilities, OFCCP's burden becomes less onerous, but in the process equal employment will become just another pretty phrase.

Women Employed's experiences with affirmative action are a clear indication that enforcement of the Executive Order is the crux of the matter.

In 1973 Women Employed went to the Department of Agriculture regarding discrimination at Kraft Foods and discovered that Kraft's affirmative action plan that promised to promote one woman had been accepted by Agriculture. We went to the Social Security Administration in 1974 regarding the insurance

industry and CNA Insurance in particular. We were informed that CNA had never had an approved plan even though they held millions of dollars in government contracts. We went to the Treasury Department with discrimination charges against Chicago's seven largest banks. We learned that these banks had not even been reviewed since 1971.

With this information, WE initiated actions to deal with the laxity in the enforcement of affirmative action requirements. After 18 months of pressure by WE, the Department of Agriculture finally issued a show-cause notice against Kraft Foods. Kraft then established specific goals and timetables for promoting women and minorities. A year-long WE campaign resulted in the Social Security Administration requiring CNA to pay half a million dollars to women who had been discriminated against.

The Treasury Department was slower to move. They fell for the banks' stalling tactics and instead of issuing show-cause notices allowed the banks to continue discriminating while negotiating on and on. After two years of pressure by WE, including testimony before the House Education and Labor Committee, Subcommittee on Equal Opportunity, participation in a GAO study of the Treasury Department, intervention by Illinois Congressmen, demonstrations, meetings, hearings, and leaflets, the OFCCP finally intervened with Treasury. In May 1976 the OFCCP agreed to undertake a "high impact investigation" of the banking industry with a specific focus on WE charges against Harris Bank. Now that investigation is also being held up.

While pursuing each of these individual campaigns, WE also focused attention on the overall issue of enforcement of Executive Order 11246, as amended. In 1974 WE launched a campaign to force the Regional Director of the Department of Labor to fulfill his responsibility for enforcement efforts in the Region. We also confronted various agencies responsible for corporate affirmative action plans. We heard the same story over and over.

The agencies claimed they had neither the staff nor the funds to adequately carry out their responsibilities. The Regional Director claimed he had neither the power nor the responsibility for ensuring strict enforcement of the affirmative action regulations.

Women Employed has also come across many examples of inadequate staffing. When Women Employed pressured the Treasury Dept. to investigate five Chicago Loop banks, Treasury sent only eight people and gave them four days to complete the task. As a result, the investigators did little more than confer with bank management behind closed doors.

The General Services Administration allotted one investigator to cover the entire corporate headquarters of Sears, Roebuck & Co.

No wonder corporations scoffed at the regulations for ensuring women and minorities equal opportunity. Employers believed that they only had to submit a few pieces, or in some cases reams, of paper saying as little as possible about their employment practices to receive federal contracts. Even in the unlikely event they would be investigated, they were certain they could stall the process of enforcement indefinitely or thwart the investigation entirely. Not until groups such as Women Employed began pressuring for strict enforcement did the government or the corporations take affirmative action seriously.

Our employers' response to increased pressure on them to obey the laws has been to mount their own pressure campaign to dismantle affirmative action altogether. The OFCCP has responded to corporate pressure by producing revised regulations that would in effect gut the enforcement apparatus entirely by eliminating any kind of effective monitoring and allow employers with clearly inadequate plans a legal out by providing for endless administrative hearings and delays. This all goes under the guise of relying on "good faith efforts".

Meanwhile, the situation for working women has actually deteriorated. According to the Department of Labor's own statistics, women earned 64% as much as men in 1955, and in 1974 they earned 57% as much.

Rather than weaken enforcement, Women Employed believes that the enforcement regulations should be strengthened. We will not be fooled by one of the oldest political tricks there is--that of putting a law on the books but allowing neither regulations nor funds to enforce it.

In order to insure that federal contractors fulfill their obligations under the Executive Order, Women Employed believes that any rules and regulations must set forth the following minimum provisions not now written into the regulations:

---Each contractor/subcontractor having contracts which, in any 12 month period, total or can reasonably be expected to total $100,000 or more, must develop a written affirmative action plan.

---The size of contracts requiring a pre-award review must be established on an industry basis.

---Pre-award reviews for contracts of $1 million or more must be conducted when there are any outstanding complaints against such contractors.

---Affirmative action plans must thoroughly address establishment of training programs, career paths, transfer mechanisms and complaint procedures.

---Goals and timetables must be established in a uniform manner based on deficiencies evidenced from the underutilization analysis.

---Contractors must establish and document qualifications required for all jobs.

---The OFCCP must monitor establishment and implementation of goals and timetables.

---Complaints regarding patterns and practices must be investigated by the OFCCP.

---All compaintants must be assured of confidentiality.

---A compliance review with a finding of compliance or notice of deficiencies with subsequent written conciliation agreement must be completed within 90 days.

---If no conciliation agreement is reached, a show-cause notice to the contractor must be issued directing the contractor to appear at an administrative hearing to be convened within 30 days.

---An administrative law judge, chosen on a rotating basis from a predetermined, published panel of administrative law judges in the OFCCP must preside.

---If the contractor appeals the decision of the administrative judge in the courts, the Director of the OFCCP must bar the contractor from any further contracts until the case has been resolved.

---The OFCCP must furnish complaintants with monthly written reports addressing the status of the investigation and planned timetable. The complaintant must also be notified of OFCCP findings, remedies being sought and final determination at the first point in time such information is established.

---Enforcement proceedings must be made public including but not limited to notice of deficiencies, issuance of show-cause notices, hearing dates, and conciliation agreements.

---Specific provision must be made for administrative hearings to be open to the public.

---The OFCCP must compile and publish quarterly reports indicating contractors which have been reviewed within the quarter and those scheduled for review during the upcoming quarter.

What affirmative action now needs is more funds, more staff, stricter regulations, and a sincere committment to its enforcement. Our tax dollars provide U.S. corporations with billions of dollars in profits. We now demand that our tax dollars also be used to ensure our employment rights. Therefore, these regulations must be withdrawn.

STATEMENT BY WOMEN EMPLOYED AT PUBLIC HEARINGS ON PROPOSED FEDERAL CONTRACTOR EQUAL EMPLOYMENT OPPORTUNITY REGULATIONS HELD IN CHICAGO, ILL.

DECEMBER 13, 1976

My name is Diane Valletta. I am an officer of Women Employed. I work in the insurance industry, and I helped to establish the Women Employed Insurance Committee in 1973. At the present time, insurance women constitute more than 25% of our total membership. Over the past three years the committee has focused primarily on pressuring the insurance industry to take the affirmative action laws seriously. In some instances we have been successful--some companies have instituted job posting and training programs, and set goals and timetables for hiring and promoting more women and minorities. Our most recent action was filing equal pay charges with the Wage and Hour Division of the Department of Labor against Marsh & McLennan, the world's largest insurance brokerage. Executive Order 11246, as amended, has been our best tool, and its enforcement, we feel, is just now beginning to be felt in the industry. My testimony today deals with what effect affirmative action has had in the insurance industry, and what effect we expect the proposed DOL regulations would have, if promulgated.

Women Employed is not the only group that has examined the effects of affirmative action in the insurance industry. Recently, the Life Office Management Association (LOMA), an association of life insurance companies, published a study entitled "Affirmative Action Activity Within the Life Insurance Industry in the United States". The study was based on data obtained from 195 life insurance companies in the United States. One significant conclusion drawn from the data was, and I quote from page 18 of the study:

> "The perceived importance of affirmative action was found to vary by company size and between government contractors and noncontractors. Larger companies and government contractors are generally more seriously committed to providing equal employment opportunities.

> These companies may be more aware of their social responsibilities and they may feel more vulnerable in the event of successful class action law suits."

And, indeed, they should feel more vulnerable. Some of the largest companies within the insurance industry who happen also to hold the fattest government contracts have been dragging their corporate heels over the past several years. Certainly, they pay lip service to affirmative action, and even hire equal opportunity specialists, but the situation for a majority of their female and minority employees hasn't changed. We remain stuck in the lowest-paying, dead-end jobs. At Prudential Insurance Company, for example, in 1974 over 80% of their male employees held jobs classified as technical and above. Less than 25% of the women were in those jobs. According to Blue Cross/Blue Shield figures, only 10% of their agents were women in 1973. After a year of "affirmative action" only 8.6% of the agents were women--a decrease of 1.4%. In the Officials/Managers category, the larger companies continue to score deplorably low. Allstate, for example, had a mere 9% women in that category in 1974. And last year, CNA Insurance, a company that had held millions of dollars in Medicare contracts, went to court to prevent the release of their affirmative action plan to the public. We can only wonder at the quality of an affirmative action plan that cannot withstand the light of day.

Notwithstanding this poor showing, it would appear that the government contractors are "more seriously committed" to equal opportunity than the non-contractors. Why? The LOMA study has this to say:

> "Government contractors, which at the time of the survey were mostly larger companies, are required to develop affirmative action programs which are on file with the Office of Federal Contract Compliance Programs. This fact and periodic audits of these programs by the OFCCP serve to increase both their commitment and effectiveness."

The LOMA study goes on to say:

> "In general, those companies with less than 250 employees...do not consider affirmative action as

> important as do the larger companies. This may be because they do not have as much pressure from government agencies or, as the [organizations] contend, they have adequate numbers of minorities and women in management."

What LOMA is saying is that the smaller companies are even less concerned with equal employment opportunity than the larger insurance companies, and that this could be due to one of two reasons--either they have not been forced to take affirmative action seriously, or they don't have to worry about affirmative action because equality has already been achieved at their companies. Let's look more closely at this latter possibility.

In 1974, the Illinois Laws Study Commission, in preparation for public hearings on women in the insurance industry, sent out questionnaires regarding employment practices to a number of large and small Illinois insurance companies. The responses to the questionnaire depicted an overwhelming failure by the industry to provide equal opportunity for women employees. Here's how the equal opportunity picture looked for the smaller companies:

--At US Life Credit, Globe Life, North American Life, and Mutual Trust Life over 80% of the men are in job classifications of technical and above, while fewer than 20% of the women have these jobs. At US life, in fact, only 1% of the women are in the upper classifications compared with 95% of the men.

--These same companies all have less than 20% women in the Officials and Managers category. In the clerical category, however, women comprise over 90% of the employees.

--The smaller companies pay 70% of their male employees $10,000 or more while 80% of the female employees earn under $10,000. US Life pays all of its male employees over $10,000 while offering less than that to 98% of the female employees.

Adequate numbers of women and minorities in management? The companies' own statistics show this to be a fabrication. Even LOMA raises questions about why these companies aren't promoting women and minorities. As the study points out:

> "It is also possible that there are greater numbers of qualified female and minority applicants for higher-level jobs than the [companies] realize. The [companies] perceptions of this situation may be influenced by an unrealistic assessment of position requirements or by a reluctance to advance females and minority-group members to the highest levels of the organization."

In other words, these companies discriminate against women and minorities.

The LOMA report made one other interesting observation which was that using very specific measures like establishing staffing goals by department, and maintaining lists of promotable individuals, resulted in the most effective affirmative action strategies.

What all this proves is that insurance companies which are monitored in a government contract compliance program with specific affirmative action programs are the most likely to take affirmative action seriously. Those companies that escape the enforcement process will continue to ignore their equal opportunity responsibilities.

Strong enforcement and explicit affirmative action guidelines are clearly two necessary ingredients for achieving affirmative action in the insurance industry. The industry itself has supplied such evidence.

Unfortunately, the proposed regulations before us today contain neither of these requisites. The enforcement process has become so protracted as to permit government contractors the opportunity to avoid compliance. The sanctions for non-compliance have been watered-down to the force and effect of a moral deterrent. More emphasis is to be placed on conciliation and "good faith" efforts. But we have shown here that enforcement of the laws, and not good faith, is what produces results.

Furthermore, the proposed regulations would eliminate essential employment guidelines already proven effective in achieving affirmative action--such things as keeping lists of promotable women and minorities or instituting job posting systems.

Finally, these proposed regulations, in exempting smaller contractors from coverage, will encourage and give rise to nonchalant attitudes toward affirmative action already demonstrated by smaller companies cited in the aforementioned study.

The insurance industry must be very pleased with these regulations. The smaller companies will be able to continue denying women and minorities access to the better-paying, more responsible positions. The larger companies will be looking forward to spending less money on their equal opportunity specialists and their slick public relations. In fact, we wouldn't be surprised if the insurance industry had a hand in developing these regulations. After all, National Health Insurance is on the horizon and the insurance companies bidding for federal contracts would find it easier competing for that plum.

The proposed regulations will, we believe, have a profound negative impact for women and minorities in the insurance industry. Without strong enforcement procedures and specific employment guidelines, they are merely a sham. Women Employed demands that the regulations be immediately withdrawn.

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STATEMENT BY WOMEN EMPLOYED AT PUBLIC HEARINGS ON PROPOSED FEDERAL CONTRACTOR EQUAL EMPLOYMENT OPPORTUNITY REGULATIONS HELD IN CHICAGO, ILL.

DECEMBER 13, 1976

My name is Jean Hoffenkamp. I am the chairwoman of Women Employed, an organization of over 1000 working women in Chicago's downtown area. Our members work in insurance companies, banks, retail stores, law offices, for the government and in many types of corporations. Women Employed has a two-fold purpose: 1) dealing with employers' discriminatory practices through direct negotiation and, when necessary, by filing charges with government agencies; and 2) monitoring government enforcement activities to ensure that working women's rights are protected. Over the past 3 1/2 years Women Employed has been very active in the affirmative action arena--in the enforcement of Executive Order 11246, as amended. We have exposed the discriminatory practices of numerous employers. We have worked with nearly every enforcement

agency that deals with the Executive Order--the contract compliance offices of the Treasury Department, Social Security Administration, General Services Administration, Energy and Research Development Administration, Department of Defense, and the Department of Agriculture. We have seen many investigations bungled, and we have seen others that have resulted in significant improvements for women and minorities. Our experiences have made us well aware of the strengths and weaknesses of current Department of Labor regulations on affirmative action.

Women Employed has already submitted a rather lengthy critique of the proposed regulations. For that reason, I will only summarize our concerns briefly.

The proposed regulations clearly demonstrate to us a blatant lack of commitment to the stated goals of the Executive Order--the elimination of employment discrimination and the promotion of equal employment opportunity for all persons. These revisions were written to serve and protect government contractors rather than the women and minorities they employ. Our main areas of criticism are six: 1) numerous contractors will now escape coverage under the regulations; 2) specific methods, procedures, and techniques already proven effective in achieving affirmative action, like training programs and job posting, have been dropped from the language of the regulations; 3) goals and timetables, the heart of any affirmative action plan, have been rendered nearly meaningless; 4) complaints may be referred to the EEOC where they will die of neglect; 5) the enforcement procedure has become a mockery with provisions for lengthy conciliation and negotiations, hearings and mediation and reliance on good faith efforts. In the end, the contractor might get a slap on his corporate hands, but he certainly needn't worry about losing any of his government contracts under these new regulations. Lastly, these new procedures to deprive women and minorities of their rights are to be carried out without any assurances of public scrutiny.

The stated purpose of these revisions has been to streamline and simplify the contract compliance program. That has been achieved. The employment rights of women and minorities have been streamlined nearly out of existence. And exempting hundreds of employers will surely simplify the work of the OFCCP.

These regulations are a sham and we call for their immediate withdrawal. Not only do the contents of the proposed regulations merit their withdrawal, but the process used to arrive at them demands it.

Today's hearing is the culmination of a six month pressure campaign to bring these regulations out in the open. We are here only because civil rights and women's groups have forced the Department of Labor to give us input. Since last spring Women Employed, along with numerous other groups, repeatedly asked for pre-publication hearings and a 90-day comment period, as well as an impact study of the proposed regulations. None of our requests were considered. And only after a public outcry were today's hearings even scheduled.

For the record, I would like to describe the history of our involvement with these regulations.

Women Employed first learned of the Department of Labor intentions to revise the regulations in April when an OFCCP official happened to mention it in passing at a meeting we were having to discuss other OFCCP matters. We were assured that only minor changes were being contemplated in order to simplify and make the regulations more consistent. We were told our input would be welcome only after any changes were published in the Federal Register.

At the same time we learned that the Higher Education Advisory Committee, set up by the Department of Labor, was drawing up recommendations for how the regulations should be revised. It has become apparent that this advisory committee, made up primarily of university administrators, was set up to figure out how to make life easier for government contractors, particularly universities.

The proposals drawn up by the committee certainly reflect this motive. On goals and timetables the Advisory Committee recommended eliminating the concept of "parity", and limiting the role of goals and timetables in enforcement proceedings. It is interesting to note that Alternative B in the proposed regulations came out of the Advisory Committee.

This committee was also quite concerned with the pre-award compliance process, and came out with several position papers on the subject. And again we see that universities, which have come under increasing fire for their discriminatory employment practices, are major beneficiaries of the new regulations. These institutions would now be virtually eliminated from pre-award certification requirements.

It is quite clear that this Advisory Committee, representing management's point of view, benefitted from their early, direct input in the revision process. No comparable group of women's and civil rights organizations was ever established. It is not surprising, therefore, that civil rights and women's groups are hard-pressed to find anything in the proposed regulations that reflect changes we think should be made in the contract compliance program.

On June 28, 1976, the Women Employed Board met with Mr. Lawrence Lorber in Chicago, and informed him of our concerns with the contract compliance program, and asked for input in the drafting process. Specifically we requested a copy of the drafted revisions and pre-publication hearings. Mr. Lorber committed himself to sending us the draft sometime in July, and said that in all probability he would hold regional meetings to get input from concerned groups.

Lorber also stated that the position papers of the Higher Education Advisory Committee did not at all reflect his views on the revisions. He only wanted to clarify and simplify. He was sure that we would approve of the revisions. His timeline for

publication, he told us, was late August or early September.

In July W.E. received a rather thick document which we soon discovered was not a draft of the revisions but were various staff working papers on the subject. These were of little use in discerning the changes that were being formulated--particularly since the sections on 'enforcement' and 'who can file charges' were "inadvertently omitted" from the document.

During the first week of August, a W.E. representative met with Mr. Lorber in Washington again requesting the draft and pointing out that two sections in the staff working papers had been omitted. Our desire for public hearings was reiterated once again at that meeting. Mr. Lorber stated that pre-publication hearings were unnecessary, but would be held after publication. He again promised us a draft within two days.

Finally, after two weeks a draft arrived which confirmed all of our worst fears about these regulations. It was not until after an irate phone call from Lorber that we realized someone in the Department of Labor had leaked us the draft and that Mr. Lorber, in his own words, had no intention of ever sending it to us!

During this time, Women Employed contacted numerous civil rights organizations and women's groups to ascertain their knowledge of the revisions. None of them seemed to know anything about such revisions, and they too began requesting drafts, hearings, and adequate comment period. Most groups never did receive a draft and those that finally did, received it only after intense pressure on Mr. Lorber to release it. In the final two weeks before publication Mr. Lorber finally began contacting some civil rights and women's groups for meetings. While Mr. Lorber wished to give the impression of consulting and coordinating with civil rights and women's groups, indeed any such discussion, held either at the very end or after the drafting process, with little or no notice given, certainly provided no real opportunity for the

meaningful dialogue necessary to ensure an adequate exchange of information. We would argue that such meetings were token gestures.

At this same time, enforcement agency people began calling us to request a draft of the revisions. It is unbelievable that the agencies that carry out the day to day enforcement work were not even consulted about these revisions.

When the regulations were finally published only a 60-day comment period was allowed even though civil rights and women's groups as well as numerous Congressional leaders, had requested a 90-day period. Furthermore, no public hearings were scheduled.

Lorber's rush to publish these regulations, in an election year, and his attempts at keeping civil rights and women's groups in the dark lead us to question the real motivation behind these revisions.

Clearly, this scenario of events indicates that Lorber's overriding consideration is his timetable for publishing and implementing these regulations. Department of Labor officials are still attempting to promulgate new regulations in a record amount of time and during this transition period.

If Mr. Lorber was truly interested in input from all groups, he would have made his draft available and met with the various groups expressing concern with the contract compliance program at the beginning of the drafting process.

We believe that the reason this has all been railroaded through is that Mr. Lorber is being influenced by the business community and corporate lobbyists. Our employers had no problem getting copies of the draft, and it is clear that Mr. Lorber is more concerned with being accountable to those interests than to anyone else.

Mr. Jack M. Sable, head of a New York consulting firm, stated at an American Banker's Association Conference that drafts of the regulations were well circulated among various industry groups.

In September, Women Employed also learned of a private group called the Equal Employment Advisory Council located at 1747 Pennsylvania Ave. This is an association of EEO specialists representing major companies, and trade associations like the National Association of Manufacturers. In existence since the beginning of the year, the group is charged with making sure that industry gets a voice in all EEO matters. Mr. Kenneth McGuiness who is General Counsel for the group spoke to one of our members on the phone, unaware, of course, of whom she was. He told her that OFCCP made the draft available to them before publication in addition to meeting with members of the Council to discuss the revisions. He said this was an important refining process since it would be much more difficult to change the regulations after publication. He, in fact, explained that corporate input was really most satisfactory in this instance--that they would only be happier if they had actually written the regulations themselves.

The Department of Labor obviously felt very free to communicate with industry, although women and minorities were afforded inferior treatment.

Corporate boasting about their input is not the only basis for our belief that the proposed regulations have been written to benefit our employers.

The employers themselves have indicated their pleasure with these revisions--their revisions.

The American Banker's Association, in written comments, said that it supported the thrust of the new rules. Their letter states in part, "The purpose of the Federal Contractor affirmative action plan is to seek voluntary action by employers... the degree of voluntary compliance the office can achieve is, we believe, directly related to the degree to which it exercises the role of a mediator rather than that of a prosecutor." The ABA must surely be delighted with the extensive amount of time provided for negotiations and conciliation between the government and contractors in the new regulations.

Another management group, the U.S. Chamber of Commerce, in testimony before Congressman Augustus Hawkin's Subcommittee on Equal Opportunities, testified that they felt the show-cause process should be dropped; that the number of reviews of contractors should be cut back; that they favored referral of complaints to the EEOC; that they opposed class-action filings; and, in fact, they thought that OFCCP should merely be an administrative office. The resulting revisions lead us to conclude that the Department of Labor does, in fact, endorse their views.

Major trade associations and corporations are in favor of these regulations. Every major civil rights and women's organization opposes these regulations. The lines are clearly drawn and equal employment opportunity for women and minorities hangs in the balance.

The Department of Labor has not yet asked civil rights and women's groups where DOL affirmative action efforts have succeeded or failed. No one has asked us what investigative procedures we think work well or what types of affirmative action plans have brought good results. No impact study has been forthcoming out of the OFCCP even though civil rights and women's groups requested one over a month ago.

If the OFCCP would make a concerted effort to consult with representatives of civil rights and women's organizations, as well as federal contract compliance personnel, it is our belief that we would develop regulations which will lead to a strengthening of Executive Order enforcement. The proposed regulations before us indicate that OFCCP has not made that effort as yet. Now if, as Department of Labor officials contend, they are really concerned with formulating more effective regulations, they will withdraw these proposed revisions and begin the drafting process again--this time including civil rights and women's organizations.

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Statement prepared for the Office of Federal Contract Compliance Programs hearings concerning proposed revisions and redesignation of the affirmative action regulations in 41 CFR Parts 60-1 through 60-60 to be presented at the OFCCP hearings in Chicago on December 13, 1976.

I am Sally March, a student with the urban studies program of the Associated Colleges of the Midwest. Recently, I have had the opportunity to work with Women Employed here in Chicago and, consequently, to learn a great deal more about something which has long been of the utmost interest to me -- affirmative action. I am very pleased to be able to address this issue today.

The Office of Federal Contract Compliance Programs is, in essence, asking people to believe that its revisions of Executive Order 11246, as amended, will cut bureaucratic red tape, strengthen enforcement of affirmative action regulations, and finally realize the stated goals of the order, i.e. the elimination of employment discrimination and the promotion of equal employment opportunity for all persons. I refuse to accept any of this.

First of all, let's look at the facts. Does the exemption of employers with less than 100 employees and less than $100,000 in contracts help accomplish the elimination of employment discrimination? Does the OFCCP believe that no major employer may possibly have a federal contract of less than $100,000? Does the exemption of employers with contracts of less than $10 million from pre-award reviews promote equal employment opportunity for all persons? Is the replacement of show cause notices with good faith efforts worth more than a laugh?

How did the OFCCP arrive at these figures anyway? These changes were made totally arbitrarily. The OFCCP has never presented the only acceptable basis for such changes which is an analysis of the present data and of the anticipated impact of these alterations.

Secondly, what basis does one have for accepting the OFCCP's position? In other words, how credible is an agency with such a notoriously poor enforcement history? I suspect that the OFCCP, having been unable in the past to live up to its legal responsibilities, is attempting to reduce its obligations.

In 1975, the General Accounting Office issued a report entitled, "The Equal Employment Opportunity Program for Federal Nonconstruction Contractors Can Be Improved". The GAO found that:

(1) Nonconstruction contractors, who in fiscal year 1974 were awarded over $50 billion in Federal contracts, accounted for 25 million employees or 80% of the employees covered by the Order. Yet until mid 1974, compliance agencies spent the majority of their time reviewing construction contracts. It has now been two years since the compliance agencies realized where their time and effort should be concentrated. Is that sufficient time to conclude that the present regulations cannot be effective?

(2) OFFCP did not have a complete list of all government contractors. It was unable to identify, as were the other compliance agencies, all of the contractors for which it was responsible. The proposed regulations will drastically cut the number of contractors covered, but surely the OFCCP can devise some better way of sorting out this befuddling mass.

(3) OFCCP did not yet have a fully operational system for measuring the progress contractors have (or have not) made in improving employment for minorities and

women. A majority of the compliance agencies reviewed less than 1/5 of the contractor facilities for which they were responsible. When the GAO conducted reviews, it found a large percentage of approved affirmative action plans which failed to meet Department standards, indicating a lax pre-award clearance policy. In eliminating the current regulations containing methods, procedures, and specific techniques for achieving affirmative action, OFCCP has made the standards meet the affirmative action plans and not vice versa.

(4) No effective measures had been taken when contractors were found to be in noncompliance with the Order. GAO reported that "compliance agencies are reluctant to initiate enforcement action when contractors are not in compliance with the Executive Order; instead, they rely on extended conciliations and negotiations with contractors to achieve compliance. In some instances, conciliation exceeded the time limits allowed by the Department." By eliminating the 30 day notice to show good cause for noncompliance and adding 180 days to the conciliatory period preceeding a hearing, the OFCCP has only legitimized its extended conciliation attempts. The sad fact is that conciliation usually means compromise, but women and minorities need stronger enforcement mechanisms rather than the bits and pieces they usually end up with after the conciliation process.

(5) OFCCP was incaple of performing its function of coordinating and providing leadership for the compliance program. Communication and coordination between the Department of Labor, the various compliance agencies, and the EEOC was found to be totally inadequate. The result of all of this has been misunderstandings, duplications of activities, and an inefficient and ineffective compliance enforcement program. Now the OFCCP intends to close the communication gap by referring the prosecution of complaints filed with it to the EEOC. The complainant may be deprived of full retribution since the EEOC lacks the extensive enforcement powers of the OFCCP and I doubt that this is the kind of communication that the GAO would have suggested.

These findings in the GAO report paint a pretty sad picture of the OFCCP's ability to handle its responsibilities. Now the Agency is asserting that in order to do more, less enforcement responsibility must be required of it. The question is why should an agency which has failed in the past to live up to its legal responsibilities be permitted to use that failure as its rationale for reducing its obligations? Requiring less to do more is totally unacceptable. Therefore, I would argue for immediate withdrawal of these proposed regulations. What we need are regulations that will truly address the enforcement problems raised by the GAO.

APPENDIX IV

Federal Contract Compliance Program
Budget Authority
FY1978

| Agency | Planned Compliance Reviews | Budget Authority | Cost per Review | Person Years |
|---|---|---|---|---|
| Commerce | 227 | $ 505,000 | $2,225 | 20.5 |
| DOD | 7,527 | 12,389,000 | 1,646 | 606 |
| EPA | 1,655 | 1,077,000 | 651 | 50 |
| ERDA | 1,368 | 4,033,000 | 2,948 | 152 |
| GSA | 4,805 | 5,024,000 | 1,046 | 218 |
| HEW | 400 | 2,856,000 | 7,140 | 102 |
| HUD | 4,259 | 5,251,000 | 1,233 | 202 |
| Interior | 620 | 1,906,000 | 3,074 | 70 |
| SBA | 625 | 364,000 | 582 | 14 |
| Treasury | 575 | 1,418,000 | 2,466 | 43 |
| DOT | 2,830 | 2,511,000 | 887 | 94 |

Source:OFCCP/OMB

APPENDIX V

ACHIEVING EQUAL OPPORTUNITY THROUGH AFFIRMATIVE ACTION:
EFFECTIVE IMPLEMENTATION OF EXECUTIVE ORDER 11246 AS AMENDED

Recent Department of Labor statistics indicate that sex and race discrimination are widespread in this country. The facts show that the vast majority of women and minorities still face unequal pay, occupational segregation and dead end jobs. The facts show that the economic status of women workers is actually deteriorating. In 1974, the median income of women was 57% of the median wage of men--a decrease from nearly 64% in 1955.

These facts demonstrate the need for concerted action to eliminate discrimination. Executive Order 11246, issued in 1965 and amended in 1967, provides for such action. The Executive Order requires federal contractors not only to eliminate employment discrimination but also to take affirmative action to ensure equal opportunity.

Approximately 250,000 companies are recipients of government contracts. In fiscal 1974, non-construction contracts alone amounted to over $50 billion. Fully one third of the labor force is dependent on federal procurement expenditures for their jobs. Thus the potential impact of the Executive Order is enormous.

However, there has been extensive criticism of the Office of Federal Contract Compliance Programs for its failure to utilize the enforcement apparatus created to implement the Executive Order. With the continued existence of widespread discrimination, enforcement mechanisms are clearly the key to bringing about equal opportunity. Thus, the most meaningful action at this time should be a strengthening of regulations not a dilution of the enforcement apparatus. In order to ensure that federal contractors fulfill their obligations under the Executive Order, rules and regulations must set forth the following minimum provisions: (Asterisk(*) indicates that provision is excluded or differs from the current Department of Labor regulations.)

COVERAGE

1. Written affirmative action plans must be developed by each contractor/subcontractor having 50 or more employees and contracts of $50,000 or more.

* 2. Each contractor/subcontractor having contracts which, in any 12-month period, total or can reasonably be expected to total $50,000 or more, must develop a written affirmative action plan.

* 3. The size of contracts requiring a pre-award review must be established on an industry basis

4. Pre-award reviews for contracts of $1 million or more must be conducted when there are any outstanding complaints against such contractors.

CONTENTS

1. Affirmative action plans must include an analysis of all job titles ranked from the lowest paid to the highest paid within each department and broken down by race and sex. Underutilization of women and minorities must be examined using this data.

2. Affirmative action plans must thoroughly address establishment of training programs, career paths, transfer mechanisms and complaint procedures.

3. Affirmative action plans must examine the existence of affected classes and provide appropriate remedies including but not limited to back pay, wage adjustments, training and promotions.

GOALS AND TIMETABLES

1. Goals and timetables must be established in a uniform manner based on deficiencies evidenced from the underutilization analysis.

* 2. Contractors must establish and document qualifications required for all jobs

3. The OFCCP must monitor establishment and implementation of goals and timetables

FILING COMPLAINTS

1. Third party complaints must be accepted by the OFCCP

* 2. Complaints regarding patterns and practices must be investigated by the OFCCP.

* 3. All complainants must be assured of confidentiality

ENFORCEMENT

* 1. A compliance review with a finding of compliance or notice of deficiencies with subsequent written conciliation agreement must be completed within 90 days.

* 2. If no conciliation agreement is reached, a show cause notice to the contractor must be issued directing the contractor to appear at an administrative hearing to be convened within 30 days.

* 3. An administrative law judge, chosen on a rotating basis from a predetermined, published panel of administrative law judges in the OFCCP must preside.

4. The administrative hearing must determine whether or not the contractor's affirmative action plan is acceptable. Remedies may be prescribed which include but are not limited to back pay, wage adjustments, promotions and training programs.

5. If the contractor fails to agree to remedies prescribed, the Director of the OFCCP must invoke sanctions.

* 6. If a contractor appeals the decision of the Administrative Judge in the courts, the Director of the OFCCP must bar the contractor from any further contracts until the case has been resolved.

PUBLIC ACCOUNTABILITY

1. The OFCCP must disclose to the public: contents of written affirmative action plans, including goals and timetables, and any other required reports including but not limited to compliance review reports and statistical reports, except as exempted under the Freedom of Information Act.

* 2. The OFCCP must furnish complainants with monthly written reports addressing the status of the investigation and planned timetable. The complainant must also be notified of OFCCP findings, remedies being sought and final determination at the first point in time such information is established.

* 3. Enforcement proceedings must be made public including but not limited to notice of deficiencies, issuance of show cause notices, hearing dates, and conciliation agreements. (Department of Labor proposals only cover conciliation agreements)

* 4. Specific provision must be made for administrative hearings to be open to the public.

* 5. The OFCCP must compile and publish quarterly reports indicating contractors which have been reviewed within the quarter and those scheduled for review during the upcoming quarter.

## NATIONAL FARMERS UNION

### STATEMENT OF RUTH KOBELL

Senator EAGLETON. Next we have Ruth Kobell. We will insert your prepared statement in the record after which you may proceed.

[The statement follows:]

## STATEMENT OF RUTH E. KOBELL

Senator Magnuson and Members of the Committee:

I am Ruth E. Kobell, Legislative Assistant, National Farmers Union, 1012 14th Street, N.W., Washington, D.C. I appreciate the opportunity to present the views of National Farmers Union and our family farm members to this committee. We have a deep and continuing interest in many of the programs you are reviewing because farm families are not only producers of food and fiber but consumers of the services funded by programs under your consideration.

We recommend full funding for the programs authorized under the Older Americans Act. We particularly urge inclusion of the $200 million authorized for FY 1978 Appropriations under Title IX of the Older Americans Act, the Senior Citizens Community Service Employment Program.

National Farmers Union has sponsored the Green Thumb program since it was begun a dozen years ago. We are proud of the services extended through this program both to our older women and men and to our rural communities.

Title IX, Older Americans Community Service Employment Act, is established "In order to foster and promote useful part-time opportunities in community service activities for unemployed low-income persons who are fifty-five years old or older who have poor employment prospects" according to the language of the Act.

Green Thumb, under this mandate, provides such employment opportunities to older men and women in rural areas to carry out community betterment and conservation projects and strengthen existing community projects, and provide special out-reach services to help the aged, shut-ins and handicapped.

Our farmers and our rural communities are in great distress. Farm prices are collapsing. Much of the western United States have had three years of drought and the winter snow pack in the mountains falls far short of the level needed to provide for summer water supplies. At the same time, heavy winter snows in the plain states brought much human suffering and heavy livestock losses. The recent blizzard in the west left 30-foot drifts around farm buildings which took out power lines but left winter wheat fields bare. We saw the pictures and the stories in the Washington Post and I hope we remembered that this meant that people were isolated without heat, with no chance to get out for food or medicine.

I speak of this to remind you that the need to expand Green Thumb services in rural areas continues to expand. We were proud that Green Thumb crews were able to help to dig out and deliver food and medicine to isolated rural residents in the bad snows in Indiana, Ohio and Pennsylvania. The winterization and repair of homes of other low income families which Green Thumbers were able to complete made the winter more bearable for many, and save precious fuel in this winter of our heating fuels emergency.

I do not want to take an undue amount of time of you and your committee, Mr. Chairman, to report on the services of our Green Thumb program. We have come before you each year to make such reports. All of you have Title IX programs in your state -- and all but three members of your subcommittee have Green Thumb programs serving their rural residents. I hope you have had an opportunity, when you are home, to visit some of our projects and talk with the workers who can tell their stories much better than I.

To bring you up-to-date I have attached a copy of the quarterly report which our National Green Thumb office prepares for the Employment and Training Division of the Department of Labor. Our present grant agreement with the Department of Labor provides for over 7,000 job opportunities in 28 states, Puerto Rico and the District of Columbia. The neat columns of figures cover a multitude of exciting human stories.

They show that over a third of the job opportunities are filled by women and the efforts of our staff to increase this balance continues. Rural women who are often denied opportunites for education, training and work experience outside the home or farm are often most harshly disadvantaged when they must seek employment late in life. Many have never been covered by social security. And in many instances widows find their husbands were not able to earn full coverage either. Farmers were brought under social security coverage many years after other groups received it, and many jobs in rural areas have been low paying and part time. So the opportunity to work in Green Thumb and use the skills they perfected as mothers and homemakers and farmers bring dignity and fulfillment to these women, in addition to the badly needed income supplement.

We are proud that Green Thumb set the challenge for their staff to reach out to the most disadvantaged of those eligible for our program. Not only are they all over 55 years of age, with incomes below the poverty level, almost 2,000 are over 65 years of age, another 1,377 are over 70 years and 837, more than 10 percent are over 75 years of age. They all use the skills developed in a lifetime of living to contribute to their community and the service of their neighbors with dignity and pride.

We are proud that during the last quarter of 1976 when unemployment continued to run high, particularly among such groups as older low income workers, Green Thumb was able to place 172 of their Green Thumb workers in private unsubsidized employment. This number was in addition to the number placed through our modest On-The-Job Training Program which is also funded through the Department of Labor. We hope we can be provided the opportunity to expand both these efforts, thus making additional opportunities available for our long waiting list of applicants for Green Thumb opportunities.

There is increasing attention being given to the number of young people who have dropped out of school and have not been able to find their place in the labor market. The plight of older dropouts is even more difficult and we are proud that more than 4,000 of our Green Thumbers with less than 8th grade educations have been able to find work on Green Thumb projects.

We appreciate the continuing support of Congress in providing the appropriations for Title IX programs, and the leadership of your committee and the Appropriations Committee on the House side in providing $59.4 million in the Economic Stimulus Appropriations Act of 1977 to help provide more job opportunities under Title IX. We are anxious to use our experienced staff and administration to help put people to work with these funds as rapidly as possible. Our state offices have waiting lists of both people who need the jobs and communities who want them to help on projects already requested.

We believe that Green Thumb has and will continue to have the initiative and flexibility to move into new fields of service as the program is allowed to expand, benefiting from our years of experience. We hope that we may have an opportunity to help in the economic stimulus program which the President has requested and you have reported to combine employment and training of young workers with the experience and skills of older workers to help meet

such continuing needs as home winterization and repair of rural housing for low income families. Rural America still has over 60 percent of the substandard housing in the nation. Such crews could also make important contributions to the improvement of our parks and forests. They might work on a whole field of environmental improvements so that we could conserve our natural resources while strengthening our human resources.

Mr. Chairman, I was honored to be present last week when you received the Trumpeter Award from the National Consumer League and Esther Peterson reviewed some of the many fields in which you have provided leadership and support for programs important to people. Certainly you have provided such leadership in seeing that funds were available for all the programs funded under the Older Americans Act so that we can continue to develop the services this important group of Americans need and should have. The other members of your committee have likewise shown continued and heartening support. We look to your continuing support for full funding of Title IX in the FY 1978 Appropriations.

Thank you.

OMB Approval No. 44-R1[illegible]

U.S. DEPARTMENT OF LABOR * Employment & Training Administration

# SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM - QUARTERLY PROGRESS REPORT

| PROJECT SPONSOR | REPORT PERIOD ENDING (Month & Year) | PROGRAM No. |
|---|---|---|
| Green Thumb, Inc. | December 1976 | 41 |

| CITY AND STATE | TYPE OF REPORT (Check One) |
|---|---|
| Washington, D.C. (Summary) | ☒ Interim ☐ Final |

| AGREEMENT NUMBER | SUBPROJECT NO. | PROJECT PERIOD From | To |
|---|---|---|---|
| 99-6-093-11-3 | | 7-1-76 | 6-30-77 |

| NO. ENROLLMENT POSITIONS ESTABLISHED | 6070 | UNSUBSIDIZED PLACEMENT GOAL | 10% |
|---|---|---|---|

## A. ENROLLMENT LEVELS (Number of Enrollees)

| | | | | | |
|---|---|---|---|---|---|
| 1. Carried over from previous project | 5592 | 3. Placed in unsubsidized employment this project | 172 | 5. Current enrollment (End of Period) | 6669 |
| 2. Started under this project | 1991 | 4. Other terminations this project | 742 | 6. Enrollment vacancies (End of Period) | -599 |

## B. JOB INVENTORY

| SERVICES TO GENERAL COMMUNITY | NO. JOBS | SERVICES TO ELDERLY COMMUNITY | NO. JOBS |
|---|---|---|---|
| 1. Education | 890 | 11. Project Administration | 188 |
| 2. Health and Hospitals | 132 | 12. Health and Home Care | 59 |
| 3. Housing/Home Rehabilitation | 58 | 13. Housing/Home Rehabilitation | 617 |
| 4. Employment Assistance | 58 | 14. Employment Assistance | 25 |
| 5. Recreation, Parks, and Forests | 896 | 15. Recreation/Senior Centers | 294 |
| 6. Environmental Quality | 305 | 16. Nutrition Programs | 650 |
| 7. Public Works and Transportation | 939 | 17. Transportation | 161 |
| 8. Social Services | 364 | 18. Outreach/Referral | 506 |
| 9. Other | 323 | 19. Other | 204 |
| 10. TOTAL (1 - 9) | 3965 | 20. TOTAL (11 - 19) | 2704 |

## C. ENROLLEE CHARACTERISTICS

| | CHARACTERISTICS | STARTS (Cum.) | CUR. ENROLL. | | CHARACTERISTICS | STARTS (Cum.) | CUR. ENROLL. |
|---|---|---|---|---|---|---|---|
| SEX | Male | 970 | 4183 | ETHNIC GROUP | White | 1605 | 5321 |
| | Female | 1021 | 2486 | | Black | 230 | 941 |
| EDUCATION | 8th & Under | 975 | 4092 | | Amer. Indian | 115 | 291 |
| | 9th - 11th | 413 | 1136 | | Other | 41 | 116 |
| | High School Grad or Equivalent | 430 | 1068 | AGE | 55 - 59 | 512 | 1072 |
| | 1 - 3 years College | 126 | 282 | | 60 - 64 | 575 | 1523 |
| | 4 yrs. College or more | 47 | 91 | | 65 - 69 | 514 | 1868 |
| Spanish American | | 70 | 242 | | 70 - 74 | 266 | 1377 |
| Veteran | | 322 | 721 | | 75 & Over | 124 | 829 |

| D. AVERAGE HOURLY WAGE/CURRENT ENROLLMENT | $2.36 | E. NARRATIVE REPORT (Attachment) |
|---|---|---|

| SIGNATURE | DATE |
|---|---|
| | |

(Formerly MA 6-140)

NARRATIVE

GREEN THUMB ACTIVITIES

OCTOBER - DECEMBER 1976

At the end of this reporting period, there were a total of 6669 workers enrolled in the program; 2486 of whom were females, 37% of our total enrollment.

Our efforts to continue to recruit appointees on Green Thumb in a manner which will balance up our workforce with respect to all minorities and females in accordance with the proportion of these groups to the general population of the communities in which we are operating Green Thumb activities have resulted in some success.

Too much can not be said about our home repair and winterization efforts. This year, with the winter months bringing unseasonably cold, snowy and icey weather conditions, many persons would have had to leave their homes or otherwise live in houses not equipped to keep out the cold, snow and ice were it not for Green Thumb workers being able to make needed and essential home repairs, etc. One recipient of Green Thumb's home repair and winterization efforts reported that this was the first winter that she could remember that she had been able to spend a winter in a house that was warm and comfortable and kept the weather outside. She said her house now feels like it's been wrapped in a blanket since Green Thumbers worked on it. During this period 1455 Green Thumbers worked on a total of 2562 homes.

A good proportion of Green Thumb activities were directed towards other older low-income persons within the communities in which Green Thumb operates. Forty-one percent of all Green Thumb workers assisted and served other elderly persons during this reporting period. Most of the services provided were in the areas

of nutrition, outreach/referral and housing repair and winterization. Six hundred-fifty (650) workers were engaged in nutrition programs for the elderly, 506 in outreach and referral to the elderly and 617 in housing repair and winterization efforts.

We are still experiencing success in moving Green Thumb workers off Green Thumb payrolls onto the payroll of a variety of non-Green Thumb employers. Seventeen percent of all workers terminated during the quarter were placed on other non Green Thumb jobs.

Despite severe weather conditions during recent months, Green Thumb workers have continued to provide nutrition services through meals on wheels programs and centers, transportation and outreach to needy persons.

Training after placement on Green Thumb jobs continue to be provided to Green Thumbers on a regular and on-going basis. Supportive services to Green Thumb workers and their families continue to be provided where needed.

Several Green Thumb states were recognized by local news media for their outstanding contributions in the area of housing repair and winterization and beautification. Green Thumb provided employment opportunities for 1113 new workers during this quarter.

Ms. KOBELL. Thank you. I am Ruth Kobell, legislative assistant for National Farmers Union. We have a deep and continuing interest in many of the programs you are reviewing because farm families are not only producers of food and fiber but consumers of the services funded by programs under your consideration.

We recommend full funding for the programs authorized under the Older Americans Act. We particularly urge inclusion of the $200 million authorized for fiscal year 1978 appropriations under title IX of the Older Americans Act, the senior citizens community service employment program.

National Farmers Union has sponsored the Green Thumb program since it was begun——

Senator EAGLETON. That is more or less on part-time basis, for senior citizens under Green Thumb?

Ms. KOBELL. And other national contractors are funded there.

Senator EAGLETON. ACTION is under a different authority?

Ms. KOBELL. Title IX.

Senator EAGLETON. RSVP is ACTION.

Ms. KOBELL. ACTION, right.

Senator EAGLETON. That gets a bit confusing.

Ms. KOBELL. Title IX is related——

Senator EAGLETON. Tell me, what is the stipend paid under Green Thumb?

Ms. KOBELL. Minimum wages, $2.30 an hour for most of the workers. Crew chiefs, people doing supervisory work are paid slightly more.

Senator EAGLETON. Senior Age pays about the same level. You don't operate that.

Ms. KOBELL. No, National Counsel of Senior Citizens. In some cases they pay $2.30 or a prevailing wage.

Our responsibility is directly to rural areas. They reach a broader rural urban mix.

Senator EAGLETON. Are you the sole national contractor of Green Thumb?

Ms. KOBELL. Green Thumb is the organization sponsored by National Farmers Union. It is the legal name.

Senator EAGLETON. Does the farm bureau or NFO, do they operate——

Ms. KOBELL. I don't think they have ever requested funds under this program.

Senator EAGLETON. For instance, you have little or no strength in my State of Missouri. What are your States of principal activity?

Ms. KOBELL. We do not operate in Missouri.

As you know, the Missouri Farmers Association has strong membership there.

Senator EAGLETON. You are in the Dakotas?

Ms. KOBELL. Dakotas, Minnesota, Wisconsin, down through what we call the heartland of America, Texas, and Arkansas, and into Louisiana.

Senator EAGLETON. What would you say to me as a Senator of Missouri where National Farmers Union doesn't operate, our State is out of business——

Ms. KOBELL. As you know Green Thumb has operated in Missouri for a good number of years. The Department of Labor has asked Green Thumb to take on responsibility in States outside of our membership.

Senator EAGLETON. It operates in Missouri under whose agency?

Ms. KOBELL. Green Thumb is an agency authorized to make contact with the Department of Labor and operates the department there as Green Thumb.

On the marginal basis we give support, program and administrative support to the program.

In each State an advisory committee of citizens helps to direct and advise State program development, and of course in each State at the request of the Department of Labor our programs work with the State agencies in suggesting where programs will be developed.

Senator EAGLETON. So Green Thumb in essence is equivalent to a wholly owned subsidiary of Farmers Union and even in the States where Farmers Union is not active, Green Thumb is, in their own right.

Ms. KOBELL. Yes. At the request of the Department of Labor. We make a contribution.

Senator EAGLETON. Do you have a breakdown of the number of enrollees on a State-by-State basis?

Ms. KOBELL. Yes, I do.

Senator EAGLETON. Do you have it with you?

Ms. KOBELL. I think I do. I will get that form out.

Quarterly Green Thumb and other programs under title IX, submit to the Department of Labor a report on their activities for the quarter, both by State and on a broad basis.

I have here a copy of the report. Here's the one for Missouri, for October, November, and December.

Senator EAGLETON. Where is the bottom line?

Ms. KOBELL. The bottom line is at the top, which says about the third line down, the number of enrollment positions established, on a national basis.

Senator EAGLETON. Number enrollment positions. This says 182.

Ms. KOBELL. So you have 182 positions enrolled in Missouri.

Senator EAGLETON. In the whole State?

Ms. KOBELL. We are able to provide opportunities for less than one-half.

Senator EAGLETON. What is this one up here? Here's one with 6,000.

Ms. KOBELL. That's the summary sheet.

Senator EAGLETON. That's all you have for the whole Nation, 6,000?

Ms. KOBELL. 6,070, yes. A little less than 7,000.

Senator EAGLETON. That isn't much nationwide.

Ms. KOBELL. No. We are able to reach one-half of 1 percent.

Senator EAGLETON. Are you saying of the 6,000 enrollees nationally, that this program is more cosmetic than substantive?

Ms. KOBELL. We feel we make a major contribution to the rural areas where we are allowed to operate, because Green Thumb does work that——

Senator EAGLETON. I realize that. You are talking about 6,000 in a country of 200 million. That is minutiae of the highest order. I

see Arkansas is the next one down the line, it has 407. Arkansas is half the size of Missouri and has 407. Missouri has 182. Here's one in California, 169. One in Colorado, 14.

Ms. KOBELL. That was just established last year.

Senator EAGLETON. District of Columbia, 27. Jacksonville Beach, Fla., 225. Eldorado, Ill., 194. Indiana, 132. Indianapolis is the same size as Missouri. Iowa, 49. The whole State of Iowa, a big farmer's State.

Ms. KOBELL. We were just able to start that one last year.

Senator EAGLETON. Kansas, 128; Kentucky, 198; Michigan, 181; Minnesota, 448; Montana, 150; Nebraska, 134; New Jersey, 317. Whole New York State, I know it's an urban State, but it has a lot of agriculture, 184. North Dakota, 143; Ohio, big State, 218; Oklahoma, 225; Puerto Rico, massive unemployment, need for all kinds of services, a total of 67 people. That isn't staff of 67, that means number of participants in the program.

Ms. KOBELL. We make every effort to use eligible workers.

Senator EAGLETON. The whole State of Texas, 308. The whole State of Washington, 30. That's Senator Magnuson's State.

Ms. KOBELL. That's one we were able to start last year with your expansion of funds.

Senator EAGLETON. You can only do what you have the funds to do.

Ms. KOBELL. You might like to keep that record. There is a formula written into the law which divides the funds according to State, on the basis of the number of people who are 65 years of age and older and on an income basis.

The Department of Labor decides within the State——

Senator EAGLETON. Are we fooling Puerto Rico, for example, fooling somebody, that we are doing anything when total enrollment is what it is with as much unemployment and poverty as they have? Aren't we going through the motions?

Ms. KOBELL. We hope to demonstrate——

Senator EAGLETON. How can you demonstrate anything when you have 60 people for Puerto Rico where the unemployment is close to 25 percent.

Ms. KOBELL. It's very heavy. They make an effort there to divide the workdays to less than a 3-day work basis, so they can reach more people because of the low level of earnings.

We would like to expand the services provided by this work, and of course as you know, Congress has expanded the funds over the years, but, as you say, we are still meeting less than one-half of 1 percent of the people in our own rural areas that need this kind of service.

Senator EAGLETON. I have the notion that sometimes we get into some Federal programs in order to salve our conscience, to have an excuse to say we are really doing something, some politician, Senator or Cabinet member goes to a meeting and says, "We are doing a lot for old people. We have an operation called 'Green Thumb,' and we are helping senior citizens in the rural environment. And isn't this a terrific program?"

We say we are really doing something, and the truth is we are not doing anything. The truth is we have 6,000 people nationwide,

which is nothing. It would be more candid—harder on the Farmers Union—but it would be more candid to say, "Look, we are not doing anything with this program, so let us not fool ourselves or anyone else. So let us do away with it."

It would be harder to face the truth. I guess that sounds like heresy for the chairman of the Subcommittee on Aging. That is what I am. But for 6,000 people nationwide—Well, go ahead. I'm sorry.

Ms. KOBELL. Under the title IX program, there are some——

Senator EAGLETON. Remind me to bring this up at the full committee level. I'm not going to move to cancel the appropriation, but I think my colleagues ought to know——

Ms. KOBELL. There are 15,000 under the program—the title IX program. Green Thumb is one of four national contractors funded. As you say, this is only a drop in the bucket. We are able, we think, to show that older workers can make an important contribution.

Senator EAGLETON. I think they can.

Ms. KOBELL. And they benefit from working in the area.

Senator EAGLETON. I do not think there is any doubt about that. The concept of the program, I think, is excellent. The concept fills or attempts to fill a national need, but the funding implementation of the program is catastrophically small.

Ms. KOBELL. This is certainly true. We have been happy that we could point the way toward winterization and home repair of low-income people, and particularly now with the energy crunch.

In studying the heating bill records of people's homes repaired who had storm windows put on, we had as much as a 40-percent energy bill savings, which for low-income people themselves is an important contribution. So we believe that also the fact that these people spend their money in their little towns, in some places a Green Thumb crew of 6 or 7 people may be the biggest payroll in town. It helps——

Senator EAGLETON. It cannot be a very big town if it is the biggest payroll in town.

Ms. KOBELL. That is right. We try to operate where we can do the most good in life. As many of them must because they have no outside retirement income. We have been proud that green thumb reaches out to some of the most disadvantaged. All of them are over 55 years of age; most of them over 60 years of age; some over 75 years of age.

These were all people who simply do not have retirement income that they can turn to otherwise. They use the skills developed in a lifetime of living, contribute to their communities and the services of their neighbor. We are proud that during that last quarter when unemployment was still high, 172 of the people that worked on Green Thumb were able to be placed in private employment, thus making jobs available for an additional 172 on Green Thumb.

There is an increasing attention being given to the number of young people who have dropped out of school and not been able to find their place in the labor market. The plight of older dropouts is even more difficult, and more than 4,000 of our green thumbers with less than an eighth grade education have been able to find work in our project.

We appreciate the fact that the Congress or the Appropriations Committees have provided a $59.4 million in the Economic Stimulus Appropriations Act to help provide more jobs under title IX. We are anxious to use our experienced staff and administration to help put people to work with these funds as rapidly as possible.

Our State offices have waiting lists of both people who need the jobs and rural communities that have projects that need doing. We believe that Green Thumb can and will continue to have the initiative and flexibility to move into new fields of service, benefiting from our some dozen years of experience.

We hope to have the opportunity to help in the economic stimulus program which the President has requested and you have reported to combine employment and training of young workers with the experience and skills of older workers to help meet such continuing needs as home winterization and repair of rural housing, because we still have 60 percent of the substandard housing in rural areas.

Senator EAGLETON. It should come as some comfort to you that Secretary Marshall, who is the most qualified individual, part of his specific expertise is in employment related to the elderly and employment of farmworkers and the like. He brings to this position a background of interest that is directly applicable to most of the work that you all are pursuing.

Ms. KOBELL. He certainly does. We are delighted that he agreed when he was in Texas to serve on the advisory committee of the Green Thumb program. He certainly brings considerable expertise.

While we would like to continue to use the mechanics of Green Thumb, Farmers Union carries the responsibility for general overseeing of the program, without any monetary reimbursement, except as we consider this a 10-percent contribution or more of our inkind contribution to the program.

We appreciate the support that you and your committee have given us over the years, and we look forward to making whatever contribution we can in the future.

Senator EAGLETON. Thank you very much.

Is every member of this panel from outside the Washington metropolitan area?

Ms. KOBELL. I am from Washington.

Senator EAGLETON. Do all of those who are from outside of Washington plan at a later date to testify before the House committee? For instance, would it be your intention to testify before the House committee?

Ms. KREITER. We do not have any plans to do so.

Senator EAGLETON. I told the staff on the Agriculture Subcommittee—we hold simultaneous hearings—the Senate committee and the House holds their—and we take one set of witnesses in the morning, then they go over to the House side in the afternoon, and vice versa. It seems to me it would be unwise to bring people back twice to give basically the same testimony. They have to give it in two different spots. It seems to me it would be more convenient to have the same kind of method or system that we use for the Senate Aging Subcommittee.

Thank you very much.

## MASSACHUSETTS DIVISION OF EMPLOYMENT SECURITY

### STATEMENT OF JOHN CROSIER

Our next witness is John Crosier, Massachusetts Division of Employment Security.

Mr. CROSIER. Mr. Chairman, I would like to request permission to submit my formal statement for the record and summarize it briefly.

Senator EAGLETON. You can put it in the record, in full.

[The statement follows:]

# STATEMENT OF JOHN D. CROSIER

## Summary of ICESA Recommendations on 1977 Grants to States Appropriations Request

State Employment Service personnel should be increased by 3,000 jobs to give a push to the objective of obtaining private employment jobs for the unemployed. This would bring ES strength to 33,000 jobs. The increase would cost $59,250,000 and would bring total costs for the Employment Service State grants to $696,350,000.

The 3% reduction on claims functions should be restored. There is widespread agreement that the claims payment process needs to be tightened if the UI Service is to reduce fraud and overpayment. Restoration of this cut would cost $20,000,000 and would bring total costs for UI State grants to $774,600,000.

Funds recommended in the appropriations request for WIN is the same as last year and makes no allowance for increased costs due to inflation. This in effect subjects the program to a cut of at least 5%. ICESA believes that the WIN program has been very successful in getting clients off welfare and that the program should not be reduced. A five percent increase to offset inflation would cost $17,500,000.

Mr. Chairman, and members of the Committee, my name is John D. Crosier, I am President of the Interstate Conference of Employment Security Agencies, Inc. I am also the Director of the Massachusetts Division of Employment Security.

Thank you for this opportunity to present to your Committee the views of the Interstate Conference of Employment Security Agencies on the President's budget proposals for FY 1978.

State employment security agencies are, as you know, 100% federally financed. They are responsible for administering three major programs--the Federal-State Employment Service which last year placed over 3.4 million individuals, eight different unemployment insurance programs which last year disbursed over $16.4 billion and the Work Incentive Program which provides

badly needed training and employment for welfare recipients.

State Employment Security Agency Administrators know that their agencies are not perfect, by any means. Nevertheless, we are convinced that the employment security system is still the best in-place system for delivering the services needed to keep the economic recovery moving.

As the problem of unemployment begins to subside, there seems to be a clear majority throughout the nation who believe we should offer the unemployed a job and not a handout, increase our effectiveness in serving the private sector's need in providing long-term solutions to the problem of the unemployed and participate to the maximum extent possible in the utilization of public service employment as a short-term solution to the problems of unemployed workers across the nation.

In addition, we hear loudly and clearly from the Congress and the public at large that we must improve our entire benefit payment control operation and minimize the opportunities for fraud in both welfare and unemployment compensation programs.

For these reasons, State Employment Security Administrators are dismayed by the President's budget proposals placed before you.

Vast sums of money are being proposed for hurry-up public service employment and other efforts to get the economy rolling, while at the same time resources to maintain the existing manpower delivery systems in the employment security agencies are being frozen or reduced.

Employment Service

The United States Employment Service--the nation's front-line troops in matching jobs with people and people with jobs--is proposed to be kept at the same staff level as existed in FY 1976. The current 30,000 staff-year level is approximately the same as in the late 1960's prior to Presidential impoundments of the recent past. While the labor force continues to grow, a standstill ES budget means reduction of overall services for the simple reason that we must serve more people with the same number of administrative personnel.

A recent study of Employment Service cost-effectiveness shows that if the Employment Service reduces the time for obtaining a new job by 1.2 days, the gross national product will be increased by more than the total

Employment Service budget. We think the Employment Service achieves this objective and it is, therefore, a good buy. The average cost for the more than 3.4 million placements made by the Employment Service was approximately $100 per placement compared to thousands of dollars per placement in other alternatives.

If we are to provide workers on a timely basis to this country's employers--and this becomes more important as the economy picks up steam--then more and better trained staff will be needed. For that reason, State Employment Security Administrators are recommending a 10% increase in the Employment Service staffing or 3,000 staff years at a cost of approximately $59 million dollars. With these additional positions, the Employment Service would be able to improve its service to the unemployed and employers alike.

Unemployment Compensation

The President's budget for unemployment compensation is a source of serious concern to the State agencies who are administering these programs. At the very time that the Congress and the public demands a tightening up of the claims-payment process, the FY 1979 budget calls for a 1,016 position decrease in the UI base level staffing.

There is little or no opportunity for cuts in initial or continued claims. Therefore, the cuts will be of necessity concentrated on three areas: fraud control, overpayment collection, and eligibility review. These are precisely the areas that the Congress and the Administrators feel should be strengthened.

In 1973, the Office of Management and Budget, the Department of Labor and the States jointly agreed to develop a system of production time standards for budgeting and measuring unemployment insurance performance--the so-called Cost Model Management System. This system provided for Comparative Analysis Studies of costs of various UI functions. An important objective of the system was to arrive at the actual cost of performing UI functions and avoid across-the-board arbitrary cuts. In spite of this objective the UI State grants budget before you has been cut 3% across-the-board for claim functions.

We State Administrators have been vigorously pushing the Department of Labor to administer the Cost Model as originally agreed to with the States. We do not want to spend one nickel more than is necessary to administer the UI program. However, we cannot in good conscience stand by and watch the implementation of arbitrary cuts devised in Washington because of what we perceive will be a disastrous impact on the legitimate unemployment insurance claimants and State agency employees.

The proposed budget will result in severe cutbacks in certain States. As a result, these agencies will be forced to lay off UI staff and then turn around and pay these same people benefits for not working. Such a result in our minds is ludicrous and we think you will agree. Therefore, we propose to restore 1,016 positions cut at a cost of $20 million.

Work Incentive Program

During the last fiscal year, the Work Incentive Program set all-time records for number of placements, average wage level of these placements, and welfare savings.

In spite of these successes, for some inexplicable reason, the Department of Labor has frozen the WIN program at the FY 1977 dollar level which is, of course, a program cut in these inflationary times. Mandatory cost increases are to be financed by cutting down on the purchase of training and day-care slots, as are any cost increases in these services.

State Employment Security Administrators do not believe that such cuts make sense in light of the need to get welfare recipients into productive employment. In our opinion, the WIN program is one of the most cost-effective ways of serving those who are on the welfare rolls and able to work. As the unemployment rate decreases, this effort should be intensified--not cut back. The Governors of the various States--including my own in Massachusetts--are vitally concerned with maximizing the opportunities for employment of Aid to Families with Dependent Children. State budgets for this program and the Health, Education and Welfare budget for the 50% Federal share have soared.

We believe that WIN is a good investment and is responsive to the country's needs. We are proud of the WIN result and in many States they

are far better than those of other manpower services.

We strongly recommend that a 5% inflation factor for the ES and Welfare programs be granted at a cost of $17.5 million.

Mr. Chairman, and members of the Committee, we know that the Federal budget must be continually scrutinized and that every possible area of savings be realized.

However, we as the Administrators of the Employment Security System of the United States cannot in good conscience believe that at a time when the demands upon the Employment Service are increasing, when the Unemployment Insurance System is being taxed within its limit, and when the WIN program is showing good progress in serving the needs of those on welfare that it is the time to cut back programs that have demonstrated effectiveness.

Mr. Chairman, that concludes my formal testimony and would be pleased to answer any questions.

Mr. CROSIER. Mr. Chairman, I sit here today representing 53 State administrators who administer the employment security program nationwide. We have 2,700 offices. We have approximately 90,000 employees. Last year, we placed 3.4 million individuals.

Senator EAGLETON. There are 32,000 people now in employment security work?

Mr. CROSIER. There are 30,000 presently today. We are asking for 3,000 more.

Senator EAGLETON. How many offices do you say you have?

Mr. CROSIER. Approximately 2,700 offices nationwide.

Senator EAGLETON. You started to talk about the offices——

Mr. CROSIER. We placed 3.4 million individuals last year. Actually, there are more placements than that, but those are individuals placed.

Senator EAGLETON. Some of these individuals have been placed twice?

Mr. CROSIER. Yes. Actually, total placements functions are up around 5.2 million individuals.

Senator EAGLETON. OK.

Mr. CROSIER. We put $16.4 billion on the street in unemployment benefits last year. Mr. Chairman, we are here today to take strong exception to the budget that is before you from the Department of Labor. We think that at a time when the Employment Service is being asked to place more people, that to continue to have a standstill budget of 30,000, which we have had since the 1960's, is doing a disservice to the Nation's front-line troops which have been in place and continue to match people with jobs.

At a time when it is badly needed because of inflation, standstill budgets mean personnel cutbacks. As far as the unemployment compensation and insurance package is concerned, we are being cut effective 1,016 positions at a time when the Congress and the American people are crying out for better benefit payment control.

We think this is unconscionable.

Senator EAGLETON. By "better benefit payment control," does that mean the avoidance of ripoffs?

Mr. CROSIER. Yes, sir.

Senator EAGLETON. We all have watched national television and have heard about these ripoffs, the most celebrated being the lady in Chicago. That is welfare; I stand corrected. That was a welfare case.

Well, we see the guy playing golf down in Florida, the golf pro. On the morning he drives in with his clubs to pick up his unemployment checks and hopes it doesn't take him too long because he might miss his first round out on the links.

Those illustrations drive people up the walls, including me.

Mr. CROSIER. It drives us up the wall, too. If this budget cut is allowed to take place, the only place we can cut is in the area of benefit control because we must maintain the front-line troops——

Senator EAGLETON. The people in need, people have to have some money to exist. You put your first priority in trying to get the money to people in need?

Mr. CROSIER. Senator, we have Federal judges looking over our shoulder on the timeliness of the first payment, and if we slip, we go to jail. That is not very attractive.

We believe the attitude taken by the administration toward this vital function is shortsighted, and we want the Congress to hear that loudly and clearly from us.

Senator EAGLETON. We got into an ancillary matter on the air controllers all becoming disabled, drawing a huge stipend as a result thereof, and they were bowling and doing all these other things.

Is there in the Department of Labor—is there an Office of Inspector General or something to supposedly monitor ripoffs nationwide, or has something to do with preventing ripoffs?

Mr. CROSIER. Each individual State is asked to run its own fraud-detection-control unit.

Senator EAGLETON. Is there any Federal group that monitors this?

Mr. CROSIER. The Department of Labor audits as far as the time spent and the audit-detection capabilities. In all candor, the State administrators in the front since 1975, when claims were so high, acknowledged they could not spend enough time on benefit payment control.

Since some of the shutdown or the reduction in unemployment, we have been able to devote more energy to it.

Senator EAGLETON. Hold it a minute. Here is a sheet that I have, Mr. Crosier. It is a catchall here. Maybe you can read it with me.

"Summary of unemployment insurance programs statistics." Staff units, in 1976 was 57,000; 1977, 52,000; 1978, it will be 46,000.

Do the figures jibe with anything from your recollection? I take it these figures are accurate. It shows a considerable downward staffing trend from 57 to 46. What you are going to have to cut out in the field is the fraud detection part?

Mr. CROSIER. That is the bottom line. I think that probably reflects the decrease most significantly in the contingencies which is tied heavily to how the claims load fluctuates. That was high because of the recession. That is total staff years. We are talking here about a bookkeeping problem that we have in total allocation.

The administration has maintained in their testimony that benefit payment control will not be hurt and we will take the savings out of other areas. As a State administrator, I am here to tell the Senate that that is not practical in the time frame considered.

The State administrators admit to the man that we can do a better job and we are all striving to do that, but in all candor, when we take the situation we have today with respect to an economy that is recovering, people are demanding job placement assistance and we have a standstill budget at $30,000, which we have only been able to maintain by coming to you in the past year.

We have an unemployment insurance system which cries out for increased payment control funds and the administration is cutting us a thousand positions. We take the work in the third program we administer, which had over a 25-percent increase last year in its effectiveness of placing people—all three programs have demonstrated track records, are doing a job and in the face of hurry-up public assistance, or public service employment, these tried and tested programs are being ignored in terms of their effectiveness.

We administrators that are out there day in and day out think the Congress and Senate at large ought to hear that protest. It is very frustrating to try and tell you in 5 minutes what it is like to run that program all year long.

The bottom line says we do not think it is smart to cut effective programs at a time when they can best serve the American public.

Senator EAGLETON. Let me tell the staff, not that everything we do on the Agriculture Subcommittee is right, but I am going to hear this, for instance, our last witness is the Secretary of Agriculture. After all the witnesses have been heard, then we would take the complaints that these people have.

For instance, here we could propound questions and say, "Here's what the record shows. What do you say?" I think we will have to call Secretary Marshall back to go into the contract compliance and go into the unemployment insurance programs and the like.

Mr. Crosier is raising some important points. We are the ones, the Senators and Congressmen, we are the first ones to write nasty letters to the Department of Labor. Maybe they don't have any alternative but to screw it up if we don't give them the money to do it right.

That is my opinion.

Mr. CROSIER. There are three things we think we would like to do. One is increase the staff allocation in the employment service by 3,000. That is approximately an increase of $59,200,000.

The second thing, restore the 1,016 cut, which means we will be able to do as well as we are doing now. And I think some of you are looking for more improvement.

A third thing, in the working center program, at a time when reform is necessary, we have a program of demonstrated effectiveness. We have a level funded budget which means a 5 percent cut. We are asking for a 5-percent increase that will allow us to keep on the track we are at, $17½ million.

The UI budget increase we are looking for is in the magnitude of $20 million. We think that those three things will allow us to continue the employment situation nationwide.

Senator EAGLETON. In Massachusetts, do your colleagues get into the policy implications of eligibility for unemployment compensation, that is who is eligible and for how long?

Mr. CROSIER. Short of the Federal action, each State controls its own eligibility criteria.

Senator EAGLETON. That is for the first 39 weeks?

Mr. CROSIER. Yes, sir.

Senator EAGLETON. We passed a 13-week add-on. We pay off of that. You administer it?

Mr. CROSIER. I would like to take exception to "we pay it." None of the money paid out in States' unemployment compensation programs comes from the General Treasury of the United States. It all comes from a tax on the private employers in the Nation.

They are now in debt $6.6 billion to the Federal unemployment trust fund. That is in debt to the General Treasury. But those programs are administered by States and they are subject to States' eligibilities for duration and suitability of work.

Senator EAGLETON. I am in error, obviously, but I thought part of the 13-week congressional add-on——

Mr. CROSIER. The one you voted is in. The one up to March 31 wasn't. The one that takes part the last of this month will be federally funded.

Senator EAGLETON. Take the new 13 weeks we just added, are there separate eligibility requirements? Or more generous eligibility requirements on that totally Federal money vis-a-vis what the States routinely allow?

Mr. CROSIER. I understand the conference committee between the Senate and House had some discussion of what finally will be suitable work. I believe that has been ironed out, but it doesn't have the concurrence of the House or Senate. That is correct?

Senator EAGLETON. That is the area I was going to get into.

Mr. GOODWIN. I was going to say, they have put into the legislation rules that makes it more strict in terms of suitable work.

Senator EAGLETON. The definition of suitable work is more strict than it has been heretofore under State administration?

Mr. GOODWIN. As was indicated, the FSB program and the one Congress just legislated, that is more strict than the first 39 weeks which are controlled by State law.

Senator EAGLETON. That is my impression. The 13 weeks will be more strict.

Now, let's illustrate that.

What does more strict mean? Give me a couple of cases or examples.

Mr. GOODWIN. I think the key point in the provisions in that law is that they must accept any job that will pay equal to what they get from the benefit.

Senator EAGLETON. What is a typical benefit?

Mr. CROSIER. In Massachusetts it happens to be $70 a week, the average unemployment check.

Senator EAGLETON. That is average. Is that average or median?

Mr. CROSIER. Average.

Senator EAGLETON. What would be the highest check one might get in Massachusetts?

Mr. CROSIER. $108—$152 is the absolute maximum, but you have to have nine children to collect that.

Senator EAGLETON. What would it be for a wife and two kids?

Mr. CROSIER. If he had been making over $216 a week, he would get $124.

Senator EAGLETON. The Federal 13 weeks that was ironed out in conference, you call a guy up and say, "Look, I have a job that will pay you $124 a week as a floor polisher at a gymnasium," and the guy says, "No, I work in scientific instruments."

You say, "Tough, you have to take it?"

Mr. CROSIER. That is my understanding. It's been tied more to monetary than work concept. I haven't seen the language.

Mr. GOODWIN. That is what we agreed to with the conference committee. This is one item. There are other things there, dealing with the distance they have to travel and they can't be paid less than the prevailing rate in the community for that particular service.

That wouldn't protect your instrument from having to take a laboring job if a laboring job paid the rate.

Senator EAGLETON. We are getting down to the more practical figures. The $124 you said was not it. You said the average was $70. There are a lot of unfilled jobs that pay $70 a week in Massachusetts.

Wouldn't the Sunday Boston Herald help wanted section— wouldn't there be hundreds, maybe thousands, of jobs that pay $70 a week listed?

Mr. CROSIER. If that is a 40-hour job that is below the minimum wage.

Senator EAGLETON. What do you fellows that administer these programs—what do you think? Should we be very strict, lay it on the line and say, "Look, we are willing to pay $70 a week unemployment comp, but if there is a $70 job and we direct you to it, down at the Boston Common, we are telling you to take the job or else?"

Mr. CROSIER. The employment security administrators break a discussion of this off at a point of 26 or 39 weeks. We believe the fundamental unemployment insurance system should maintain for 36 weeks or 39 weeks, and once you go beyond that point and you are still unemployed, we don't believe that it should be an unemployment insurance program. It is something else.

We believe FSB is the best vehicle Congress could latch onto. We think it served the Nation well. I think beyond 39 weeks it should be something else. It gets into the whole issue of the Government as the last employment resort, when you talk about moving people from a private sector job to suitable wages for 39 weeks and then something less after that, then there are going to be differences.

If you can't get a job in the private sector after 39 weeks of unemployment, when you enter some other form of employment, subsidized or unsubsidized, the wage expectations ought to be sufficiently lower so there is an incentive to return to the private sector when the economy picks up.

Our basic problem today—today it is more attractive to be on welfare than working at minimum wage. It is more attractive to be on unemployment insurance, or be in a private seated job than on unemployment.

We need a system where it is always more attractive to be on the next rung of the ladder.

Frankly, we think that is lacking. We think the attention that is being addressed to it now by the joint group Secretary Califano and Secretary Marshall is working on, this is going in the right direction.

Senator EAGLETON. I think it is an important point.

My father-in-law, now retired, was a very successful businessman. It came as a source of great anxiety to him when he ran ads in the St. Louis newspapers for a job above the minimum wage and got no takers.

He then would call the unemployment office—he was paying considerably more than the minimum wage, at least 25 or 30 cents an hour more—they would send a guy down and he would last a couple of days, and that would be repeated with another worker. He found—and to a certain extent I find—it is mind boggling to have all of these jobs listed in the newspaper, especially the Sunday paper, and no takers.

Mr. CROSIER. It continues to be a problem.

Senator EAGLETON. So the thrust that you all must consider, whether the base period ought to be 26 or 39 weeks one can argue, but you would agree that after the basic period—try to get a guy a

job similar to the job lost, that the clock runs out after a certain period of time, and therefore you are in a situation where he has to take some job or else?

Mr. CROSIER. Yes, sir.

Senator EAGLETON. You are absolutely right that the President, in trying to devise his new welfare reform package—if the benefits in that package are more attractive than that being offered in the private sector, that is self-defeating as well.

It is a tough problem.

Did you all ever take a position on Moynihan's family assistance program during the early 1970's, when——

Mr. CROSIER. I don't believe so, Senator.

Senator EAGLETON. It wasn't all that bad, even though it was Nixon.

We will take a 2-minute recess.

[A brief recess was taken.]

## AMERICAN LEGION

### STATEMENT OF AUSTIN E. KERBY

Senator EAGLETON. Next witness is Mr. Kerby from the American Legion, and Mr. Lord accompanies him.

Mr. KERBY. Good morning, Senator.

It is a privilege to appear before this distinguished committee. I always appreciate it, each year.

My name is Kerby.

First I might say I would like to have the statement and the accompanying resolutions to be a matter of record.

Senator EAGLETON. It will be.

[The statement follows:]

## STATEMENT OF AUSTIN E. KERBY

Mr. Chairman and Members of the Subcommittee:

The American Legion has traditionally supported adequate funds for the Department of Labor and the State Employment Security Agencies in order that they may operate and carry on an effective job counseling, placement, and training program for veterans, as well as other programs designed to enhance the economic capabilities of veterans.

Current resolutions asking support and adequate funds for these programs and activities were adopted at our 1976 Annnual National Convention. Copies of pertinent resolutions mentioned in my statement are attached hereto. I would appreciate your making these resolutions a part of the hearing record.

Traditionally Congress has recognized the importance of assuring the Nation's veterans special assistance in finding jobs on their return to the mainstream of civilian life. The American Legion is appreciative of legislation in the 92nd and 93rd Congresses specifically designed to improve the delivery of these employment services to veterans.

Resolution No. 58 of our 1976 National Convention specifically states that The American Legion "support an effective Veterans Employment Service...and urge Congress to appropriate sufficient funds to adequately provide services necessary to the security and welfare of veterans." This resolution also called for necessary steps to be taken to establish administrative fiscal controls to ensure that the expenditure of funds so appropriated reflect accurately those amounts used by State Employment Agencies and local offices to serve veterans employment and training needs.

This need for an effective Veterans Employment Service is widely recognized. The President has put among his highest priorities the plight of thousands of Vietnam era veterans who continue to bear a disproportion-

ate share of unemployment. Newly sworn in as Secretary of Labor on January 27, 1977, F. Ray Marshall cited an unemployment rate in the previous month of 8.6 percent for young male veterans in the 20 to 34 age group, compared to the Nation's overall unemployment rate of 7.9 percent, in announcing a new three-point program to improve these conditions.

The American Legion has pledged its full support and assistance in this three-point program of (1) Disabled Veterans Outreach Program, placing disabled veterans in local employment offices to assist in placing disabled veterans; (2) Help Industry Re-training Employment, designed to place Vietnam era and disabled veterans in on-the-job training with corporations with multi-plant operations; and (3) Public Service employment for Vietnam era veterans. The main emphasis of this program is, very properly, on the unemployed disabled and the young Vietnam era veterans, but there is also a great need for employment among other veterans. Recent studies showed that unemployed older workers, including these other veterans, remained on the unemployment compensation rolls far longer than other classes of claimants, many going off because their entitlement ran out rather than because they found employment. Those "other" veterans who turned to the State employment services for help in finding work were placed at a rate below any other applicant group. Using ESARS statistics based on individuals placed in jobs as a percentage of new and renewal applicants, the public employment offices during the fifteen months ending September 30, 1976, placed only 19.4 percent of the older veterans ("other than Vietnam era" - mostly World War II and Korea); however, placed 23.5 percent of all veteran applicants; 26.2 percent of all Vietnam era veterans; and 24.7 percent of the disabled veterans.

It is these "other than Vietnam era veterans" who also need a more effective job counseling and placement assistance program. Their plight

shows that employment assistance to veterans is not a one-shot deal immediately after discharge; this country has mandated for its veterans an employment service ready to assist at any time needed. Resolution No. 77, American Legion 1976 National Convention, asks that employment services to older veterans be increased and intensified and that adequate funds be designated to Federal and State agencies for this purpose. We hope the Subcommittee will take this need in consideration in its deliberations.

Ultimately, when the new three-point program is completed, the responsibility for veterans employment will rest with the Veterans Employment Service, where it has been since its establishment over thirty years ago as an integral part of the legislation that established our system of public employment offices. It has performed well over the years, and can again do the job for which it was created if given sufficient funding and leadership.

Unfortunately, there has been an anti-veteran attitude within the Department of Labor over the past few years, which we hope will fully disappear with the appointment of the first Deputy Assistant Secretary of Labor for Veterans Employment.

The Department of Labor in its proposed fiscal year 1978 budget has requested $5,941,000 to cover salaries and expenses of the Veterans Employment Service, representing an increase of $343,000 over the amount of $5,598,000 as authorized by Congress for FY 1977. The Veterans Employment Service has been under-financed for several years. The American Legion, therefore, believes that the requested amount of $5,941,000 is inadequate. Last year the Office of Management and Budget transmitted to Congress a request for $5,270,000 for the Veterans Employment Service, but Congress increased this to the $5,598,000. However, the Veterans Employment Service informs us the Department of Labor made only

$5,565,300 available to them, which is $32,700 less than the amount appropriated by Congress. This limited amount has caused the Veterans Employment Service to operate in FY 1977 on a very tight budget, postponing many necessary and essential items.

For FY 1978, OMB's requested amount of $5,941,000 is only $343,000 more than the amount Congress appropriated for the Veterans Employment Service for FY 1977, even without considering in-grade step increases, and promotions, etc. A projected government-wide salary increase of 6.5 percent would increase the FY 1978 expenses of the Veterans Employment Service by $335,000, leaving only $8,000 of the $343,000 increase over FY 1977 for all other contemplated increased expenses, including the salary and staff expenses of a Deputy Assistant Secretary of Labor for Veterans Employment as required by PL 94-502. An effective and competent staff is essential to the proper operation of this Deputy Assistant Secretary position. The Department of Labor has before it, its experience in adding ten Regional Veterans Employment Representatives several years ago, but to date the Department has not provided any secretarial help for these positions. Most of these RVERs have makeshift arrangements with regional administrators and, in some cases, do their own typing. We ask that this Subcommittee give consideration to the need for adequate secretarial assistance for each of the ten RVERs.

For sometime the Veterans Employment Service has been promising to publish some badly needed pamphlets and booklets on veterans employment rights under the various laws, the services available to veterans and employers through the Veterans Employment Service, etc. The American Legion recommends that Congress include an adequate amount in the FY 1978 budget to allow the immediate publication of this material.

The Veterans Employment Service has informed us they need at

least $445,000 for travel expenses for FY 1978, an increase of $103,500 over the figure of $341,500 for FY 1977 travel. Secretary of Labor Marshall, by letter of March 7, 1977, in answer to American Legion Resolution No. 183, 1976 National Convention, which urged that Congress and the Department of Labor provide adequate and realistic travel funds for the Veterans Employment Service, assured the Legion there has been a 12 percent increase in funds carmarked for travel funds for the Veterans Employment Service between fiscal years 1975-1977. Considering the rate of inflation in travel costs in these years and the inadequacy of funds earmarked for Veterans Employment Service travel in FY 1975, this 12 percent increase is still not realistic and adequate. It barely keeps Veterans Employment Service travel at the 1975 level, which was so insufficient it prompted our resolution. It is essential that the VES have an increase in travel funds if it is to successfully carry out the increased monitoring responsibility assigned to it by Congress.

President Carter has announced a vigorous three-point program for veterans employment, but the Federal agency with the long time responsibility for veterans employment, and now with the administrative costs of overseeing and coordinating the President's three-point program, announced after the submission of the Department of Labor's budget request, has been assigned a budget that would barely permit it to operate at the current fiscal year level.

The American Legion respectfully requests that the FY 1978 appropriations for the Veterans Employment Service be increased to $6,700,000, which is $759 thousand over the OMB budget request.

Another sensitive and important area of financing employment services, including those to veterans, is in the area of grants from the Department of Labor to the States for employment security purposes, and

in which funds for veterans services are not earmarked or accountable.

It is estimated that no less than $70 million will be available for services to veterans by the State employment offices, but, contrary to the intent of Section 2006(d) of PL 92-540, this estimate is based only on the anticipated veterans' work load for FY 1978 as a percentage of total employment service work load and costs. While we urge adequate funding for State employment security agencies for employment to veterans, they should include accountability for state funding as required by this Section 2006. Such accountability should include a requirement that the salaries and related personnel cost of all State employment service staff who work full time on behalf of veterans (such as full time local VERs, mandatory listing coordinators, and assistant local VERs) shall appear as separately identified items in the State employment service annual budget which must be approved by the Department of Labor. State employment services should be required to separately identify in the State employment service budgets all monies to be used for LVER training, and a thorough description of how it is to be used, such as for Statewide LVER training, workshops, etc.

The State employment service time reporting system should also separately identify the total local office staff time in performing services to veterans, to include as separate items (a) functional supervision and the other duties performed solely by the LVER, as described in Sections 2003 and 2004, title 38, U.S. Code; (b) counseling services; (c) job training referral and placement; (d) duties pursuant to the mandatory listing requirements of Section 2012, title 38; and (e) referral of veterans to CETA programs.

There is an unfortunate tendency in some States, reinforced by the reluctance of the Department of Labor to establish regulations and to in-

sist on the placement of LVERs in those offices which, by law, require them, to regard LVERs as expendable, to be reassigned to any office emergency; for LVER vacancies to be left unfilled; and, often, for LVER grades to be kept low and the jobs dead-end.

Disturbed by statistics showing lack of employment services to veterans as mandated by law, The American Legion by Resolution No. 32, Fall 1976 National Executive Committee meeting, called upon each American Legion Department Commander to visit the administrative head of the employment service in their State and determine four items:

1. The number of veterans applications on file with the State Employment Service;

2. The number of veterans reported to have received no service upon application as reflected by their State ESARS during the period of July 1, 1975 to June 20, 1976;

3. Whether or not full time identifiable veterans employment representatives have been assigned in each local office as required by law; and transmit roster of LVERs assigned by local offices; and

4. Whether or not State Administrators have included estimates of funds necessary to ensure each veteran receives a reportable service as a line item request in the annual Plan of Service and budget request.

Many of the Department Commanders, after supplying the requested information, added their comments on employment services in their States. Besides the difficulties of the LVERs, many mentioned trying to perform all the assigned programs with limited funds.

Such requirements for accountability by the States as we have outlined should ensure the best and maximum use of the money assigned to the States for services to veterans in the State employment offices.

However, as our Department Commanders pointed out, it is also essential that the States be adequately financed and staffed to take care of their responsibilities. We understand the Department of Labor is recommending funding for 30,000 jobs in the State employment services, the same number

for which funds were granted last year. We believe, however, since the labor force has been growing along with population increases and the entering into the work force of more women, and the employment services have increasingly been given responsibility for special emphasis programs, such as for migrants, youth, and disadvantaged, as well as the legislatively mandated programs for veterans, this 30,000 job figure appears inadequate. It is also at the level of the local employment office that complaints under the affirmative action legislation for veterans are initiated. Since the law applies to all Federal contractors and subcontractors, there is a potential for an extremely heavy work load for the LVERs in this area alone, although little has been done so far. The American Legion recommends an increase of another 3,000 jobs for a total of 33,000 jobs, which includes the LVERs. We request that this Subcommittee consider appropriating $59.25 million over the budget request for the necessary State employment service personnel.

Mr. Chairman, in considering this request, we would like to ask that the Subcommittee consider also the situation of the disabled veterans who are being given short term appointments in the Disabled Veterans Outreach Program as part of the President's three-point program. They are aware that these are to be temporary appointments, but it is anticipated that they will be performing a job on the same basis as other employees. We would like to see these experienced disabled veterans incorporated into the regular work force in their respective States when DVOP is completed.

Several years ago, when there was a sudden strain on the unemployment compensation system, many States pulled other staff, including those normally assigned to placing veterans, off regular assignments and assigned them to unemployment claims. Regular placement services

almost came to a standstill, and catastrophe was only averted with prompt Congressional action. We understand that now the Administration is so confident that complete prosperity is on its way, that the unemployment compensation work force is to be cut three percent. We ask, in the light of previous experience, that adequate UI funding be restored and this three percent cut be eliminated.

Inasmuch as so much of the President's three-point program to assist veterans with employment will call upon funds from the Comprehensive Employment and Training Act programs, we hope this Subcommittee will consider this when deliberating on appropriations for CETA.

The American Legion cooperates with the President's Committee on Employment of the Handicapped in promotion of the first full week in October as "Employ the Handicapped Week." This year we will also be participating in the White House Conference on Handicapped Individuals, May 25-29, 1977. The Legion has also been a long time supporter of the President's Committee's work to remove architectural barriers for the handicapped, especially in employment. Recent legislation that requires all companies which benefit financially from Federally funded programs to remove architectural barriers will be especially helpful to open employment to disabled veterans when fully implemented.

I thank you for this opportunity to express the view of The American Legion. May I again urge you to act favorably upon the fiscal 1978 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. We particularly ask for your favorable consideration of those suggestions of The American Legion which we believe will improve this program.

FIFTY-EIGHTH ANNUAL NATIONAL CONVENTION
OF THE AMERICAN LEGION
SEATTLE, WASHINGTON, AUGUST 24-26, 1976

RESOLUTION NO.: 77

COMMITTEE : ECONOMIC

SUBJECT : ASKING FEDERAL AND STATE EMPLOYMENT SERVICES TO INCREASE SERVICES TO DISABLED VETERANS AND OLDER VETERANS

WHEREAS, The American Legion has looked with compassion on the specialized needs of the disabled and the older veteran; and

WHEREAS, Seriously disabled Vietnam veterans in increasing numbers are seeking gainful employment; and

WHEREAS, The advancing age of World War II and Korean veterans and the incidence of disability creates serious employment problems for these veterans; and

WHEREAS, The responsibility for providing specialized services to meet the unemployment problems of older veterans and disabled veterans has been given to the U. S. Department of Labor through the U. S. Employment and Training Administration, the Veterans Employment Service, and the various State employment services; now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Seattle, Washington, August 24, 25, 26, 1976, that the Department of Labor, the U. S. Employment and Training Administration, the Veterans Employment Service, and the various State employment services be asked to increase and intensify services to disabled veterans and older veterans; and be it further

RESOLVED, That The American Legion inform Congress of the specialized employment needs of these veterans and request provision for adequate funds so that the designated Federal and State agencies can fully comply with their responsibilities to serve disabled veterans and older veterans.

NATIONAL EXECUTIVE COMMITTEE
OF THE AMERICAN LEGION
INDIANAPOLIS, INDIANA, OCTOBER 6-7, 1976

RESOLUTION NO. : 32

COMMITTEE : ECONOMIC

SUBJECT : SURVEY OF EMPLOYMENT SERVICES PROVIDED TO VETERANS AS REQUIRED BY PUBLIC LAW.

WHEREAS, Chapter 41, Public Law 92-540, the "Veterans Employment and readjustment act of 1972" clearly declares the intent and purpose of the Congress to be an effective Employment Service Program for eligible veterans; and

WHEREAS, Public Law 92-540, Section 2004, provides there shall be assigned by the administrative head of the Employment Service in each state one or more employees "whose services

shall be fully devoted to discharging the duties prescribed for the State Veterans Employment Representative"; and

WHEREAS, Public Law 92-540, Section 2003, specifically details those duty requirements as

> "(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."; and

WHEREAS, Public Law 92-540 authorizes appropriation of funds necessary for the proper and efficient administration of the Act; and

WHEREAS, Public Law 92-540, Section 2006, provides that funds necessary shall be included as a special item in the annual Federal budget of the U. S. Department of Labor; and

WHEREAS, Section 2006 (c), Public Law 92-540, further provides

> "(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."; and

WHEREAS, Section 2007, Public Law 92-540, provides that the Secretary of Labor shall establish necessary controls to insure "each eligible veteran...who requests assistance 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"; and

WHEREAS, The Secretary of Labor has failed since enactment of the 1972 Federal statute to establish necessary controls to insure proper job placement services to all veterans; and

WHEREAS, Many veterans who apply at State Employment Service offices receive no reportable service; and

WHEREAS, Many State Employment Security Administrators have failed to assign full time local veterans employment representatives in each local office; and

WHEREAS, Eligible veterans entitled to preferential consideration by mandate of various statutes, including the Wagner Peyser Act of 1933 as well as the Veterans Readjustment Assistance Act of 1972, are not receiving adequate services upon application to State Employment Security offices by reason of failure to implement Public Law 92-540; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on October 6-7, 1976, that The American Legion urge Commanders of each Department to call upon the administrative head of the Employment Service to determine and report:

1. The number of veterans applications on file with the State Employment Service.

2. The number of veterans reported to have received no service upon application as reflected by their State ESARS Reporting System during the period of July 1, 1975 to June 30, 1976.

3. Whether or not full time identifiable veterans employment representatives have been assigned in each local office as required by law; and transmit roster of LVER'S assigned by local office.

4. Whether or not State Administrators have included estimates of funds necessary to insure each veteran receives a reportable service as a line item request in the annual Plan of Service and budget request; and, be it further

RESOLVED, That the Commander of each Department be urged to determine and transmit to the National Economic Commission a statement of action deemed necessary to secure full and complete compliance to implement the intent and purpose of Public Law 92-540.

FIFTY-EIGHTH ANNUAL NATIONAL CONVENTION
OF THE AMERICAN LEGION
SEATTLE, WASHINGTON, AUGUST 24-26, 1976

RESOLUTION NO.: 183

COMMITTEE : ECONOMIC

SUBJECT : REQUEST ADEQUATE AND REALISTIC VETERANS EMPLOYMENT SERVICE TRAVEL FUNDS

WHEREAS, The Congress has established a Veterans Employment Service in the United States Department of Labor to promote employment counseling, job placement, and job training opportunities for veterans and to monitor and functionally supervise the various laws pertaining to veterans employment and training; and

WHEREAS, Recently enacted legislation has increased the responsibilities of State Veterans Employment Representatives (VERs) and additional Regional Veterans Employment Representatives (RVERs), and Assistant VERs require a marked increase in travel throughout their areas; and

WHEREAS, The Employment and Training Administration, Department of Labor, has reduced the 1976 budget, and has not made adequate allowance for traveling by the Veterans Employment Service staff; and

WHEREAS, All travel costs are materially increased and are expected to continue to increase; now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Seattle, Washington, August 24, 25, 26, 1976, that The American Legion urge the Congress, the Secretary of Labor, and the Employment and Training Administration to provide adequate and realistic travel funds for the Veterans Employment Service.

FIFTY-EIGHTH ANNUAL NATIONAL CONVENTION
OF THE AMERICAN LEGION
SEATTLE, WASHINGTON, AUGUST 24 - 26, 1976

RESOLUTION NO.: 58

COMMITTEE : ECONOMIC

SUBJECT : SUPPORT ADEQUATE FUNDS FOR VETERANS EMPLOYMENT SERVICE AND STATE EMPLOYMENT SERVICES AND ACCOUNTABILITY FOR STATE FUNDING

WHEREAS, It has been The American Legion's long established policy to promote a maximum employment program for all veterans; and

WHEREAS, The Servicemen's Readjustment Act of 1944 provided for the establishment of facilities for effective counseling and placement services for all veterans; and

WHEREAS, The Vietnam Era Veterans Readjustment Assistance Acts of 1972 and 1974 update these benefits, with special emphasis directed toward disabled veterans and veterans of the Vietnam Era, surviving widows of veterans who died of service connected disabilities, the spouse of any person who has a total disability permanent in nature resulting from a service connected disability, or the spouse of a veteran who died while a disability so evaluated was in existence; and

WHEREAS, The United States Department of Labor has the legal responsibility to establish policies for carrying out provisions for Chapters 41 and 42 of Title 38, United States Code; and

WHEREAS, The Veterans Employment Representatives in the States and the State employment agencies have been mandated to carry out these policies as provided in said Chapters of Title 38, United States Code; and

WHEREAS, By contrast to these mandates, the Department of Labor has failed miserably to properly support the Veterans Employment Service and the state employment service agencies in their efforts to implement the law as intended by Congress, and, for example, services provided by the Department of Labor not only do not resemble the "maximum" or "effective" services to veterans intended, but placement and other services for veterans is at a rate below that of nonveterans; and

WHEREAS, Section 2006(d) of Title 38, United States Code, as amended by PL 92-540, requires the Department of Labor to assure that all Congressionally appropriated funds for veterans employment services, whether to the Federal or the State sectors, shall not be available for any other purposes; now therefore be it

RESOLVED, By The American Legion in National Convention assembled in Seattle, Washington, August 24, 25, 26, 1976, that The American Legion support an effective Veterans Employment Service and the State Employment Services for all veterans and urge Congress to appropriate sufficient funds to adequately provide services necessary to the security and welfare of the veterans; and that the Department of Labor and State Employment Security Agencies establish administrative fiscal controls to insure that the record of expenditure of funds so appropriated reflect accurately those amounts used by State employment agencies and local offices to serve veterans employment and training needs.

Mr. KERBY. I don't think it is necessary to look at the details. I hope the committee will look it over.

The problem is quite great for the veterans at this time. We have about 1.5 million unemployed young veterans and it is at least half a million older veterans. They have a problem, too, I might say. Their placement record is less than the veterans, of course. As I pointed out in the statement.

As an example, also, the veterans as a whole are receiving less services throughout the program.

According to ESAR figures, during the 15-month period ending September 30 of last year, of 3,183,500 veteran applicants plus renewals for this period, only 779,713 of the veterans, or 23.5 percent of those who sought placement assistance, were placed in jobs. By comparison, 25 percent of all male nonveterans were placed during this period.

Likewise in the placement in training slots. They received less.

As an illustration, nonveterans received 1.2 percent of those registered, were placed in job training; and veterans, 0.8 percent.

We are interested in, and of course we appreciate the President's recent announced three-point program for veterans, and we hope this will alleviate some of the problems, yet we still are a little concerned, quite a bit concerned, about it, and we certainly have pledged our full support through the Secretary of Labor.

We mentioned earlier, we would like for some of the questions on veterans be brought to the attention of the Secretary when he comes back before the group, this committee I should say.

Senator EAGLETON. I think we will bring him back. He did in his initial testimony—he did place great emphasis, I am pleased to say, on unemployment of veterans. That is very high up on his list of priorities.

I don't know if any of us have the handle on it yet. I don't know if any of us know just what the foolproof way is of getting more jobs to veterans.

There are some things in life you just don't know what to do for sure.

I have great confidence in the Secretary, and when he tells me he wants to make that one of his top targets, I believe he will do it.

How much he will succeed, maybe we will come back a year from now and the picture will be worse.

Mr. KERBY. He mentioned he wants to put aside 35 percent of the CETA jobs for veterans. I understand the law will have to be amended to do that. I understand the law will just be extended.

Our concern is with the veterans employment services. There is 230 people employed there. You have the national staff. Then, of course, you have one or more state VR's in each State, depending upon the population; if it is more than a quarter million, there is one VR.

This is a Federal program, of course.

Senator EAGLETON. Does the VA do anything about veterans employment or are they purely educational, health?

Mr. KERBY. More or less working with labor and helping if they can.

Of course, the program is really the responsibility of the Labor Department.

Senator EAGLETON. That is with Marshall and not with the VA.

Do you think that is right from the structural point of view?

Mr. KERBY. Our committee has studied this on several occasions. The old system back in 1944 was the Veterans' Administration, Labor, and DOD, I guess it was, at that time, or probably the Draft Board, Selective Service, at that time.

And it worked quite well, of course, until 1948 it was transferred over to the Labor Department.

We have thought something like that and we have also thought in terms of putting it back with the VA—I mean with the VA.

We have not come up with any conclusion.

The American Legion I am speaking of now.

When we get to the Veterans' Administration, they have requested in the Bureau of Budget's request a request—request for $5,149,000. We feel that is inadequate.

In the first place, we have a——

Senator EAGLETON. We are back with the Department of Labor, veterans employment?

Mr. KERBY. That's right.

In the budget request for $5,941,000. We feel that is inadequate and for several reasons.

Public Law 94–93 I should say, 502 of last year, they will appoint a Deputy Assistant for the Department of Labor. We hope that will alleviate the problems.

Nothing has been set up in the budget for his salary or staff. We feel we at least need $153,600, up to about $200,000 for that alone.

Senator EAGLETON. The figures we have—this is from the budget book again—it says this, for 1977, this is Veterans Employment and Readjustment Act, money for 1977, $5.8 million; money for 1978, $5.9 million—the previous witness—that doesn't even take into account inflation. Instead of moving forward, it will be a drop backward situation.

Mr. KERBY. That's right.

Senator EAGLETON. Let's ask the Secretary about that.

Mr. KERBY. That is one reason.

This will be a new job, and also the staff.

Also no consideration has been taken for the 6.5 percent projected increase in salaries which would be in itself, that would take up this increase.

It will be—that alone would be $335,000.

Then, of course, we got the problem of travel for the VS. They have had inadequate travel for several years. And the Secretary said he was going to increase it 12 percent.

We don't feel 12 percent will be enough for the way travel has increased.

Then, too, they have to oversee the new veterans, the Secretary's new programs, and we feel that this is necessary for more travel funds, and, also, about 2 years ago the Labor Department administratively set up a regional veterans fund representative for each of the 10 regional offices.

First, we have to fight for space——

Senator EAGLETON. Are you talking about the regional offices of VA or the Labor Department?

Mr. KERBY. The Labor Department. They oversee the State people in each particular region. They would have to fight for adequate space and the office and so forth, and yet they do not have a secretary. They have to do their own typing, many of them do. There should be a representative for each region. Yet they don't even have a secretary.

Sometimes they may get one for a few months under CETA. Then it ends up.

So that I think should be considered in the budget.

Also, no consideration spent for in-step promotions, et cetera. Increase in grades.

We think that should be lifted, to increase at least to $7 million—I am sorry, $6,700,000. At least that much. More if the committee would see fit.

Then, too, we are interested in grants to States.

This, as you know, goes to the States and includes—included in this is the local veteran employments representative, which is to counsel and place veterans.

We have had the problem over the years, and then 92–540, Public Law 92–540 came along in 1972. This, of course, was to say that in each local office, 2,400 of them, or plus, there would be a local veterans employment representative to take care of veterans' problems and help get placement.

Many of the States have not as yet complied with the law.

In the budget there has been designated no less than $70 million will be available for services to veterans.

Now, whether this is enough or not, we don't know.

Last year they had $50 million. Year before it was $25 million. Still the problem is not being resolved.

So we feel——

Senator EAGLETON. Veterans Employment Readjustment Act, is that grants to States?

Mr. KERBY. Yes, sir.

On the bottom line it says no less than $70 million.

Senator EAGLETON. Fiscal 1977, $65 million; fiscal 1978, $70 million.

Mr. KERBY. Right. Now, there is no accountability for the local ER's, or services to veterans. In other words, they don't put this separate. As a matter of fact, we were so concerned we had a resolution at our meeting last October, Resolution No. 32, a matter of record in this statement, and asked our department commanders to check with the State agencies on four questions, which are set forth there, one of them was: Are the local VER's being assigned as required by law, and quite a large number came back that they were not.

Another question was: How many were being turned away with no service. Not turned away, but put on the inactive roll with no service. It was around 49.5 percent that had no service at all. I know they will come back and say, well, these statistics concern people that just went for unemployment insurance.

I don't think that is so great. If that is so, I think they should get another system for accounting and not put those in the system. That is our concern. On pages 7 through 9, we have outlined—I won't deal with them, due to time here—how some of these could be corrected for the local VER's.

I would like to specially call your attention to that. That deals with accountability. Now, Interstate Conferences testified awhile ago and they mentioned the fact they need 3,000 more jobs. We agree. We feel it should be, because in this group is also the local VER's. That is one thing we are concerned about.

We feel, due to the additional programs and the problems of unemployment today, that there should be adequate people to handle the program, so we certainly also——

Senator EAGLETON. Let's take any big city, my home city of St. Louis. Where are you from?

Mr. KERBY. Maryland.

Senator EAGLETON. Let's take an unemployment office——

Mr. KERBY. He is from Virginia.

Senator EAGLETON. Let's take an unemployment office in the District or Virginia, where guys or women come in seeking unemployment. That is where they have to fill out the forms to qualify for unemployment compensation. Let's assume five guys come in the room together. Let's assume that they are all teenage blacks. Let's say they are all about 21 years of age. Let's say two of them are Vietnam veterans. I am running out of time. Let's say three of them are not. Let's assume that all five of them have marginal academic skills; that is, reading, writing skills that are not too terribly great.

Now, what did the veteran guy in that office downtown, what did he do for the two or three veterans versus the other two that are not veterans?

Mr. KERBY. The veterans are supposed to have preference, referral to the job openings first. That didn't mean he has to hire him. We feel this is not being done as it should be.

There is a 2-percent difference in the placement of nonveterans against veterans, as we pointed out in the Labor Department's own statistics. Something is wrong. Therefore, we feel maybe some of these offices, if the office didn't require a full-time veteran's representative, maybe the person has been assigned to do other duties first.

I have called some States to see how they were doing and said, "I want to talk to the local VER" and they said, he is not at his desk and gave me another number and he was handling something else, and I asked how come you are not handling your responsibilities and he says: "The office manager says, this is more important."

Senator EAGLETON. Is it the intended policy that in every unemployment office in the country, there is at least one person dealing with veterans?

Mr. KERBY. Public Law 92–540 is very firm; it says: "Responsibilities are the same as the State VER." In some States, like Oklahoma, they have a tremendous system. They have one or more local VER's in each office and they have assistant representatives. The local VER goes out and builds up job leads; then the assistant stays in, in place. It is a fabulous system. I recognize that maybe the law didn't require you to go that far, but the law did say, it should be a local veterans

representative in each office. It is to demonstrate the lack of need, determined by the Secretary of Labor. I feel it is something in this system here. I know, due to time——

Senator EAGLETON. Let's assume another hypothetical. Let's assume coming into the employment office is a veteran and he has been out of work 3 weeks and along with him comes another fellow, roughly the same age; he has been out of work 30 weeks.

The guy that has been out of work 3 weeks has no dependents—the guy that is the veteran—the guy that has been out of work 30 weeks has a dependent elderly mother and a dependent younger sister. Did the veteran get the preference?

Mr. KERBY. What we do now, the veteran would go to the veteran's representative and the other person would go to a counselor. He wouldn't know the problem. The two counselors would be maybe at a far end of the office. The law, is however, that the veteran should have the preference. Disabled veterans first.

Senator EAGLETON. So, if the office is running according to law, according to the intent, when a guy walks in there, if he is a veteran, he immediately goes to a different department?

Mr. KERBY. He should be referred to the veterans counselor. Another matter is, was mentioned here, unemployment insurance, because we know the Labor Department through the office did handle UCX benefits, but our prime concern here is that several years ago, there was a problem, a high influx of UI claims and they were taking people, including local veterans off their jobs and putting them to handle UI claims. This is, of course, a special job.

Most anyone can handle VUI claims. So we feel, if they cut down 3 percent of their staff, they may go back to this system again, if it is a high influx of cases, VEI cases.

We would appreciate the Committee's consideration of restoring the 3-percent cut. It was 1,016 jobs, I believe it was, being cut. Other than that, I believe that concludes my summary, unless you have some other questions, Senator.

Senator EAGLETON. No. That is fine.

Mr. KERBY. We certainly appreciate the opportunity. In conclusion, I would appreciate additional funds for the veteran employment representative, that includes the staff, the headquarters staff and the State-Federal program and also looking into the local situation.

Senator EAGLETON. We will take that up with the Secretary. I think the Secretary is an excellent man and he is a man of his word. I think he wants to really try and move on this veterans thing, but we have to ask how he can, with money less than he had last year, maybe. I think we ought to ask him about that and bring it to his attention.

Mr. KERBY. Thank you so much.

## STATEMENT OF JOHN WEINTRAUB, NATIONAL ASSOCIATION OF COUNTIES

PREPARED STATEMENT

Senator EAGLETON. We now have John Weintraub from the National Association of Counties, who will discuss the Comprehensive Employment and Training Act.

Mr. WEINTRAUB. I would like to summarize my statement and have the full statement incorporated in the record.

Senator EAGLETON. It will be.

[The statement follows:]

# STATEMENT OF JON WEINTRAUB

Summary of NACo Recommendations
on CETA and Older Americans Act
Appropriations for Fiscal 1978

●

I. CETA

- title I: $2.5 billion
- titles II & VI: $1.54 billion
- new youth title: $2.5 billion
- summer youth: $725 million
- against the repeal or waiver of section 4(e)

II. Older Americans Act

- title II: $450,000
- title III: $209 million
- title IV: $31.5 million
- title V: $40 million
- title VII: $250 million
- title IX: $200 million
- supports committee action on title IX allowing 50% of funds to be distributed to state and local governments

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, MY NAME IS JON WEINTRAUB, LEGISLATIVE REPRESENTATIVE AT THE NATIONAL ASSOCIATION OF COUNTIES. I SERVE AS STAFF TO THE NATIONAL ASSOCIATION OF COUNTIES' EMPLOYMENT STEERING COMMITTEE. THIS STEERING COMMITTEE IS RESPONSIBLE FOR DEVELOPING NACO'S POLICY ON ALL EMPLOYMENT AND TRAINING RELATED PROGRAMS.

I AM TESTIFYING TODAY ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES, THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN THE UNITED STATES. NACo IS PLEASED THAT YOUR SUBCOMMITTEE IS HOLDING PUBLIC HEARINGS ON THE CRITICAL ISSUE OF THE LABOR-HEW APPROPRIATIONS FOR FY 1978.

I AM HONORED TO BE ABLE TO APPEAR BEFORE YOUR SUBCOMMITTEE AND PRESENT OUR VIEWS. WE BELIEVE THAT THESE HEARINGS WILL FOCUS ATTENTION ON THE NEED FOR INCREASED FUNDING OF THE COMPREHENSIVE EMPLOYMENT AND TRAINING ACT. THE REASON IS VERY SIMPLE, MR. CHAIRMAN, AS TO WHY COUNTY GOVERNMENT IS INTERESTED IN THE FISCAL 1978 FUNDING LEVEL FOR THE COMPREHENSIVE EMPLOYMENT AND TRAINING ACT. IN FISCAL 1977, 41% OF THE CETA PRIME SPONSORS WERE SINGLE COUNTIES, WHILE 15% WERE CITIES AND 33% WERE CONSORTIA, ALMOST ALL OF WHICH INCLUDE COUNTIES. THUS, OVER 70% OF THE CETA PRIME SPONSORS ARE COUNTIES. THIS DOES NOT INCLUDE ALL OF THE SMALLER COUNTIES SERVED BY BALANCE OF STATE. SIMPLY STATED, COUNTIES ARE PRIMARY DELIVERERS OF MANPOWER SERVICES IN THIS COUNTRY.

I. CETA TITLE I FUNDING

THE PRESIDENT'S REQUEST FOR TITLE I OF CETA FOR FISCAL 1978 REMAINS AT $1.88 BILLION. IT REMAINED UNREVISED DESPITE INCREASED COSTS DUE TO INFLATION AND THE 8.7% PROJECTED INCREASE IN THE MINIMUM WAGE FROM $2.30 AN HOUR TO $2.50 PER HOUR AS OF JULY 1, 1977 REQUESTED IN SECRETARY MARSHALL'S HOUSE SUBCOMMITTEE TESTIMONY ON MARCH 24TH. SECRETARY MARSHALL ALSO PROJECTS AN INCREASE TO $2.73 BY JULY 1, 1978, OR AN 18.7% INCREASE OVER THE EXISTING $2.30 AN HOUR. THIS WOULD RESULT IN AN 11.2% INCREASE OVER $2.30 AN HOUR DURING FISCAL 1978. THEREFORE, A MINIMUM HOLD-HARMLESS LEVEL VERSUS FISCAL 1977 WOULD BE $2.11 BILLION FOR TITLE I IF ONE PRESUMES THE ADMINISTRATION'S MINIMUM WAGE REQUEST WILL BE ADOPTED BY CONGRESS. THE HOUSE BILL, HR 3744, ASKS FOR EVEN LARGER INCREASES IN THE MINIMUM WAGE ($2.85 AN HOUR 30 DAYS AFTER ENACTMENT, A 23.9% INCREASE OVER THE PRESENT $2.30 AN HOUR).

THE $2.11 BILLION MINIMUM HOLD-HARMLESS LEVEL DOES NOT INCLUDE INCREASES FOR INFLATION NOR DOES IT REFLECT THE NECESSARY INCREASE IN TITLE I TRAINING OPPORTUNITIES SO IMPORTANT TO THE NATION'S MANPOWER DELIVERY SYSTEM WHEN UNEMPLOYMENT SHOWS SOME SIGNS OF DECREASING. THUS, THE NATIONAL ASSOCIATION OF COUNTIES SUPPORTS A $2.5 BILLION APPROPRIATION FOR TITLE I OF THE COMPREHENSIVE EMPLOYMENT AND TRAINING ACT FOR FISCAL 1978.

II. CETA TITLES II AND VI

NACo SUPPORTS THE CREATION OF 600,000 NEW PUBLIC SERVICE JOBS. HR 4876 WOULD CREATE 725,000 PUBLIC SERVICE JOBS BY THE END OF FISCAL 1978. IN ORDER TO CREATE AN ADDITIONAL 185,000 PUBLIC SERVICE JOBS AT $8300/JOB, WE ESTIMATE THAT A MINIMUM OF AN ADDITIONAL $1.54 BILLION WOULD BE NECESSARY.

III. YOUTH PROGRAMS

WE ARE CONCERNED WITH THE IMPACT OF LEGISLATION INCREASING THE MINIMUM WAGE ON THE SUMMER YOUTH PROGRAM FOR FISCAL 1977 AND FISCAL 1978. THE FOLLOWING TABLE PRESENTS THIS IMPACT:

| | Fiscal 1977 Dollars Appropriated | Minimum Wage Increase Projected by Secretary Marshall | Hold-Harmless Amount re: Sec. Marshall |
|---|---|---|---|
| Fiscal 1978 | $595m | $2.73/hour (18.7% increase) | $706.3m |

| Minimum Wage Increase Projected by HR 3744 | Hold-Harmless Amount re: HR 3744 |
|---|---|
| $2.85/hour (23.9% increase) | $737.2m |

ASSUMING THE ADMINISTRATION'S MINIMUM WAGE REQUEST PREVAILS AS PRESENTED BY SECRETARY MARSHALL, WE WOULD SUPPORT A MINIMUM OF $725m FOR THE FISCAL 1978 SUMMER YOUTH PROGRAM.

WE SUPPORT THE SENATE HUMAN RESOURCES' COMMITTEE REQUEST OF $2.5 BILLION FOR THE NEW YOUTH TITLE OF CETA.

IV. REPEAL OF SECTION 4(e) OF CETA

WHILE REALIZING THAT THIS IS PRIMARILY AN AUTHORIZATION ISSUE, WE WOULD HOPE THAT MEMBERS OF THIS SUBCOMMITTEE WOULD VOTE AGAINST ANY ATTEMPT TO REPEAL OR TO WAIVE SECTION 4(e) OF CETA.

V. OLDER AMERICAN ACT

NACO SUPPORTS FULL FUNDING OF ALL SECTIONS OF THE OLDER AMERICANS ACT. IN LIGHT OF THAT COMMITTMENT WE SUPPORT THE REQUEST OF THE SENATE SPECIAL COMMITTEE ON AGING:

| OLDER AMERICANS ACT | $ (in thousands) |
|---|---|
| TITLE II | 450 |
| FEDERAL COUNCIL ON AGING | |
| TITLE III | 209,000 |
| STATE ADMINISTRATION | 20,000 |
| AREA PLANNING & SOCIAL SERVICES | 169,000 |
| MODEL PROJECTS | 20,000 |
| TITLE IV | 31,500 |
| RESEARCH | 9,500 |
| TRAINING | 18,000 |
| MULTIDISCIPLINARY | 4,000 |
| TITLE V MULTI-SERVICE CENTERS | 40,000 |
| TITLE VII NUTRITION | 250,000 |
| TITLE IX EMPLOYMENT | 200,000 |

NACO SUPPORTS THE SENATE COMMITTEE ACTION ON TITLE IX WHICH ALLOWS 50% OF THE FUNDS TO BE DISTRIBUTED TO STATE AND LOCAL UNITS OF GOVERNMENT. WE SUPPORT THE CONCEPT THAT TITLE IX MONIES BE OBLIGATED BASED ON NUMBER OF PERSONS IN STATES WHO ARE 55 OR OLDER.

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, THE NATIONAL ASSOCIATION OF COUNTIES THANKS YOU FOR THE OPPORTUNITY TO PRESENT ITS VIEWS ON FISCAL 1978 FUNDING FOR THE COMPREHENSIVE EMPLOYMENT AND TRAINING ACT AND THE OLDER AMERICANS ACT.

Mr. WEINTRAUB. We are quite concerned that the President's request for title I of CETA stands at last year's level of the 1.88 billion. This remained at that level despite increases of inflation and a projected 8.7-percent increase in minimum wage to $2.50 an hour, if one accepts the prognosis of Secretary Marshall's request that the increase will rise to $2.50 on January 1.

He also projected in his testimony of the 24th, a rise to $2.73 per hour by July 1, 1978, or an 18.7-percent increase over the existing $2.30.

When you prorate those two increases over the fiscal year you are dealing with a minimum of 11-percent increase and this would result in a hold harmless level of $2.11 billion for title I, assuming the timetable of Secretary Marshall.

If you look at Congressman Dent's bill on the House side, H.R. 3744, the minimum wage will go to $2.85 per hour, 30 days after enactment. This would be a 24-percent increase. In other words, to maintain a hold harmless you would need $2.35 billion.

If you look at AFL-CIO's request of $3 an hour, you would project about $2.55 billion.

Senator EAGLETON. What you are saying, you can use any projection you want, Mr. Meany's, Mr. Dent's, or Mr. Marshall's taking any one of those you want, and taking into account a hold harmless clause it will take more than $1.88 billion.

Mr. WEINTRAUB. Definitely. That does not include any increase for inflation.

If you couple in the increases for minimum wage, the inflation needs and the fact that the unemployment rate is going down gradually, slowly, but still going down to some degree we feel now is the time to start beefing up the training function that has been forgotten under the CETA system with public service employment being emphasized and, therefore, we would like to recommend an appropriation level of $2.5 billion for title I of the Comprehensive Employment and Training Act.

Senator EAGLETON. What are the training components in that title? We all know—we sort of think we know what public service jobs are. Such training as is encompassed there, on-the-job training with the city or county or whatever it is, what is the training component in the other facet of title I?

Mr. WEINTRAUB. OK.

There are 12 allowable activities in title I as defined in the law. They include things like skill training, GEDO high school equivalency preparation, English as a second language, on the job, work experience, job sampling, any of the mix and match of those types of activities can be carrried on by a CETA prime sponsor, depending upon the local definition of need.

Senator EAGLETON. Of course, Job Corps is totally separate.

Mr. WEINTRAUB. Yes.

Senator EAGLETON. Are you getting to that in your testimony, are you going to recommend more for Job Corps?

Mr. WEINTRAUB. We are not speaking to that specifically, although we support the administration's thrust to approximately double the Job Corps.

Senator EAGLETON. Is this a fair oversimplification? If I am not right I want you to set me right. The kind of training envisioned in title I–C is training that can apply to an individual who has certain skills, that you can bring them along, whereas Job Corps training is directed to the tough, hard, difficult cases of people that really have minimal basic skills. The Job Corps is more in depth in dealing with difficult cases than the programs under CETA title I.

Is that generally true?

Mr. WEINTRAUB. As a broad-brush statement that is probably true, but again individual prime sponsors by defining what segment of the population in need within their community they want to mostly serve, let's say, could be doing a lot of similar in-depth skill training, paralleling the type of thing that goes on in the Job Corps but with a different age group.

Moving on to public service jobs for a moment, we support an immediate increase of 600,000 public service jobs. The current economic stimulus bill 4876 brings that up to 725,000; our steering committee, the employment steering committee of organization recommended an increase to 910,000.

Therefore, we would like you to take a look at the possibility of adding another 185,000 jobs in fiscal 1978 which we estimate at a cost of $1.54 billion, figuring about $8,300 per slot.

Senator EAGLETON. My recollection of Secretary Marshall's testimony in this regard was something like the following: In the early days of his being designated Secretary of Labor, he had the notion that these programs could be expanded in much larger magnitude, similar to what the witness is now saying, but he modified his views later on, because he didn't think it was practical to beef up the programs that much in one fell swoop.

Is that about what he said? He doubled the Job Corps because that is as fast as you can do it, from 40 Job Corps centers to 80, whatever it was.

How would you rebut what seems to be the Secretary's current position?

Mr. WEINTRAUB. Well, we have testified before the Employment Opportunity Subcommittee on the House side and have had individual discussions with Members of the House and Senate on this issue, and our response is that we feel this can occur under the title II mechanism. We feel that there is a certain time delay when working through title VI, because of the eligibility certification problem that the new title VI amendments bring in, and we are quite concerned with the ability of the unemployment insurance system.

As was mentioned earlier by other witnesses, that they are understaffed, they have to certify eligible clients under three out of the four criteria in the new title VI amendment in order for them to be eligible for a title VI job.

By the targeting of title II which targets funds only to areas above 6.5 percent and has length of unemployment as a client eligibility factor, we feel we could move a lot quicker under the less burdensome design of title II and still target jobs to those who reside in high unemployment areas.

Taking a look at the impact of minimum wage on youth programs, we are quite concerned again, just depending upon how quickly the

Congress deals with the minimum wage issue, whether or not any increase in minimum wage will affect this summer.

We kind of doubt it. Just looking at the schedule of the Congress, but we are looking at fiscal 1978.

Again if you project from Secretary Marshall's increases the last—well, the fiscal 1977 summer youth program was at $595 or is at $595 million. Secretary Marshall's statement did not have a specific figure, but said that they would go along with that figure for the meantime, if you will.

If you look at the impact in minimum wage, a hold harmless, based on Secretary Marshall's testimony would take the dollar figure up to $706 million for fiscal 1978.

If you project Congressman Dent's approach, the hold harmless for summer jobs would take the figure up to $737 million. We are requesting a minimum of $725 million, pending the outcome of the minimum wage debate, but we feel that would be a good approximate ballpark figure, given the differences in the requests for minimum wage.

Senator EAGLETON. What is in the administration's budget, five what?

Mr. WEINTRAUB. There was no specific request as I remember. The $595 million—$595 is fiscal 1977 appropriation. Mr. Marshall said that we would temporarily go along with that as a ballpark estimate, but would want to come back and revise that figure. In light of his request for increased minimum wage, I think that our request of $725 million is quite reasonable.

Senator EAGLETON. Do you as a matter of policy have an opinion on the youth differential in the minimum wage?

Mr. WEINTRAUB. We feel that that is really a bogus issue, that in general——

Senator EAGLETON. Mr. Meany doesn't think it is bogus.

Mr. WEINTRAUB. In general, we feel the minimum wage for youths, a kid working at McDonald's, that there should be no real differential for youths, as our general—that is our general position on that subject. We are quite concerned with some of the earlier drafts of the administraton's youths bill which would include consideration for youths and we feel that is quite out of line.

The Senate Human Resources request of $2.5 billion for the new youth title of CETA, assuming that will take effect probably by July of this year, we are against any repeal of section 4–E of the Comprehensive Employment and Training Act. This section would set, or currently sets a limit of 20 percent of all funds appropriated on titles III and IV of the act. We feel that while targeting is desirable, we don't feel that there is any reason to go back to categorical programs under title III and we feel it would be best to establish an income criteria for client participation.

Moving on to the Older Americans Act, if I can take a couple of moments on that. We support full funding of all sections of that act and, therefore, support the request of the Senate Special Committee.

We are supportive of the Senate Committee's action on H.R. 4876 which allows for 50 percent of the funds to be distributed to State and local units of government. And would like to further support

the notion that title IX moneys are obligated based on the number of persons and States who are over 55 percent.

In hearing the earlier witness from green thumb, I do not think it would be an inaccurate estimate to say that the allocation of slots within green thumb was not a reflex action of a number of persons of 55 percent in each of those States. I think that that should be looked at for each of the national contractors, regarding administration of that program.

Before I close, I would like to urge you and members of the subcommittee to do whatever can be done to bring H.R. 4876 to the Senate floor for vote before recess. Our local prime sponsors who administer public service jobs have been told to get ready by the end of May, early April, they have the projects lined up, they are ready to hire people, people are calling in need of jobs.

We are waiting basically for that money to be released. There is no difference in the CETA figures, as I understand it, between the House and Senate and we would wish that that part of the package be expedited, as soon as possible.

I appreciate the opportunity to testify. Thank you.

Senator EAGLETON. Thank you, Mr. Weintraub.

## AFL–CIO MIGRANT LEGAL ACTION PROGRAM

### COLORADO RURAL SERVICES

**STATEMENTS OF:**

**RAY ANDREWS AFL–CIO**
**KEN PETERSON, AFL–CIO**

**ACCOMPANIED BY:**

**GEORGE BRADFORD**
**MIKE SEMLER, MIGRANT LEGAL ACTION PROGRAM**
**DICK GINSBERG, COLORADO RURAL SERVICES**

### PREPARED STATEMENT

Senator EAGLETON. Next, we have a panel on OSHA. The prepared statment will be placed in the record at this point.

[The statement follows:]

## STATEMENT OF ANDREW J. BIEMILLER

We thank the subcommittee for this opportunity to express our views on appropriations for the Departments of Labor and Health, Education and Welfare.

The most serious problem facing our country today is unemployment. The first priority of the Congress should be to increase funding for programs that will most effectively stimulate the economy and put people back to work.

The most recent figures still indicate an unemployment rate of 7.3 percent. Adding discouraged workers and part-time workers seeking full-time jobs brings the unemployment rate to 10.0 percent. The Administration's budget proposals are based on reducing unemployment to just above 6 percent at the end of calendar year 1978. The result would be an unemployment rate higher than any post-World War II year except 1958 and 1961, and the last two horrible years. Six million people would still remain unemployed at the end of 1978 unless Congress includes more direct job creation programs in its budget. While the Administration budget recommendations are a significant improvement over the unrealistic Ford Administration proposals, more needs to be done to put people back to work.

The AFL-CIO recommends that the budget for public service employment be increased by $1.5 billion over the Administration request for fiscal 1978. This would enable the public service jobs program to expand its employment to more than 1,000,000 during fiscal 1978. This is 275,000 more jobs than recommended by the Administration.

The fear that raising government spending to solve social problems will result in burdensome deficits, excessive government spending or inflation is completely unwarranted.

It is a fact that the budget deficits of the last few years have been huge. During the years 1970-76 there were back-to-back deficits totaling $180.4 billion. That's almost 2½ times as much as the accumulated deficit of the previous 23 years.

But these deficits were the result of years of economic mismanagement which have included two deliberately engineered recessions. The deficits were caused by lost taxes due to high unemployment, underused production facilities, and higher unemployment insurance and welfare payments.

The deficits by themselves did not cause any economic problems. Despite the occurrence of these large deficits, no calamities have occurred. The $66

billion deficit of 1976 did not "crowd out" private borrowing or drive interest rates up to new highs. In fact, interest rates fell during 1976 as a result of the weak economy.

The only way to wipe out the budget deficit is to rapidly reduce unemployment. Each 1 percent cut in the unemployment rate will cut the budget deficit by $16 billion, approximately $14 billion in added tax receipts and $2 billion in lower costs of unemployment. In addition, state and local governments would have their budget positions improved by $5 billion.

Fears that government spending is "excessive" or "out of control" are groundless. Federal expenditures amounted to 19.9 percent of Gross National Product in fiscal 1974 before the full impact of the recession was felt. The average over the previous decade was 20 percent. The trend from 1968 to 1974 was significantly downward. The increase in 1975 to 23% was not a sign of increased federal involvement in the economy. The increase was the result of the recession's impact. The recession decreased total output and tax revenues and increased federal recession related expenditures. Government spending as a percent of GNP will again fall when the economy recovers.

Fears of inflation resulting from increased government spending are also groundless. The price increases of recent years have not been caused by excess demand for goods, shortage of workers, excessive wage increases or federal deficits. The major cause has been the rapid price increases of fuel, food and interest rates.

Inflation was further aggravated by the engineered recessions. The slump conditions gave us an economy with large amounts of unused plant and equipment and unemployed workers. This waste and inefficiency slowed down the pace of productivity which placed additional cost pressures on all segments of the economy.

Groundless fears of a deficit or inflation should not be allowed to prevent the Congress from adequately addressing the needs of our nation in the 1978 budget. The solution of the unemployment problem will ease inflationary pressures and reduce the deficit. The goal of rapidly decreasing unemployment and funding programs to help solve our nation's social ills are the only goals that should be set by Congress.

EDUCATION

The education budget is clearly tied to the ability of our nation to solve its unemployment problems. The most vital need is for an increase in

funding for Title I of the Elementary and Secondary Education Act.

Title I is designed to prove the education of economically deprived children. This program should be expanded by $700 million to properly fund these important services.

The AFL-CIO is very disturbed by the Administration acceptance of a $317 million cut in impact aid, also known as school assistance in federally affected areas. Impact aid is a program which is not generally understood. This program provides aid to local school districts deprived of property taxes by federal installations or public housing projects. Major cities will lose a staggering amount of money if the program is terminated. For example, New York City would lose $19.8 million, Chicago $5.9 million, Philadelphia $4.1 million and Washington, D.C. would lose $3.7 million. The termination of impact aid will mean a cut in services for many school systems.

Impact aid can be used to ease the problems of increased energy costs and job cut-backs. Because of forward funding, impact aid is the one program where an increase will aid school districts this coming September. We recommend that budget authority for impact aid be increased to $1.2 billion dollars.

We would also like to express our strong support for increased funding for education for the handicapped (+$375 million), bilingual education (+$15 million), vocational education (+$?00 million), library resources (+$274 million), and the higher education programs (+$1.6 billion).

The National Direct Student Loan Program should not be cut by $323 million as has been requested by the Administration. This program which provides loans to low income students at 3 percent interest is badly needed by low income students.

Also, the 1976 Education Act amendments which include "Lifelong Learning" should be given funds to begin their programs.

The total education budget should be increased $4.1 billion over the Administration's recommendation to $13.5 billion to provide adequate support for these vital programs.

YOUTH EMPLOYMENT PROGRAMS

The budget authority for youth employment and basic training programs under CETA Titles I, III and IV needs to be expanded by $400 million in order to provide a more appropriate level of opportunity for young people to learn basic job skills and to provide summer employment opportunities for youth.

Youth unemployment is a serious part of the total unemployment picture. Official statistics indicate that one out of every five teenagers and one of every three black teenagers is jobless. High unemployment for young Americans wastes human resources, breeds frustration and often leads to anti-social activity. Adequate job creation and training for all youth is essential for a constructive beginning to adult worklife.

OCCUPATIONAL SAFETY AND HEALTH

The President's budget recommendation for the Department of Labor's OSHA program are exactly the same for FY 1978 as for the previous fiscal year, except for increases in mandatory items. This is also basically true for the NIOSH budget requests.

It is difficult to understand the reason for those proposals in the face of these facts:

1. More and more information is becoming available on the multiplying health hazards besetting millions of workers in places of employment covered by this act;

2. Only a small proportion of workplaces can be inspected with existing manpower levels;

3. There is a need to expand training, education and consultation services;

4. A mounting number of occupational health standards need to be processed and promulgaged;

5. There is an absence of skilled manpower to operate the OSHA program protecting the safety and health of federal employees; and

6. There are additional responsibilities of both agencies in coordinating their operations with those of the Environmental Protection Agency under the Toxic Substances Control Act.

The AFL-CIO requests the following increases in money and manpower over the President's Fiscal Year 1978 Budget for implementation of the Occupational Safety and Health Act:

1. For the Occupational Safety and Health Administration of the Department of Labor - 255 additional professional and 47 clerical backup positions. This would require $6,125,000 in new money, since we are requesting your Subcommittee to reprogram $4.5 million budgeted for state programs to federal enforcement.

2. For the National Institute for Occupational Safety and Health of the

Department of Health, Education and Welfare - 107 additional professional positions, involving an increase of $16,800,000 over the Carter-Ford Budget for Fiscal Year 1978. Authorization of appropriations to proceed with site selection and construction of the vitally needed NIOSH laboratory facility.

Occupational Safety and Health Administration, Department of Labor

Federal Enforcement: Our request for funds to increase federal enforcement personnel (Industrial Hygienists) is based first on the expectation that the backlog in health standards awaiting OSHA rulemaking will be sharply reduced in the next fiscal year under the new administration, and that it will adopt a new policy of standards relating to exposure to carcinogens, as well as promulgation of its so-called standards completion policy on several hundred airborne contaminants. Secondly, the diversion of one-third of existing enforcement personnel to the National Emphasis Program on foundries makes it essential that additional enforcement personnel for general inspection areas be acquired.

Thus, enforcement of health standards will become more widespread, necessitating acquisition of additional Industrial Hygienists beginning in Fiscal Year 1978. In addition, there is a continuing high rate of deaths and injuries incurred by workers exposed to conventional safety hazards, and more Safety Inspectors are needed. We suggest to your Subcommittee that 200 compliance officers we proposed be broken down into 150 Industrial Hygienists and 50 Safety Officers (COSHO's).

We have further examined the Carter-Ford Budget for state OSHA programs under Section 18 (b) of the Act. Data we have received from nearly all of the 24 states with Section 18 (b) programs show that their Fiscal Year 1977 budgets now awaiting legislative action total about $30.8 million as against $35.6 million in the Carter-Ford Budget, a difference of $4.8 million. We urge this subcommittee to direct reprogramming of $4.5 million from state programs to federal enforcement.

Safety and Health Standards: As previously mentioned, it is expected that the number of rulemaking proceedings on occupational health standards will sharply increase during Fiscal Year 1978. We propose that 10 additional positions be funded, with 2 backup clerical personnel at a cost of $350,000. Specially needed are a bio-statistician, a toxicologist, and a skilled engineer in industrial design and process.

Federal Programs: The 2.8 million employees of the federal government have been given only the slightest amount of attention under OSHA, although their workers

face the same occupational hazards as workers in the private sector. Our recommendation is for 10 additional professional positions, with 2 clerical backup jobs, requiring $350,000 in additional funds for Fiscal Year 1978.

Statistical: The Bureau of Labor Statistics has informed the National Advisory Committee on Occupational Safety and Health that to provide a more effective statistical program there is a need for at least 19 additional personnel.

Much needed, but not being provided, is the development of a valid measurement of the extent of occupational illnesses which the present system lacks, further expansion of special studies on causes of accidents and illnesses; more intensive evaluation of the OSHA program, and identification of areas of greatest hazard.

We request 20 new statistical positions, 4 clerical backup and $660,000 in new money for this program.

Training, Education and Consultation: We request the funding of $165,000 in new money to add five professional and one clerical position for training, education and consultation. Their services should be used in developing programs now almost lacking in orientation and training of workers and developing simple factual information to small employers on how to comply with the Act. We urge that this subcommittee instruct OSHA to continue existing direct support contracts with three colleges and universities now providing training programs for workers, and to enlarge this program to include other land grant colleges with are capable of such an undertaking.

Executive Direction and Policy Research: Fifteen new professional and three clerical backup positions are needed to improve OSHA functioning under its reorganized status. Field coordination must be improved and backlogs significantly reduced. Better priority systems for scheduling inspections are badly needed, less paperwork and more field work should be performed by compliance personnel, and an evaluation of the effectiveness of OSHA's enforcement and voluntary compliance programs, including consultation should be made. More effective methods of developing occupational health standards must be found, and means of uniform application among the regional and area offices of coordination with EPA on the Toxic Substances Control Act is an immediate priority.

National Institute for Occupational Safety And Health - Department of Health, Education and Welfare

The National Institute of Occupational Safety and Health which has far reaching responsibilities particularly for research for the development of health standards proposals, hazards evaluation and manpower training, is badly in need of increased funding.

Without a successful effort to forestall future crises which have arisen over exposure of workers to such substances as asbestos, vinyl chlorides, kepone, lead, arsenic, cotton dust and leptophos, new substances, processes and technologies and energy fuels there will be an increasing frequency of such episodes which always result in thousands of human victims of prevention and abatement actions that come too little too late.

Organized labor is in strong support of the proposed NIOSH budget for FY 1978 submitted by the Secretary of HEW to the Office of Management and Budget, where it was stripped of its meat and left at a level of $2.6 million less than the Congressional appropriation for FY 1977.

We urge that there be money appropriated to provide for 107 new professional jobs and $16.8 million additional money than that setforth in the Carter-Ford budget, and $13.6 million over the conference action by the Congress for FY 1977. The attached table details the programs areas where the increases are indicated.

NIOSH has developed and needs to be enabled to implement its "Forward Plan" for fiscal years 1978-82, inclusive. Authorization of the AFL-CIO proposals for FY 1978, identical to those in the Departmental Budget would provide for an orderly start without needless delay.

We are submitting for the record the elements of the Forward Plan as set before NACOSH by the National Institute for Occupational Safety and Health. We believe that this subcommittee will share the AFL-CIO's endorsement of this forward looking program and authorize the necessary appropriations to give it life.

As a final recommendation for the NIOSH program, we urge that language be written into the FY 1978 appropriations bill authorizing appropriations be made annually to proceed with the two stage construction of the NIOSH laboratory. NIOSH personnel are at present attempting to do their job under the most trying conditions in inadequate temporary facilities which lack adequate equipment. The matter of site selection should be carefully and properly resolved, but should not delay authorization of the laboratory itself.

Health Maintenance Organizations

The hope that the Health Maintenance Organization Act of 1973 would provide the needed leverage to reform the fee-for-service health care system is hampered by inadequate funding. The $18.1 million budget proposed by the Ford Administration and unchanged by the new administration is woefully inadequate.

The Comptroller General recently reported to Congress that lower than expected financing and a staff limited in numbers and expertise for administration of financial assistance and regulations has impeded and will continue to impede the development of the HMO program.

For FY 1978 $44.8 million will be required to continue and improve the existing HMO grant program. Of this amount $35.8 million would provide continuation and minimal expansion of the existing program and $9 million would remedy the staffing and training deficiencies noted by the Comptroller General.

Alcoholism Treatment Programs

The AFL-CIO recommends that the project grants and contracts for community treatment programs for alcoholism be funded at the authorization level of $91 million. This is $22.3 million more than recommended by the Administration.

Labor and management have a great concern for workers who suffer from alcoholism. The AFL-CIO, working through its Community Services Department and in cooperation with other interested organizations, is promoting and assisting in the establishment of joint union management programs to provide early identification, referral, treatment and rehabilitation of the alcoholic worker. Some of these programs have achieved recovery rates as high as 80%.

At present about $30 million in project grants that have been approved by the National Institute on Alcohol Abuse and Alcoholism cannot be implemented because of insufficient appropriations.

One of these grants, which was awarded to the Appalachian Council, is of particular interest to the AFL-CIO. This grant would provide funds to initiate labor-management programs and community-wide programs which would reach out to the poor and underprivileged.

An appropriation of $91 million would enable NIAAA to fund the program of the Appalachian Council and other treatment programs which have already been approved.

JOB PLACEMENT FOR THE HANDICAPPED

The AFL-CIO recommends that funding for Section 304(d) of the Rehabilitation Act be increased by $5 million and set aside for Projects with Industry to be utilized by

the AFL-CIO and its affiliated unions to train the handicapped for employment.

There are 5 million handicapped individuals that can be trained for productive jobs. The $5 million we are requesting will result in the placement during the next year of about 5 thousand individuals.

Most jobless disabled individuals are receiving welfare and other forms of public assistance. Jobs for these people would relieve the nation of welfare costs and turn these handicapped persons into tax payers. At $1 thousand per placement, this is a very cost effective program.

The manpower rehabilitation program under the law involves an active partnership between the rehabilitation facility, industry and organized labor.

The involvement of unions helps to assure a high quality training program. As a former Secretary of Labor said, "We recognize that unions have a talent and special concern in improving the skills of the workforce. They have cooperated in helping train young people, veterans, the long term jobless, members of minority groups and others."

The involvement of unions also helps handicapped individuals to get placements in higher paying union plants. The better pay and fringe benefits such as health care and pensions make these placements much more beneficial to handicapped individuals.

AFL-CIO RECOMMENDATIONS FOR INCREASES IN APPROPRIATIONS
FOR LABOR-HEW ABOVE THE CARTER ADMINISTRATION RECOMMENDATIONS
FOR FY 1978

| PROGRAM | RECOMMENDED INCREASES IN BUDGET AUTHORITY (IN MILLIONS) |
|---|---|
| Public Service Jobs (CETA Title II and VI) | $ 1,500 |
| CETA I, III, and IV, Summer Youth, and WIN | 650 |
| Education | 4,100 |
| Occupational Health and Safety | 22.9 |
| Health Maintenance Organizations | 26.7 |
| Alcoholism Treatment Programs | 22.3 |
| Job Placement for the Handicapped | 5.0 |
| Total | $ 6,327 |

AFL-CIO BUDGET PROPOSAL FOR OCCUPATIONAL SAFETY AND HEALTH

FISCAL YEAR 1978

I. OSHA -- U.S. Department of Labor

Increases Over Carter-Ford Budget

| Program | Positions | | Amount |
|---|---|---|---|
| | Professional | Clerical Backup | |
| Federal Enforcement | 200 | 40 | $8,750,000 |
| State Programs | --- | -- | -$4,500,000 |
| Standards | 10 | 2 | 350,000 |
| Federal Employee OSHA | 10 | 2 | 350,000 |
| Statistical | 20 | -- | 660,000 |
| Exec. Direction & Policy Research | 10 | 2 | 350,000 |
| Trng., Consultation, Educ. | 5 | 1 | 165,000 |
| Net Total | 255 | 47 | $6,125,000/1 |

/1 Reprogram to Federal Enforcement

II. NIOSH -- Department of HEW

Increases Over Carter-Ford Budget

| Program | Professional Positions | Amount |
|---|---|---|
| Surveillance | 10 | $ 300,000 |
| Criteria Documentation | -- | 200,000 |
| Industry-wide studies | 45 | 2,500,000 |
| Laboratory Research & Services | 45 | 6,200,000 |
| Coal | -- | -------- |
| Technical Assistance | -- | 100,000 |
| Manpower Development | 7 | 7,400,000 |
| Program Direction | -- | 100,000 |
| Net Total | 107 | $16,800,000 |

## STATEMENT OF DICK GINSBURG

SUMMARY OF TESTIMONY

The rider to the OSHA appropriations bill for the fiscal year 1977, which prohibits the expenditure of funds for any activities pertaining to farming operations with ten (10) or fewer employees, was enacted in response to criticism of the OSHA program in general. This enactment did not consider the need of farmworkers for on-the-job protection. Agriculture is a very dangerous industry and the forementioned rider results in the vast majority of farmworkers losing their protection under OSHA.

Additionally, this rider frustrates the efforts of States which have opted for State-Plan programs to the exclusion of OSHA. Such programs are funded on a matching-dollar basis and the rider's prohibition on the expenditure of federal funds effectively negates efforts to protect farmworkers under these State-Plans. In Colorado virtually all farmworkers are now unprotected even though standards remain in effect.

This type of rider is not an effective way to attack the problems of OSHA and unfairly penalizes farmworkers. It should not be renewed.

My name is Dick Ginsburg. I am from La Salle, Colorado. I am an attorney with the Farmworker Division of Colorado Rural Legal Services and my comments today are made in representation of a specific client and seasonal and migrant farmworkers in general.

My comments are directed to the proposed rider which would prohibit the expenditure of funds appropriated to the Occupational Safety and Health Administration for any activities which pertain to farming operations employing ten (10) or fewer employees.

A reading of the Congressional Record of the debate on this question last year shows that the real issue here is not whether farmworkers need on-the-job protection. There is no disputing of National Safety Council statistics that farming is the third most dangerous industry in our country. But rather it is OSHA itself - how it is administered and how it carries out its legal mandate.

If small farmers are being harassed by OSHA inspectors, they should be "protected". But this should not be done in a manner which threatens the health and safety of the workers in the nation's third most hazardous industry. Exemption of any industry or group of workers is not the solution to the problem. This only undermines the intent of the Congress in creating OSHA. The appropriations rider now in

effect and proposed for renewal means that, according to a Department of Labor statistic, 87.5% of the nation's farms can ignore the safety of their workers. And it does absolutely nothing to remedy the problems which were cited as the reason for its enactment. Rather, it hands a nearly blanket exemption to an industry with a bad safety record but a strong lobby and does this at the cost of hundreds of thousands of farmworkers. These farmworkers are paying the price of being unorganized. They carry the burden of the incompetency of OSHA's bureaucrats. Someday they will shed their second-class citizenship and attain the rights enjoyed by other workers in this country.

I would like to draw your attention to another ramification of the OSHA appropriations rider. Section Eighteen of the OSHA Act provides for State-Plans by which individual states can assume the responsibility for development and enforcement of occupational safety and health standards to the exclusion of OSHA. The State-Plan only must be "as effective as" the OSHA program in all of its aspects.

The State of Colorado was one of the first states of the Union to undertake such a State-Plan. And Colorado has shown that through local control, it can run a program much better than OSHA could ever hope to. COSH, as the program is called, has given both employers and employees full access to the promulgation of standards process. It also regularly consults advisory committees for various industries which are composed of equal members of employers and employees.

The COSH Standards Board undertook a careful and deliberate consideration of the agricultural industry before promulgating standards. Its Agricultural Advisory Committee met many times and recommended standards which its members felt were adapted to the Colorado situation and which both employers and employees could live with.

COSH began inspections of agriculture in mid-August, 1976. Then on October 1, 1976, the darkness fell. The appropriations rider took effect and because every local program dollar is matched by a federal OSHA dollar, COSH was forced to stop all inspections and other activities having to do with farm operations with ten (10) or fewer

employees. I ask, was this the Congressional intent?

There are no OSHA inspectors in Colorado harassing small farmers or anyone else. COSH has done an admirable job of tackling the ticklish problem of safety and health on the farm worksite. But the appropriations rider, an ill-conceived form of retaliation against OSHA for its past sins, totally undermines Colorado's efforts, and Colorado farmworkers are penalized and subjected to occupational hazards due to the errors of OSHA in a state where OSHA isn't even present.

I am not referring to just a few unfortunate farmworkers in Colorado. The Director of the Division of Labor of the Colorado Department of Labor estimates that 90% of Colorado's farms have ten (10) or fewer employees. The Chief of Compliance for COSH estimates that 95% of the farm employees work on farms with ten (10) or fewer employees. Finally, a member of the Colorado General Assembly who represents a farming district has stated that not even one-tenth of one percent of Colorado's farms have over ten (10) employees. So this appropriations rider has meant, and if renewed, will continue to mean that farmworkers in Colorado have been abandoned by the Government and left to their wits as far as on-the-job safety is concerned. And the irony of the tragedy is that there are standards in effect to protect them . . . but there are no funds to enforce the standards.

This rider not only endangers workers who produce the nation's food, while, I might add, other workers producing non-essential products remain protected, but it frustrates the efforts of a State to find its own solution to the OSHA problem. The appropriations rider was intended to last one fiscal year and now is the time to scrap it. Its cost in human safety is wholly unjustified. The problem must be tackled without sacrificing the objectives of the OSHA act. One logical way to address these problems would be the confirmation hearings for the new OSHA administrator. The Congress should remain concerned, but what is needed is an executive

department solution and not a legislative one. Wiping out enforcement isn't the solution. I strongly urge this committee and the whole Congress to consider the rights of farmworkers - Those unseen and second-class citizens who provide our daily bread - and restore the protections they are due by letting this OSHA appropriations rider die.

INTRODUCTION OF WITNESSES

Mr. ANDREWS. Ray Andrews, with AFL–CIO in Community Services.

Mr. PETERSON. Ken Peterson, AFL–CIO.

Mr. BRADFORD. George Bradford.

Mr. SEMLER. Mike Semler, migrant legal action program.

Mr. GINSBERG. Dick Ginsberg, with the farm workers division of Colorado Rural Services.

Senator EAGLETON. Who funds you.

Mr. GINSBERG. Legal Services Corporation.

Senator EAGLETON. Somebody start.

Mr. PETERSON. Substituting for Andy Beimiller.

We will submit our statement for the record, and I just want to bring out some of the highlights that we are asking for. We are interested in increasing the number of jobs and positions in OSHA. The budget this year is the same as last year. It is a much maligned program.

There was a time when the administration was unfriendly to it, and it continues. We believe it actually tried to sabotage the program. Even the money appropriated for last year, 178 inspectors, were not used——

Senator EAGLETON. You say 178 were authorized but not hired?

Mr. PETERSON. Yes.

Senator EAGLETON. What is the total number of inspectors on board?

Mr. PETERSON. I have no idea.

Senator EAGLETON. 2,400, I understand.

What does the Carter budget, envision in that area? I understand it has been the same as 1977.

Mr. PETERSON. We are asking for approximately 400 more positions. We have them detailed here, and the reasoning—and it costs almost $23 million additional. This is what we are asking for. It is detailed here.

We are asking for improvement in the health maintenance organizations. Budget is 18.1 proposed by the Ford administration. Unchanged by the new administration.

Senator EAGLETON. This is health maintenance?

Mr. PETERSON. Yes.

Senator EAGLETON. I am doing the Labor budget. Senator Magunson is doing HEW. I will listen to it.

Mr. PETERSON. I was just stating we are looking for an increase.

Senator EAGLETON. Do you think HMO's have thus far lived up to the high hopes and expectations of Congress?

Mr. PETERSON. Yes; we believe so.

Senator EAGLETON. Some would disagree with you on that.

Mr. PETERSON. Did you say OSHA?

Senator EAGLETON. HMO.

Mr. PETERSON. We think so. We think it is coming along great. Of course, we will find some disagreement somewhere.

Senator EAGLETON. I just read a document. I read a lot of stuff. It was on HMO's, and it was very critical.

Mr. PETERSON. We would expect some, but we believe they are doing well and with additional money they will improve.

I would like to talk on the alcohol treatment program. This is also in HEW. Ray Andrews made a study on this through the years.

Senator EAGLETON. Is your testimony here today going to be the total testimony of AFL–CIO on all Labor-HEW matters?

Mr. PETERSON. Yes.

Mr. ANDREWS. I would like to emphasize on that portion of the budget allocated for alcohol abuse, we feel it is extremely important the full authorization of $19 million for project grants and contracts be appropriated. There are several reasons why. These project grants and contracts are used to get out into the working field, to furnish seed money for developing community programs, and particularly for encouraging labor and management to develop joint occupational alcohol programs, which covers the whole field of identification, referral, treatment, and rehabilitation.

We are beginning to make some headway in that direction now. But we run into a problem. There are over $30 million in grants that have been approved, but cannot be put into operation because insufficient money is appropriated.

One major grant we are very proud of is beginning to show some progress, that was given to an organization that we work with, where representatives of major corporations and labor share the management committee, where 10 major cities have programs that are financed by this grant, and we have joint representatives from management and labor that go in and encourage management and labor in the community to develop an overall program.

What we have run into as we are getting underway, that because of insufficient funds these grants must be cut back 20 percent across the board.

You cannot cut staff because you have that balance and it is staffed only to a minimum, so you have to cut down the operational money where you would work with people.

We have another very important program for the Appalachian program of the AFL–CIO that provides trained people to develop joint occupational programs and go into the community and areas where people are working below the poverty level and develop a program to cover the whole community as well as the occupational work force. That was approved a year ago. We cannot get moving because it is part of those contracts and grants that are tied up with this $30 million insufficient appropriation.

So, if the full $91 million that is authorized could be granted, we think that the 5 to 10 percent of our population, and particularly those that are working on jobs, that have alcohol problems would see a great dent made in that amount, and certainly where we have a good program. What I'm saying, we have 70- to 80-percent recovery, where the people who are put into those programs are rehabilitated, they go back on the job, and the company saves money because not having to train a new employee——

Senator EAGLETON. 70 to 80 percent permanent?

Mr. ANDREWS. That is right. Where we have a good joint union-management program, where they are working together. We are just being able to prove ourselves, and we find the one good program we have, that is being cut back 20 percent, and the program that will help supplement it cannot get off the ground because NIAAA

in the project grants and project section is being funded enough to keep its head above water.

So, the backlog for just about a year is still there. It means new programs cannot develop or old ones will just continue and then will die out.

We strongly urge that the full $91 million for project grants and contracts be authorized, and we think it will bring manyfold times more back even in taxes for the people who are working.

Senator EAGLETON. I am told we approved $9.2 million for this——

Mr. ANDREWS. For the supplemental. I certainly hope that goes through, because it would help.

Senator EAGLETON. With respect to OSHA, you stated in your testimony it is a much maligned program, and it is.

I get a certain amount of mail, and sometimes it heats up a little, but it is a source of concern. OSHA inspectors are delighted in being nitpickers, I understand. They have a job to do, a law to enforce, but you can try to enforce in a spirit of cooperation and understanding, or you can try to enforce it like some storm trooper.

It is the excesses or abuses that we hear about that put the whole program in jeopardy.

Mr. PETERSON. I wonder how much of this has been deliberate. Whether they went out deliberately to sabotage this program because its interest is the American worker and his safety. That is all. You have the rightwing, part of the John Birch program against OSHA, Buckley and Kilpatrick writing columns, making a political issue out of an item that concerns the health and safety of the American workers. It is a disgrace.

Senator EAGLETON. What would you say as a concept, talking general terms, the thrust of OSHA inspectors and inspection programs should be with a view to conciliation, working out the problem with citations and lawsuits, et cetera, as the last resort when mediation, conciliation and sweet persuasion does not work.

Would you subscribe to that?

Mr. PETERSON. Sure. We think anything approaching fairness, where something is not deliberate, you see, certainly. Certainly. We are interested in safety and health.

Senator EAGLETON. Are you talking about some of the regs they issue about how many knotholes in a ladder?

Mr. PETERSON. The most famous one is two toilets for the mom and pop stores, and we have inquired all over the 50 States, and have not found that anywhere. Some of the things that have become popular, the interfering with the barber and so forth, we trace them down and they do not even exist. It has become a terrible thing, with the exemptions and the things we have to put up with on the appropriation.

Senator EAGLETON. I know one Senator from Wyoming——

Mr. PETERSON. I am familiar with that. That is a horrible thing. This agency report that was made by the Secretary of Labor's own college and supposedly most knowledgeable on agriculture and their excuse was that the people that work in these departments are very seldom literate and they put it in the most basic English they knew. They say it is not so. They are as highly educated as the factory worker and the rest of them.

According to the agriculture college they are nomads that keep wandering and they put it in the basic terms, as you know, about the slip on and this sort of stuff.

Senator EAGLETON. Let me ask another question. You were here earlier when we had the unemployment compensation guys from the States. What is the AFL–CIO's policy or philosophy, that after 26 weeks or after 39 weeks, whichever one, is there a point when a fellow ought to take that $70 a week job or else?

Mr. PETERSON. No. We don't think so.

Senator EAGLETON. There is growing sentiment for that.

Mr. PETERSON. I know. Also there is growing sentiment for the subminimum wage. As you said, Mr. Meany doesn't agree with that. We certainly do not. We believe this is where the father would lose the job and the son would get it.

Senator EAGLETON. I can see some criticism on the minimum wage. That could be a dangerous thing. I must tell you, I'm getting to the mind that after a certain period on unemployment compensation, I think I would require the individuals to take the job, albeit, it may not be the job he would like, but I think after a period of time, he would have to take it.

I'm making sort of a public confession to you.

Mr. PETERSON. We believe the man is entitled—this, of course, would bring him in under the minimum wage. Right?

Senator EAGLETON. The testimony of the man from Massachusetts, his name was Crosier, said the average check in Massachusetts was $70 a week.

Mr. ANDREWS. It's $1.75 an hour.

Senator EAGLETON. After 36 or 26 or 39 weeks, or at the very least, the minimum wage, say a guy was a machinist making $4 or $5 an hour, I think there would be a point where he would have to take the job, as long as those jobs are unfilled.

Mr. PETERSON. The minimum wage we are talking about is not a living wage and if a man has a wife and two children as you said, you are condemning him to a life of poverty.

Senator EAGLETON. I'm giving him a choice to either take the job and work for the minimum wage or else.

Mr. PETERSON. But you can't live on it, Senator, with your family, you just can't live on that kind of money.

Senator EAGLETON. Maybe the payout benefits are too low but, I'm just taking his testimony, he said the average check is $70 a week.

Mr. BRADFORD. Senator, having been an unemployed machinist, having been from St. Louis, when I went up and down Cass Avenue, going to the different companies trying to find work, I have seven children and I needed a lot more money to support my family, I couldn't find a better job if I took that $70 a week job, but I always was hoping that something would open. I would sometimes wonder how many of the companies are keeping it there, looking for the best, cheapest.

Senator EAGLETON. What was your unemployment check during that period of time?

Mr. BRADFORD. I don't remember now. It was low, I know that.

Senator EAGLETON. How did you feed your kids on that?

Mr. BRADFORD. I went out and found some work in real estate.

Senator EAGLETON. You can't live lavishly on $70 a week in this country. We all know that. But I am troubled by the notion that there are jobs available out there.

Let me give you a case in point. A company in St. Louis, maybe you heard about it, Champ Spring Co. down on Shouto, and they make replacement springs for trucks, among other things, big trucks, and they make new springs. It's been a company that has been in business for a long time. I went to school with the guy that runs it. His name is Foreman Champ. He tells me, this is a very low-skilled production line, very, very marginal skills. He told me a couple of years ago.

This guy is a liberal. One of the few liberal types that I know. He called the State unemployment office downtown on Washington, on Broadway near Washington and said "I have two or three jobs open." He was paying well above the minimum. He told me the figure. They sent out three guys. The longest lasted 4 days. Four days. One didn't come back the second day. Then he asked for three more. That next set, the longest lasted 2 weeks, and he said "You know, I get pretty frustrated about this." Believe me, take my word for it, this guy is a liberal. Great Carter booster and he was for Muskie. What do you tell him if you were talking to him?

Mr. BRADFORD. First, I would look and see what his turnover rate was, what the job was, and ask him what he was asking people to do for that wage.

Senator EAGLETON. I guess a rather boring low-skilled job paying above the minimum wage. There was no travel problem. It wasn't a job out at the Chrysler plant. You and I know it's hard to get out there. Shouto, down near 12th and Shouto, around in there, I'm talking about intercity residents, out-of-work residents, it's easy for them to reach that. That's the kind of frustration I hear about and it troubles me.

Mr. PETERSON. As you say this, I'm wondering with all the unemployed that there are, what is the matter with a country that can do so much but can't get its unemployed employed?

I recognize what you are saying, but the problem, your friend's problem, and I recognize there has to be a certain type of worker, as you say, probably low pay in a boring job.

Senator EAGLETON. But it's a job. In the quote, "Free enterprise system," there is a market for these springs. I don't know. I don't have easy answers. I wish I did.

Mr. PETERSON. I think it's more of a social problem.

I have one more thing, this is Charley's department, job placement for the handicapped, we are looking for another 5 million in the Rehabilitation Act to be set aside for projects with industry. Charley is experienced in this and he brings in a figure of $1,000, placement of one person, employed handicapped person, taken from the relief rolls.

Mr. BRADFORD. I think our experience has been with the Department of Labor program that we have had, that our program opens at probably less than $1,000. Working through the labor movement, we have found by putting people into shops that have a contract, where they have fringe benefits, our figures show the union's placements are usually $1 an hour better than the nonunion placement and the retention rate is somewhat better.

We believe we can apply the same principle in the projects with industry. While the statistics are not too good on the handicapped or what kind of employable—more work needs to be done in the placement of the handicapped. We think we can apply the same principles that we have used in the AFL–CIO human resources program.

Senator EAGLETON. What moneys are going in for employment of the handicapped in terms of job placement?

Mr. BRADFORD. I don't know. It would be very low in comparison to services. There is a lot of money there which is important when you are dealing with the handicapped, but we are talking now about placement. There is not too much job counseling for, how do you get your job and hold on to it.

Also, in talking with the corporations, in making the architectural changes which there are funding available, to make those, and we feel as though a lot of types that can be done at a minimum cost.

I know personally, I worked at Krine, I'm not sure if you are familiar with that, down on the south end of Cass Avenue, where the new highway went through. We worked with the handicapped. It was the policy of that company to hire the handicapped. That was way back in 1960. It can be done right.

Senator EAGLETON. Is the AFL–CIO's position on anything in which public money is spent that it must have the equipment or whatever in order to make it conveniently available for the person with even the most—for every individual, including persons with the most severe handicapped? Is that still the policy?

Each subway stop is to have an elevator and have it manned 24 hours a day, if it's in operation. I take it you subscribe to that.

Mr. BRADFORD. If that's the policy.

Mr. PETERSON. I would believe that would be the general policy. I don't know that we specifically took that position, but I think that's the humanitarian thing——

Senator EAGLETON. I went to Montreal to look at their system and they shook their head and they said there is no way you can design a subway system and have it pay off financially if you are going to have attendants for the handicapped 24 hours a day. What they do in Montreal, they have special surface transportation programs to take care of paraplegics and the like, but a subway system cannot be designed and be a financial success or even financially viable if it's designed for worse case uses.

Mr. BRADFORD. I'm not familiar with the subway system, but I'm familiar in plants where we have operations, say you are operating a trip lever that could be operated by the foot just as easily if the man only had one arm. There is a lot of other operations, modifications that can be made to the machinery that just, you know, given the chance and the possibility, we think that the handicapped could become more employable.

Mr. PETERSON. Reasonable accommodation is our position on the handicapped subject.

Thank you very much.

## LEGAL ACTION FUND

### STATEMENT OF MR. SEMLER

Senator EAGLETON. Thank you, gentlemen.

Mr. SEMLER. I am an attorney with the Legal Action Fund here in Washington, funded by the Legal Services Corp. to assist local legal aid attorneys in representing farmworkers.

I have submitted a written statement which I will summarize. Mr. Ginsberg will comment on his experiences in Colorado. Do we appear this morning on behalf of a number of individual farmers. We are here to oppose any exemption for the farms of 10 or fewer employees from occupational and safety protection.

Senator EAGLETON. Have we done that?

Mr. SEMLER. The appropriations bill from last year exempted from OSHA protection all those with 10 or fewer employees in farming operations.

Senator EAGLETON. You don't want that done again?

Mr. SEMLER. Not at all. The workers we represent have no unions and must accept the working conditions as they find them, however deplorable, without governmental protection because many of them migrate interstate, local protective legislation isn't sufficient.

Consequently they must look to the Federal Government to set minimum conditions in terms of wages, hours, and job safety. The Occupational Safety and Health Act of 1970 was a giant step forward and it, for the first time, treated farmworkers on an equal basis in terms of providing protective legislation, as with the more visible and powerful American workers.

The appropriations bill of last year was a disheartening retreat from this. That act exempts farms with 10 or fewer employees, thereby exempting the vast majority of agriculture employers. Ninety-nine percent of the producing farms, that is with $2,500 or more in sales, employ fewer than 10 full-time employees.

Of the producing farms which employ any seasonal workers, 73 percent employ fewer than 10. No rational basis was ever offered for this unique exemption for the agriculture industry. The farm lobby has created the impression that the Department has been overly aggressive in this area and in fact nothing could be further from the truth.

Under the last administration only six agriculture standards were ever promulgated, only one of which, housing, has any significant effect on farmworkers.

The enforcement record has been miniscule, especially at small farms. Less than 1 percent, 0.5 percent has been against farms with 10 or fewer employees. In fiscal year 1975, only 11 such small farms were cited for serious repeated or willful violations.

We do not oppose, as you mentioned earlier, constructive efforts which would encourage the abatement on hazards, while limiting it for small employers.

For example, lowering the penalty amounts or increasing the education effort. We believe it is inconsistent with the act. This is no more than a return to the days when farmworkers for many years were considered second-class citizens and excluded from all Federal legislation.

The essence of my recommendation is that you report out a bill that does not contain the conclusion that the fiscal year 1977 bill included.

Senator EAGLETON. Secretary Marshall agrees with you, that the exclusion ought to be dropped. In a sense, it was conceived in the frustration, that was felt by some Members of the Senate, over OSHA, you know, sometimes you can take out your frustration in almost a vindictive way. That may well be the case with respect to the exemption.

Mr. SEMLER. I understand a bill has been introduced which would amend the act with the same effect.

Senator EAGLETON. You specialize in migrant labor and farmworkers.

Do you have any recommendations to the Congress with respect to the illegal immigration situation?

Do you have any suggestions about what we can do about that? There are now, in the country, at the very least, I am told, 7 million illegal immigrants, the large percentage of them from the area of farm labor you are talking about, and some people think the 7 million is on the low side.

Mr. GINSBERG. I might make one specific suggestion that has something to do with the gentleman who testified earlier. There is an interstate recruitment system through the Federal Department of Labor which can arrange for employees who need jobs.

One of the problems we see, the housing which must be up to standard for the workers to be recommended is very much in it. This is a stumbling block for the process.

What we would recommend would be for the Government, whether it is the Farmers Home Administration or the Department of Labor, to get more involved in housing and take the farmers out of the business. They don't want to be landlords and have to have eviction attorneys and fund the projects through the housing or upgrade it, so it meets the Department of Labor regulations and the farmer doesn't have to worry about this.

Then he can better utilize the programs that the Government already has to bring workers from Texas to Colorado or many of the other States in the stream.

Senator EAGLETON. How would this work? Say in California in the truck garden area and what have you, the Federal housing project would be built by the Government?

Mr. GINSBERG. We had, in Grenada, Colo., a project that was built about 10 years ago by a grocers' association. They didn't take care of the physical plant. They defaulted on their payments and there was foreclosure. A nonprofit housing corporation took it over with a grant from Community Services Administration, rehabilitated it. We also had a grant from the division of housing in the State of Colorado. They are now running the housing on a nonprofit basis. They are not farmers, or farmworkers and the housing is still available. They have brought the rent down through a HUD section 8 project. They have gotten a solar water heating grant for the project, and it is running beautifully.

The rate of vandalism is down and it has taken the matter out of the hands of the farmers who were never good landlords and

it has provided housing which is good for the farmers, good for the farmworkers, and it is good for the neighborhood merchants because the population of that town doubles in the summer.

This is the type of thing that we would like to see. And the farmers don't have to worry about meeting the OSHA or the DOL standards for their housing. They can get workers through existing recruitment system programs, because housing is adequate.

They don't have to pay to fix it up every year.

Senator EAGLETON. This is one such example.

Do you know of other examples that have been equally as successful?

Mr. GINSBERG. No. But we know of many situations where the housing has been deplorable and has prevented the interstate recruitment for that reason and the undocumented workers from out of the country have flowed into those jobs.

Senator EAGLETON. I admit housing for migrant workers as a general proposition is bad. Maybe deplorable as you say. Is the answer to that putting the Federal Government in this housing business?

Mr. GINSBERG. I don't see any other solution, Senator. I don't think the farmers have shown they are capable of doing it.

Senator EAGLETON. Do you think as a matter of policy, if there is an unmet social need the Federal Government should act then to rectify that?

Mr. GINSBERG. I would certainly look for other solutions before I looked to the Federal Government but I think our experience in this particular area shows that Federal intervention can help. They don't have to own it or run it.

Senator EAGLETON. There seems to be a prima facie case, for example, take camp safety, a prima facie case, some youngsters get injured at youth camps in the summer, or other places where even kids have lost their lives. Ergo, the Federal Government should get in the business of youth camp safety inspectors, running around looking at youth camps?

Mr. GINSBERG. I am not really familiar with that situation. Obviously someone should be concerned about it.

Senator EAGLETON. I think if you had discussed this with me in my first year in the Senate I would have agreed totally with you and would have instantly signed a bill that is called the Federal Government Migrant Farmworker Housing Quality Act, and would have supported funding it with hundreds of millions of dollars.

Eight years later, I don't think I would support that bill. That is, I draw in my mind some limits to the Federal Government, just pragmatic limits beyond which it cannot go, either in terms of dollars spent, or in terms of capacity to render the service. That isn't very satisfactory in terms of unmet social needs, but I just am beginning to draw some lines, to try to narrow the scope of Federal Government responsibility or intervention.

When you draw lines, sometimes they are drawn in a way that on the surface appears to be arbitrary, but I have seen so many Federal programs—well, were you here this morning when we had the lady from Farmers Union?

Mr. GINSBERG. Yes.

Senator EAGLETON. Everybody is for helping elderly people in the rural as well as urban environment. Obviously we are not doing much with that program, 6,000 people nationwide. We are only kidding ourselves. Maybe with respect to migrant housing, you know, we could pass a great Federal law and it would be called Betterment of Migrant Workers Act, one of those great titles. I wonder how well it would be implemented, how meaningful it would be implemented to bring about the desired social result.

Mr. SEMLER. I think the major thrust is asking for a little less. We are asking only the act passed in 1970 be enforced as to farmworkers. Not that the appropriations be increased. We are not here to discuss that. Just that farmworkers not be withdrawn from the protection which they receive, which all other workers receive.

Senator EAGLETON. If it were more meaningfully enforced, it is not just a question of putting it back on the book, you have to put the money in it to enforce it or that would be another sham.

Mr. SEMLER. A lot depends on administration. You referred earlier—that the new Secretary seems interested. All we would want is that Congress not preclude them from moving into this.

OSHA has operated under adverse circumstances for 6 years, with an administration which people suspected actually deliberately sabotaged. Give this administration a chance to do something in this area. That is all we are asking for, the same chance for farmworkers as for all other employees.

Mr. GINSBERG. Senator, if I could add a couple more comments, we feel the appropriations rider given last year doesn't solve OSHA's problem. It really handed a blanket exemption to an industry that has a strong lobby.

It did this at the cost of the millions of farmworkers that bore the burden of OSHA's incompetency.

Senator EAGLETON. What kind of presumptive burden could we legislate to put some onus on the employer for the employment of illegal immigrant workers?

You are both lawyers, aren't you?

Mr. GINSBERG. Yes.

Senator EAGLETON. I am a retired lawyer.

What kind constitutes—what can we inflict upon the employer to try to make sure that he is not hiring immigrant labor?

Mr. SEMLER. The Supreme Court ruled last year in terms of State statutes that that kind of burden was constitutional.

Senator EAGLETON. You have to presume something in that, don't you?

Suppose the employer says,"Look, I had no idea these people were illegals. Yes, they had Spanish surnames and talked a lot of Spanish but we have Americans with Spanish surnames and talk a lot of Spanish."

What kind of constructive notice can we legislate that would be of benefit?

Mr. SEMLER. I assume there is some element of willfulness in that statute.

Senator EAGLETON. Certainly. If there is a criminal penalty, it has to be knowingly, but how do you prove knowingly if he says, "I don't know it?"

Mr. SEMLER. I think that burden could be overcome, but the larger question is what is the sentiment in the community for this type of legislation? The farmworker community, the sentiment is as mixed among them as the people generally, because of the civil liberties positions it would impose.

Most organizations have not been able to formulate a policy on this because of that.

Senator EAGLETON. The Federal Government hasn't either. We share in that disquiet, on the one hand wanting to do something, on the other hand knowing it may have civil liberty consequences and humanitarian consequences.

What was it—the Border Patrol fellows, in some months he has arrested the same wetbacks three times, by the way. They only get a small percent, but they round them up, take a bus and drop them back off at Tijuana or wherever, and the next night they come back another way.

That is very frustrating.

At a time when the unemployment rate is 7.3 percent, it is all the more exacerbating.

Mr. GINSBERG. We might suggest, Senator, that farmwork be made more rewarding to workers. Right now they don't get overtime or a lot of things. It is not attractive to come off of unemployment to do farmwork.

Senator EAGLETON. It is to a wetback.

Mr. GINSBERG. Certainly. There is a vacuum to be filled and that is who is filling it. It is a second-class type of employment the way it is now. It is not too attractive to people who are moving to the cities and looking for better jobs.

I would like to make one more comment on the point we have here since I don't think we are going to offer a solution to the undocumented worker question.

There is another ramification of this rider that hasn't really been discussed. OSHA, as you know, provides for individual States to assume the responsibilities for occupational safety and health through State plans, as they are called.

Colorado is one of the first States to do this. I am a member of the Advisory Commission Committee to the Colorado Occupational Safety and Health program called COSH, and we have shown that through local control we can run a program far better than OSHA can.

COSH gives employers and employees full access to the promulgation of standards. They participate. They don't write comments to Washington when something is proposed. COSH took a comprehensive look at agriculture. It had an agriculture advisory committee with seven employees, seven employers, no lawyers——

Senator EAGLETON. No lawyers?

Maybe that program will work.

Mr. GINSBERG. They sat down many, many times and came up with recommendations for standards that were adapted to Colorado's needs and which they felt both employers and employees could live with.

Inspections began in mid-August last year, and then on October 1, the beginning of fiscal year 1977, the darkness fell. This rider

went into effect. COSH gets matching funds from OSHA to run its program and continue inspecting farms with 10 or fewer employees. I think that COSH has done an admirable job of tackling this particular program.

Our farmworkers pay the penalty for OSHA's incompetency when OSHA doesn't even operate in Colorado.

Senator EAGLETON. How many States—you are correctly stating the Federal law. OSHA obtains—unless a State works out a State plan and does it on its own. How many of the 50 States have operable State plans? Do you know?

Mr. GINSBERG. A minority. I would estimate 15——

Senator EAGLETON. My State, for instance, I don't think has a State plan.

Mr. GINSBERG. The chief of compliance for COSH, the man in charge of inspections estimates 95 percent of our farmworkers are on farms with 10 or fewer employees.

Senator EAGLETON. 95 percent.

Mr. GINSBERG. A member of the Colorado General Assembly who represents a farming district stated last week in a committee hearing that not even one-tenth of 1 percent of the farms have over 10 employees, so we have seen farmworkers in Colorado really left to their wits as far as job safety.

The irony is there are standards on the books to protect them, but there is no money to enforce them. Another irony, the people out there producing food and fiber have lost their protection while employees in other industries making televisions and other nonessentials are protected under the law. It was intended to last 1 year, if you read the Congressional Record from the debate. Now is the time to scrap it. It can't just be testified. The safety council says that agriculture is the third most dangerous industry, right behind mining and quarry work and construction.

I would suggest to you that a logical way to attack this is through the confirmation hearings for Miss Bingham. This is an administration problem that the Congress should be concerned about.

It is not a legislative solution that is now called for. I would strongly urge this committee and the whole Congress not to forget the farmworkers. They are unseen, they are the second-class citizens producing your daily bread and who are due the protections of every other worker.

Senator EAGLETON. I think you have made a positive case. Of all the disadvantaged people in this country, you have various groups that are at times disadvantaged, but one of the largest groups with continual disadvantages in the agriculture work, only now are they beginning to get some attention that they should have had years ago.

For instance, Governor Brown in California, you have to give him high marks for making some inroads on this at the State level.

Mr. GINSBERG. But they still lack the representation.

As you mentioned when we started this testimony, the action last year really didn't respond to whether there was a lack of dangers on the farm worksite or whether the economic burden was too high, but rather Congress was upset, justifiably, with OSHA. There was a strong lobby that gave the Congress a vehicle last year and the farmworkers suffered, and they don't deserve such a fate.

There are other solutions that should be considered.

Senator EAGLETON. Thank you, gentlemen. We appreciate it.

Our next panel will be the group that will discuss the Community Services Administration.

COMMUNITY SERVICES ADMINISTRATION

**STATEMENT OF FRANK HEYMAN, EXECUTIVE DIRECTOR, ALLEN COUNTY, ECONOMIC OPPORTUNITY COUNCIL**

**ACCOMPANIED BY:**

**JOSEPH LO PRESTI AND DAVID LIZARRAGA, NATIONAL CONGRESS OF COMMUNITY ECONOMIC DEVELOPMENT**

**JIM OLIVER, COMMUNITIES IN ACTION TOGETHER**

PREPARED STATEMENTS

Senator EAGLETON. Joseph LoPresti, representing National Congress of Community Economic Development. Next is David Lizarraga. And he represents the same group. Frank Heyman, representing community agency executive directors. Jim Oliver, representing Communities Action Together, which is the same thing. May we have your written statements and anything you wish to include in the record?

[The statements follow:]

## Statement of Frank Heyman

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, WE APPRECIATE THIS OPPORTUNITY TO DISCUSS WITH YOU THE FINANCIAL NEEDS OF THE COMMUNITY SERVICES ADMINISTRATION. IT IS THE RESPONSE TO THOSE NEEDS WHICH WE HOPE TO SEE REFLECTED IN THE COMMUNITY SERVICES ADMINISTRATION APPROPRIATIONS FOR FISCAL YEAR 1978.

I AM FRANK HEYMAN, EXECUTIVE DIRECTOR, OF THE ALLEN COUNTY ECONOMIC OPPORTUNITY COUNCIL, INC. OF FT. WAYNE, INDIANA; TO MY LEFT IS MR. JAMES M. OLIVER, DIRECTOR, JAMES WELDON JOHNSON COMMUNITY CENTER, NEW YORK; TO MY FAR RIGHT IS MR. PHILLIP LoPRESTI, PRESIDENT, THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT AND MR. DAVID LIZARRAGA, CHAIRMAN OF THE BOARD OF DIRECTORS, THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT.

MY PURPOSE IN THIS SHORT TIME IS TO GIVE AN INSIGHT INTO THE 1978 APPROPRIATION NEEDS OF THE COMMUNITY SERVICES ADMINISTRATION, AND, THEREFORE, THE LOCAL COMMUNITY ACTION AGENCIES. PLEASE RECOGNIZE THE COMMENTS I PROVIDE TODAY, COME FROM ONE CAP DIRECTOR AND ARE BASED ON SEVERAL YEARS OF EXPERIENCE ADMINISTERING ANTI-POVERTY AGENCIES AND HUNDREDS OF DISCUSSIONS WITH FELLOW COLLEAGUES IN AMERICA'S ATTEMPT TO ELIMINATE POVERTY.

THE HISTORY OF OEO/CSA IS FAMILIAR TO ALL OF US.

THE "WAR ON POVERTY", OFFICIALLY DECLARED BY PRESIDENT JOHNSON IN MARCH OF 1964, HAS NOT BEEN WON.

THE INITIAL FOCUS BY THIS GOVERNMENT TOWARD ELIMINATING POVERTY GAVE WAY TO A MORE PRESSING WAR, VIETNAM. THE MILLIONS OF POOR IN OUR NATION WERE SOON TO FIND OUT THAT THE DRAIN OF FEDERAL RESOURCES TO SOUTH EAST ASIA WOULD THWART THE EFFORTS OF THE U.S. GOVERNMENT TO WAGE AND WIN A WAR ON POVERTY. LYNDON JOHNSON, THE "CREATOR" OF THE "GREAT SOCIETY" WAS TO BECOME OF NECESSITY AN ABSENTEE FATHER OF AMERICA'S "WAR ON POVERTY."

LATER, THE TRANSFER OF ELEVEN (11) OEO PROGRAMS TO OTHER AGENCIES IN 1973 AS PART OF PRESIDENT NIXON'S ALL-OUT EFFORT TO DISMANTLE THE OFFICE OF ECONOMIC OPPORTUNITY WAS NOT ONLY UNSUCCESSFUL, BUT WITH THE HELP OF CONGRESS, THE POOR OF THIS NATION TOLD OUR EXECUTIVE BRANCH, THAT THEY TOO WILL HAVE A VOICE IN OUR GOVERNMENT. WE WERE PLEASED WHEN BOTH PRESIDENTS FORD AND THEN CANDIDATE CARTER PLEDGED THEIR SUPPORT TO AN ACTIVE REVITALIZED AND INDEPENDENT COMMUNITY SERVICES ADMINISTRATION.

THE CAUSE REMAINS JUST, THE GREAT NEED CONTINUES. NOW IS THE TIME TO RENEW THE FULL SCALE WAR ON POVERTY.

RECENT GOVERNMENT FIGURES SHOW A STARTLING INCREASE IN THE NUMBER OF POOR IN AMERICA. TO THOSE WHO DOUBT AMERICA'S POOR DESERVE THIS RENEWED COMMITMENT, I CHALLENGE ANYONE TO RIDE THE STREETS OF A SOUTH BOSTON, A ROXBURY, OR AN EAST CHICAGO AND PROCLAIM AMERICA'S "WAR ON POVERTY IS OVER."

TO WIN THIS WAR, THE VEHICLE MUST BE THE COMMUNITY SERVICES ADMINISTRATION. IT IS THE ONLY AGENCY IN THE FEDERAL GOVERNMENT WHOSE MANDATE IS TO ELIMINATE POVERTY IN AMERICA. IT IS THE ONLY AGENCY WHOSE LEGISLATION ALLOWS ENOUGH PROPER FLEXIBILITY TO RESPOND TO THE MANY CHANGING CRISIS OUR POOR FACE EACH YEAR.

SPECIFICALLY, COMMUNITY ACTION NEEDS THE FOLLOWING APPROPRIATIONS FOR FISCAL YEAR 1978.

LOCAL INITIATIVE — 1978 REQUEST: $379.5 M

WE ARE REQUESTING A 15% INCREASE IN LOCAL INITIATIVE FUNDS, RAISING THE DOLLAR AMOUNT FROM $330 MILLION TO $379.5 MILLION.

SECTION 221 OF THE COMMUNITY SERVICES ACT OF 1974 (WHICH AMENDS THE ECONOMIC OPPORTUNITY ACT OF 1964) AUTHORIZES FEDERAL FUNDING OF COMMUNITY ACTION AGENCIES, THE KEY STRUCTURES FOR

ADMINISTERING A FLEXIBLE AND WIDE RANGE OF PROGRAMS TO COMBAT POVERTY AT THE LOCAL LEVEL. OVER THE PAST TWELVE YEARS THESE COMMUNITY ACTION AGENCIES (CAAs) HAVE BEEN THE PRIMARY COORDINATORS AND OPERATORS OF ALL FEDERAL ANTI-POVERTY PROGRAMS. A NETWORK OF ALMOST 900 CAAs, WORKING THROUGH OVER 5,000 NEIGHBORHOOD CENTERS, BOTH RURAL AND URBAN, ARE SERVING OVER 20 MILLION POOR PERSONS WITH PROGRAMS FUNDED BY COMMUNITY SERVICES ADMINISTRATION, HEW, DOL, HUD AND VARIOUS OTHER FEDERAL, STATE AND LOCAL SOURCES.

THESE CAAs ADMINISTER OVER $1.6 BILLION WORTH OF ANTI-POVERTY PROGRAMS NATIONWIDE, WITH A STAFF OF ABOUT 110,000 PERSONS, 79% OF WHOM EARN LESS THAN $8,000 A YEAR AND MANY OF WHOM WERE THEMSELVES DRAWN FROM WELFARE ROLLS AND THE RANKS OF THE POOR.

THE SECTION 221 LOCAL INITIATIVE FUNDS ARE NOT ALL ADMINISTRATIVE FUNDS; MOST LOCAL INITIATIVE FUNDS ARE USED FOR GENERAL PROGRAMMING. AS A MATTER OF FACT, THE ADMINISTRATIVE COST OF ALL CAAs NATIONWIDE IS CONSIDERABLY LESS THAN 10%. FOR EVERY DOLLAR OF FEDERAL CSA MONIES USED TO ADMINISTER ANTI-POVERTY PROGRAMS, CAAs HAVE GENERATED AT LTEAST $5 IN OTHER FEDERAL FUNDS TO SERVE THE POOR IN THEIR LOCAL COMMUNITIES.

IN FY 71 THE APPROPRIATION FOR LOCAL INITIATIVE FUNDING WAS ABOUT $350 MILLION. SINCE THAT TIME, INFLATION HAS CAUSED THE FEDERAL INVESTMENT IN COMMUNITY ACTION TO SHRINK BY ABOUT 35%. WE MUST RESTORE AT LEAST SOME OF THE FUNDING THAT HAS BEEN LOST, NOT DUE TO ACTIVITIES BY THE POOR, BUT BECAUSE OF CONDITIONS BEYOND THEIR CONTROL.

CSA ADMINISTRATION — 1978 REQUEST: $33.5 M

THIS CATEGORY REPRESENTS THE ADMINISTRATIVE COST OF RUNNING THE COMMUNITY SERVICES ADMINISTRATION. WE ARE REQUESTING $33.5

MILLION, WHICH REPRESENTS AN INCREASE OF $6.5 MILLION OVER LAST YEARS FUNDING LEVEL.

IN 1973, WHEN MR. HOWARD PHILLIPS WAS APPOINTED DIRECTOR OF THE OFFICE OF ECONOMIC OPPORTUNITY WITH INSTRUCTIONS TO DISMANTLE IT, THE PERSONNEL LEVEL WAS 2,160. WHEN HE LEFT A FEW MONTHS LATER, ONLY 1,006 STAFF MEMBERS REMAINED, EVEN THOUGH THE LEVEL OF CSA PROGRAMMING REMAINED CONSTANT AND, IN SOME CASES, ACTUALLY INCREASED. CONGRESS SHOULD THEREFORE KEEP IN MIND THAT THE CURRENT 1,067 MEMBER STAFF STILL REPRESENTS A RAVAGED NATIONAL ADMINISTRATIVE EFFORT. IT IS CONSERVATIVELY ESTIMATED THAT BETWEEN 1,200 and 1,450 CSA EMPLOYEES ARE REQUIRED TO EFFICIENTLY MANAGE, MONITOR AND EVALUATE CSA PROGRAMS, TO CARRY OUT CSA'S LEGISLATIVE MANDATES, AND TO PERFORM CSA'S ROLE AS AN ADVOCATE FOR THE POOR.

WE RECOGNIZE THERE ARE DEFICIENCIES WITHIN THE NATIONAL STRUCTURE, SOME OF HOWARD PHILLIPS APPOINTEES STILL REMAIN, STILL TRYING TO DISMANTLE THE PROGRAM, HOWEVER, THERE CAN BE A RENEWED COMMITMENT, A RENEWED EMPHASIS ON WINNING THE "WAR ON POVERTY", BUT ONLY IF ADEQUATE STAFFING OF THE RESPONSIBLE, REORGANIZED NATIONAL OFFICE IS ENSURED.

COMMUNITY ECONOMIC DEVELOPMENT — 1978 REQUEST: $85 M

MR. LoPRESTI AND MR. LIZARRAGA WILL DISCUSS THEIR VIEWPOINTS ON COMMUNITY ECONOMIC DEVELOPMENT, WHICH ALL OF COMMUNITY ACTION SUPPORT.

EMERGENCY ENERGY CONSERVATION — 1978 REQUEST: $110 M

THE SUCCESS OF LOCAL COMMUNITY ACTION AGENCIES IN RESPONDING TO AMERICA'S ONGOING ENERGY CRISIS IS WELL RECOGNIZED.

THE TENS OF THOUSANDS OF HOMES WINTERIZED BY CAPS OVER THE

PAST WINTERS HAVE SAVED AMERICANS HUNDREDS OF THOUSANDS OF DOLLARS IN HEATING BILLS AND THOUSANDS OF GALLONS OF PRECIOUS FUEL OIL.

ONGOING CONGRESSIONAL SUPPORT WAS RECENTLY REAFFIRMED BY YOUR COMMITTEE IN PASSAGE OF THE 1977 SUPPLEMENTAL BILL THAT ALLOWS $200 MILLION FOR CRISIS INTERVENTION, AND $82.5 MILLION FOR WEATHERIZATION.

WE ARE REQUESTING ENERGY APPROPRIATION LEVELS AT YOUR ACTUAL FISCAL YEAR 1977 LEVEL, THAT BEING $110 MILLION.

I MIGHT ADD, IN THE CURRENT CRISIS INTERVENTION LEGISLATION, RECENTLY PASSED BY BOTH HOUSES, ALLOWS FOR NO FEDERAL FUNDS FOR ADMINISTRATION OF THE PROGRAM.

WHILE COMMUNITY ACTION WILL ONCE AGAIN STRETCH ITS RESOURCES TO SUCCESSFULLY CARRY OUT THIS EFFORT, I HOPE CONGRESS RECOGNIZES THAT IMPLEMENTATION OF PROGRAMS OF THIS MAGNITUDE REQUIRE SUPPORT COSTS, WHICH ARE NON-EXISTENT AT THE LOCAL LEVEL.

COMMUNITY FOOD AND NUTRITION — 1978 REQUEST: $40 M

THE COMMUNITY FOOD AND NUTRITION PROGRAM (CFNP) IS A NATIONAL EMPHASIS ADVOCACY PROGRAM ADMINISTERED BY CSA.

BECAUSE OF LANGUAGE PROBLEMS, DISCRIMINATION, LACK OF TRANSPORTATION OR EDUCATION, THE POOR OFTEN FIND THAT OTHER FEDERAL FOOD AND NUTRITION PROGRAMS ARE NOT AVAILABLE TO THEM. THE COMMUNITY FOOD AND NUTRITION PROGRAM WAS MANDATED BY CONGRESS TO SUPPLEMENT, EXTEND, AND BROADEN OTHER FEDERAL FOOD PROGRAMS TO ASSIST THE POOR.

IN FISCAL YEAR 1977, THE COMMUNITY SERVICES ADMINISTRATION COMMITTED $27.5 MILLION FOR APPROXIMATELY 700 COMMUNITY FOOD AND NUTRITION PROGRAMS. WITH THE EXCEPTION OF THE LARGEST METROPOLITAN AREAS, THIS RESULTED IN ONLY A FEW THOUSAND DOLLARS PER PROJECT, WITH NOT ALL AGENCIES BEING ABLE TO PARTICIPATE; THEREFORE, WE ARE REQUESTING AN

APPROPRIATION OF $40 MILLION, WHICH WAS THE FIGURE RECOMMENDED BY THE SENATE IN FISCAL YEAR 1977, FOR THIS MUCH NEEDED SERVICE AREA.

SENIOR OPPORTUNITIES AND SERVICES — 1978 REQUEST: $11.5 M

SECTION 222(a)(7) OF THE COMMUNITY SERVICES ACT OF 1974 AUTHORIZES THE SENIOR OPPORTUNITIES AND SERVICES PROGRAM, ONE OF A NUMBER OF SPECIAL IMPACT PROGRAMS CREATED BY CONGRESS, TO "DEAL WITH PARTICULARLY CRITICAL NEEDS OR PROBLEMS OF THE POOR ..." THE SOS PROGRAM FUNDS PROJECTS OPERATED BY COMMUNITY ACTION AGENCIES, ULTIMATELY LEAD TO THE PERSONAL DEVELOPMENT OF THE ELDERLY, AND GENERALLY FACILITATE THE GREATER USE OF OTHER SOCIAL SERVICE PROGRAMS BY THE AGING POOR. WE ARE REQUESTING A 15% INCREASE OVER PRESENT FUNDING, BRINGING THE TOTAL TO $11.5 MILLION.

OVER 400 COMMUNITY ACTION AGENCIES SERVE MORE THAN ONE MILLION ELDERLY INDIVIDUALS ANNUALLY WITH A COMBINATION OF SOS, CSA 221 LOCAL INITIATIVE, AND OTHER FUNDS.

SOME EXAMPLES OF THESE SERVICES INCLUDE:

-- 1499 SENIOR CENTERS, -- 133 EMPLOYMENT TRAINING AND JOB FINDING PROGRAMS, -- 173 CIVIC ACTION PROGRAMS, -- 174 CONSUMER ED PROGRAMS, -- 248 OUTREACH AND REFERRAL PROGRAMS, -- 139 OTHER EDUCATION PROGRAMS, -- 69 HOME HEALTH SERVICES, -- 46 CREDIT OR BUYING CLUBS, -- 127 OTHER HEALTH SERVICES, -- 204 FEEDING PROGRAMS, -- 89 HOMEMAKER SERVICES, -- 214 RECREATION PROGRAMS, -- 61 HANDYMAN SERVICES, -- 186 VISITING SERVICES, -- 218 CRAFT PROGRAMS, -- 261 TRANSPORTATION PROJECTS, -- 132 TELEPHONE REASSURANCE PROJECTS, -- 115 LEGAL SERVICES, AND -- 96 OTHER PROGRAMS.

ONE-HALF OF ALL FEDERAL FUNDS FOR THESE PROGRAMS HAVE TRADITIONALLY BEEN ADMINISTERED THROUGH THE SOS PROGRAM.

FUNDING MUST BE INCREASED BECAUSE OF THE GROWING NUMBER OF ELDERLY WHO ARE POOR. ONE OF EVERY TEN AMERICANS IS ELDERLY, AND A FOURTH OF ALL OLDER AMERICANS ARE POOR. THE SOS PROGRAM SPEAKS SPECIFICALLY TO THIS GROUP.

WITH RESPECT TO OUR TIME ALLOTMENT, I WOULD LIKE TO BRIEFLY ADD THAT WE ARE REQUESTING THE FOLLOWING APPROPRIATION -- $10 MILLION FOR RESEARCH & DEVELOPMENT. THIS FUNDING WILL ALLOW CONTINUED R & D PROJECTS IN HEALTH EDUCATION, YOUTH PROGRAMS AIMED AT DELINQUENCY PREVENTION RATHER THAN DETENTION OR INSTITUALIZATION, AND MANY OTHERS.

TRAINING AND TECHNICAL ASSISTANCE — 1978 REQUEST: $3 M

HISTORICALLY, PRIOR TO 1973 THE OFFICE OF ECONOMIC OPPORTUNITY PROVIDED TRAINING AND TECHNICAL ASSISTANCE SERVICES TO THE MORE THAN 1,100 GRANTEES IT SERVES. SINCE 1973, NOTHING HAS BEEN ALLOCATED FOR TRAINING AND TECHNICAL ASSISTANCE UNDER SECTION 230. THIS IS INCREDIBLE IN AN AGENCY ADMINISTERING ALMOST $1.5 BILLION, IN HUMAN SERVICE PROGRAMS. THERE IS A TREMENDOUS NEED FOR TRAINING AND TECHNICAL ASSISTANCE THAT IS BOTH IDENTIFIABLE AND VALIDATED UNDER THE FOLLOWING CATEGORIES: (a) TRAINING UNDER THE REORGANIZATION PLAN FOR CSA EMPLOYEES THROUGHOUT THE COUNTY; (b) TRAINING OF COMMUNITY ACTION AGENCY STAFFS IN MANAGEMENT IMPROVEMENT SYSTEMS, COST EFFECTIVENESS PLANNING AND FINANCIAL PROCEDURES; (c) TRAINING OF COMMUNITY ACTION AGENCY BOARDS OF DIRECTORS; AND (d) TRAINING OF COMMUNITY ACTION AGENCY DIRECTORS AND OTHER STAFF IN FEDERAL PROGRAM OPPORTUNITIES FOR SERVICES TO THE POOR.

WHEN THE OFFICE OF ECONOMIC OPPORTUNITY WAS AT THE PEAK OF ITS FUNDING, AROUND 1970, $25 MILLION PER YEAR WAS SET ASIDE FOR TRAINING AND TECHNICAL ASSISTANCE. THE LOWEST FIGURE EVER ALLOCATED FOR THIS

CATEGORY PRIOR TO THE ERA OF MR. HOWARD PHILLIPS IN 1973 WAS $5 MILLION. WE ARE REQUESTING ONLY $3 MILLION FOR FISCAL YEAR 1978.

OTHER REQUESTS INCLUDE CURRENT LEVEL FUNDING OF $17 MILLION FOR SUMMER YOUTH RECREATION. A FIFTEEN PERCENT INCREASE IN FUNDING FOR STATE ECONOMIC OFFICES BRINGING THE TOTAL TO 13.8 MILLION AND PRESENT LEVEL FUNDING OF NATIONAL YOUTH SPORTS AT $6 MILLION.

OUR TOTAL REQUEST THEREFORE IS $729.3 MILLION.

AT THIS TIME MR. JAMES OLIVER HAS A FEW THOUGHTS HE WOULD LIKE TO SHARE WITH YOU.

THANK YOU.

STATEMENT OF DAVID LIZARRAGA

THANK YOU, GENTLEMEN, AND THANK YOU, MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE.

I AM DAVID LIZARRAGA, CHAIRMAN OF THE BOARD OF DIRECTORS OF THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT, A NATIONAL TRADE ASSOCIATION OF ORGANIZATIONS INVOLVED IN COMMUNITY-BASED ECONOMIC DEVELOPMENT. MANY OF OUR MEMBERS ARE FUNDED THROUGH THE SPECIAL IMPACT PROGRAM OF THE COMMUNITY SERVICES ADMINISTRATION. THE SPECIAL IMPACT PROGRAM IS LISTED AS THE COMMUNITY ECONOMIC DEVELOPMENT SECTION OF THE CSA BUDGET, PURSUANT TO THE COMMUNITY SERVICES ACT, TITLE VII. I AM ALSO THE PRESIDENT OF THE EAST LOS ANGELES COMMUNITY UNION, OF LOS ANGELES, CALIFORNIA, A SPECIAL IMPACT PROGRAM-FUNDED COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATION, OR CDC.

I WOULD ASK THAT MY FULL STATEMENT BE SUBMITTED FOR THE RECORD, AS I HAVE ONLY A BRIEF STATEMENT I WOULD LIKE TO MAKE TODAY. I INCLUDE AS PART OF THE STATEMENT, A SURVEY COMPLETED LAST MONTH BY THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT OF 33 CDCS FUNDED UNDER THE SPECIAL IMPACT PROGRAM.

ON BEHALF OF ALL OF THOSE INVOLVED IN THE COMMUNITY-BASED ECONOMIC DEVELOPMENT PROGRAM, I AM HERE TO REQUEST A FISCAL YEAR 1978 FUNDING LEVEL OF NOT LESS THAN $85 MILLION. THIS LEVEL OF FUNDING REPRESENTS A MODERATE, BALANCED GROWTH OF THE PROGRAM OVER THE LAST SEVERAL YEARS. WHILE WE HAVE REQUESTED THIS LEVEL FOR SEVERAL YEARS, WE HAVE NEVER RECEIVED THE FULL AMOUNT.

WE FEEL THAT THIS YEAR WE CAN UTILIZE THIS MONEY EFFICIENTLY

AND EFFECTIVELY TO MOVE FORWARD IN OUR ATTEMPT TO REVITALIZE OUR NATION'S POVERTY-STRICKEN COMMUNITIES. IN THIS FIRST YEAR OF A NEW ADMINISTRATION, WITH WHAT WE FEEL IS A NEW COMMITMENT TO OUR NATION'S POOR, WE CAN MOVE TO A NEW AND EFFECTIVE POSITION OF IMPROVING THE ECONOMIC IMBALANCES WHICH EXIST IN MANY OF OUR URBAN AND RURAL AREAS.

THE COMMUNITY ECONOMIC DEVELOPMENT PROGRAM STANDS ON THE THRESHOLD OF A NEW ERA, IN THIS TENTH YEAR OF ITS EXISTENCE. WE HAVE EXISTED AS A DEMONSTRATION PROGRAM, AT A MERE SUB-SISTENCE LEVEL FOR EIGHT YEARS. WE HAVE NOT HAD SUFFICIENT FUNDING OR SUPPORT TO ACTIVELY SHIFT FROM A DEMONSTRATION FORMAT, TO A FULLY OPERATIONAL STATUS. THIS $85 MILLION FUNDING LEVEL FOR FISCAL 1978 IS ONE WAY TO HELP TO MOVE WITH THIS NEW ADMINISTRATION TO A CONCENTRATED AND EFFECTIVE ATTACK ON THE ROOT CAUSES OF POVERTY.

COMMUNITY-BASED ECONOMIC DEVELOPMENT IS A CONCEPT WHICH DATES BACK TO THE EARLY AMERICAN COLONIAL TRADING COMPANIES. IN ITS PRESENT STATE, CED IS ONE OF THE MOST EFFICIENT AND EFFECTIVE TOOLS TO ENABLE LOW-INCOME AREAS TO BREAK THE CYCLE OF POVERTY WHICH GRIPS THEM. CED WORKS BY FOCUSING RESOURCES ON ONE OR TWO CRUCIAL LINKS IN THE POVERTY CYCLE OF EACH COMMUNITY.

CDCS, THE USUAL PRACTITIONERS OF CED UNDER THE SPECIAL IMPACT PROGRAM, HAVE SHOWN THAT THEY CAN EFFECTIVELY MOBILIZE NON-FEDERAL RESOURCES ON A MASSIVE SCALE, IF THE INITIAL FEDERAL SEED MONEY IS AVAILABLE. THE SURVEY WHICH IS TO BE READ INTO THE RECORD ILLUSTRATES SOME EXAMPLES. IF I MAY QUOTE A FEW RELEVANT FIGURES, THE IMPACT OF THE CDC LEVERAGING OF SMALL AMOUNTS OF FEDERAL DOLLARS BECOMES APPARENT.

THE MARKET VALUES OF REAL ESTATE, GENERATED SOLELY THROUGH CDC CONSTRUCTION AND REHABILITATION EFFORTS IS OVER $120,900,000 REPRESENTS A MAJOR REDEMPTION OF THE ENTIRE FEDERAL COMMITMENT TO THESE 33 CDCS OF $172 MILLION OVER TEN YEARS. ADDED TO THE REAL ESTATE VALUE CAN BE THE NUMBER OF JOBS CREATED, JUST ABOUT 7000, AND THE MORE THAN $38 MILLION PAYROLL FOR 1976 ALONE. AND THESE JOBS ARE PERMANENT AND PRODUCTIVE JOBS. THE MULTIPLIER EFFECT OF THE SPECIAL IMPACT PROGRAMS CAN BE SEEN IN THESE TWO EXAMPLES AND MANY MORE IN THIS STUDY. THE USE OF SPECIAL IMPACT MONIES IS VERY EFFICIENT IN TERMS OF RETURN AND REDEMPTION OF EACH FEDERAL DOLLAR INVESTED.

WE HAVE NEVER HAD A SATISFACTORY LEVEL OF FUNDING FOR THIS PROGRAM. PAST PRESIDENT HAVE ASKED FOR ONLY A VERY SMALL AMOUNT OF FUNDS FOR OUR PROMISING NEW PROGRAM. THE CONGRESS HAS WISELY

AND CONSISTENTLY INCREASED THAT FIGURE SEVERAL TIMES. WE FEEL THAT THIS YEAR WE CAN EFFICIENTLY AND EFFECTIVELY UTILIZE AN INCREASED FUNDING LEVEL OF NOT LESS THAN $85 MILLION.

WE WOULD UTILIZE THE FUNDING IN THESE AREAS:

THE SPECIAL IMPACT PROGRAM, INCLUDING NEW CDCS JUST GOING OPERATIONAL WOULD RECEIVE $66.5 MILLION.

THE INNOVATIVE, BUT AS YET UNFUNDED CONCEPT OF USING RURAL CO-OPERATIVES TO INCREASE THE EFFECTIVENESS OF THE SPECIAL IMPACT PROGRAM WOULD RECEIVE $2 MILLION.

THE UNTESTED, BUT MANDATED BY CONGRESS AND VERY PROMISING, RECYCABLE LOAN FUNDING MECHANISMS WOULD RECEIVE $5.5 MILLION. THESE PROGRAMS PROMISE EVEN MORE EFFICIENCY OF FUNDING, SINCE THE FUNDING WOULD BE IN TERMS OF LOANS RATHER THAN ONLY GRANTS. STILL, THEY HAVE NOT YET BEEN SUFFICIENTLY DEVELOPED OR IMPLEMENTED FOR LACK OF FUNDING.

AND THE VERY VITAL SUPPORT MECHANISMS AND ORGANIZATIONS WHICH PROVIDE THE TECHNICAL ASSISTANCE AND RESEARCH SO IMPORTANT TO THE PROGRAM WOULD RECEIVE $8.5 MILLION. THE ADMINISTRATIVE COSTS, $2.5 MILLION WOULD TAKE UP THE REMAINDER OF THE $8.5 MILLION.

I WOULD LIKE TO MENTION IN CLOSING THAT, EVEN BESIDES THE ARGUMENTS FOR EFFICIENCY AND EFFECTIVENESS WHICH I HAVE PUT BEFORE YOU TODAY, THERE IS THE ADDITIONAL POINT THAT THE SPECIAL IMPACT PROGRAM IS USUALLY THE ONLY PROGRAM WHICH IMPACTS ON MANY OF THESEBLIGHTED AREAS. WITHOUT THE SPECIAL IMPACT PROGRAM, THESE COMMUNITIES WOULD BE LEFT WITHOUT ANY COORDINATED ASSISTANCE FROM THE FEDERAL GOVERNMENT. WE IN THE PROGRAM ARE ASKING THAT WE RECEIVE SUFFICIENT FUNDS TO MOVE FORWARD WITH THIS NEW ADMINISTRATION TO CARRY OUT THE MANDATE WHICH CONGRESS HAS GIVEN TO US IN THE LEGISLATION.

I WOULD LIKE TO ADD THAT THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT WHOLEHEARTEDLY SUPPORTS THE RECOMMENDATIONS GIVEN TO YOU EARLIER BY OUR COLLEAGUES ON THIS PANEL. WE FEEL THAT THE CAAS NEED AN INCREASE IN 221 FUNDS AS WELL AS IN SPECIFIC PROGRAMS, AND WE SUPPORT THEIR REQUESTS FOR FUNDING LEVELS.

THANK YOU VERY MUCH FOR THIS OPPORTUNITY TO ADDRESS YOU. I AM SURE THAT ALL OF US ON THIS PANEL WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE FOR US AT THIS TIME.

SUMMARY OF APPROPRIATIONS TESTIMONY, DAVID LIZARRAGA FY '78

THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT, ON BEHALF OF ALL ORGANIZATIONS INVOLVED IN COMMUNITY-BASED ECONOMIC DEVELOPMENT, IS REQUESTING A LEVEL OF FUNDING FOR FISCAL 1978 OF NOT LESS THAN $85 MILLION FOR TITLE VII OF THE COMMUNITY SERVICES ACT OF 1975 (COMMUNITY ECONOMIC DEVELOPMENT LINE OF COMMUNITY SERVICES ADMINISTRATION BUDGET).

THE INCREASE OVER THE LEVEL OF FISCAL 1977 IS NECESSARY TO:

(1) INSURE THAT OPERATIONAL COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATIONS (CDCS) FUNDED THROUGH THE SPECIAL IMPACT PROGRAM CAN RECEIVE ENOUGH FUNDS DURING THIS YEAR TO ENABLE THEM TO MOVE TOWARD THE GOALS THE UNITED STATES CONGRESS SET FORTH IN THE ACT.

(2) CONVERT SEVERAL CDCS IN THE FINAL STAGES OF PLANNING GRANT PROGRAMS INTO FULLY OPERATIONAL CDCS AS MANDATED BY THE DEVELOPMENTAL PROCESS OF THE SPECIAL IMPACT PROGRAM.

(3) FUND RURAL COOPERATIVES AS SET FORTH BY THE U.S. CONGRESS UNDER SECTION B OF TITLE VII OF THE ACT.

(4) ACTIVATE, FUND, AND IMPLEMENT THE COMMUNITY DEVELOPMENT AND RURAL DEVELOPMENT LOAN FUNDS AS MANDATED BY THE U.S. CONGRESS IN THE ACT.

(5) FUND SUPPORTIVE PROGRAMS AND ORGANIZATIONS WHICH HAVE BEEN, AND WILL CONTINUE TO, CARRYING OUT THE ASSISTANCE TASKS NECESSARY TO ENABLE CDCS TO CARRY OUT THE GOALS SET FORTH IN THE ACT.

(6) FUND TEN NEW PLANNING GRANT ORGANIZATIONS FOR EVENTUAL DEVELOPMENT INTO CDCS.

(7) ADMINISTER THE PROGRAM.

RECOMMENDED FUNDING:

| OF TITLE VII OF THE ACT: | MILLIONS |
|---|---|
| SECTION A | $ 66.5 |
| SECTION B | 2.0 |
| SECTION C | 5.5 |
| SECTION D | 8.5 |
| ADMINISTRATION | 2.5 |
| TOTAL | $ 85.0 |

I AM DAVID LIZARRAGA, CHAIRMAN OF THE BOARD OF DIRECTORS OF THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT, A NATIONAL TRADE ASSOCIATION OF ORGANIZATIONS INVOLVED IN COMMUNITY-BASED ECONOMIC DEVELOPMENT. MANY OF OUR MEMBERS ARE FUNDED THROUGH THE SPECIAL IMPACT PROGRAM OF THE COMMUNITY SERVICES ADMINISTRATION, (CONTAINED IN THE COMMUNITY ECONOMIC DEVELOPMENT SECTION, TITLE VII OF THE COMMUNITY SERVICES ACT OF 1975). I AM ALSO THE PRESIDENT OF THE EAST LOS ANGELES COMMUNITY UNION, OF LOS ANGELES, CALIFORNIA, A TITLE VII FUNDED COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATION.

ON BEHALF OF ALL OF THOSE INVOLVED IN THE COMMUNITY-BASED ECONOMIC DEVELOPMENT PROGRAM, I AM HERE TO REQUEST A FISCAL YEAR 1978 FUNDING LEVEL OF NOT LESS THAN $85 MILLION. THIS LEVEL OF FUNDING REPRESENTS A MODERATE, BALANCED GROWTH OF THE PROGRAM OVER THE LAST SEVERAL YEARS. WHILE WE HAVE REQUESTED THIS LEVEL OF FUNDING FOR THREE YEARS, WE HAVE NEVER RECEIVED CLOSE TO THIS FIGURE.

WE FEEL THAT THIS YEAR WE CAN UTILIZE THIS MONEY EFFICIENTLY AND EFFECTIVELY TO MOVE FORWARD IN OUR ATTEMPT TO REVITALIZE OUR NATION'S POVERTY-STRICKEN COMMUNITIES. IN THIS FIRST YEAR OF A NEW ADMINISTRATION, WITH WHAT WE FEEL IS A BRAND NEW COMMITMENT TO OUR NATION'S POOR, WE CAN MOVE TO A NEW AND EFFECTIVE POSITION OF IMPROVING THE ECONOMIC IMBALANCES WHICH EXIST IN MANY OF OUR URBAN AND RURAL AREAS.

THE COMMUNITY-BASED ECONOMIC DEVELOPMENT PROGRAM STANDS ON THE THRESHOLD OF A NEW ERA, IN THIS TENTH YEAR OF ITS EXISTENCE. WE HAVE MERELY EXISTED AT A SUBSISTENCE LEVEL FOR EIGHT YEARS. WE HAVE NOT HAD SUFFICIENT FUNDING OR SUPPORT TO ACTIVELY SHIFT FROM A DEMONSTRATION FORMAT, TO A FULLY OPERATIONAL STATUS. THIS LEVEL OF FUNDING FOR FY 78 IS ONE WAY TO HELP US TO MOVE WITH THIS NEW ADMINISTRATION TO A CONCENTRATED AND EFFECTIVE ATTACK ON THE ROOT CAUSES OF POVERTY.

COMMUNITY-BASED ECONOMIC DEVELOPMENT IS A CONCEPT WHICH DATES BACK TO THE EARLY AMERICAN COLONIAL TRADING COMPANIES. IN ITS PRESENT STATE, COMMUNITY ECONOMIC DEVELOPMENT IS ONE OF THE MOST EFFICIENT AND EFFECTIVE TOOLS TO ENABLE LOW-INCOME AREAS TO BREAK THE CYCLE OF POVERTY WHICH GRIPS THEM, BY FOCUSING RESOURCES ON ONE OR TWO CRUCIAL LINKS IN THE CYCLE. I INCLUDE FOR THE RECORD A SURVEY CONDUCTED BY THE NATIONAL CONGRESS FOR COMMUNITY ECONOMIC DEVELOPMENT OF 33 COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATIONS, IN ORDER TO SHOW THE TREMENDOUS PROGRESS WE HAVE MADE IN THE DECADE SINCE THE PROGRAM WAS STARTED ON THE FEDERAL LEVEL.

COMMUNITY ECONOMIC DEVELOPMENT TAKES THE FORM OF A CORPORATE STRUCTURE FOR AN ORGANIZATION WHICH INCLUDES COMMUNITY PARTICIPATION AND DIRECTION IN ITS DECISION-MAKING PROCESS. MOST COMMUNITY ECONOMIC DEVELOPMENT ORGANIZATIONS ARE COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATIONS (CDCS). THE CDC USES A SMALL AMOUNT OF GRANT MONIES TO LEVER ADDITIONAL MONIES FROM PRIVATE SOURCES. THE INCREASED EQUITY IS THEN USED TO FINANCE VENTURE SUBSIDIARIES. THIS USE OF EQUITY FUNDS TO PRODUCE SUBSIDIARY COMPANIES IS AN ESSENTIAL ELEMENT IN THE COMMUNITY ECONOMIC DEVELOPMENT EQUATION.

THE CDC IS A FEDERAL PROGRAM, SOMETIMES THE ONLY ONE IN ITS AREA, WHICH USES THE PRIVATE AND FREE ENTERPRISE MECHANISMS TO INCREASE THE EFFECTIVENESS AND EFFICIENCY OF THE SMALL AMOUNT OF

GRANT MONIES IT RECEIVES. THE CDC ALSO USE A SOPHISTICATED SET OF PLANNING AND MARKETING MECHANISMS TO INDICATE THE MOST EFFECTIVE USE OF THESE MONIES. AND THE USE OF PROFESSIONALLY BUSINESS-LIKE METHODS HELPS TO INSURE THAT THE MONIES ARE UTILIZED EFFICIENTLY.

BUT, BESIDES THESE BUSINESS-LIKE OPERATIONS, THE CDCS ALSO HAVE A HUMAN SIDE, WHICH IS AS IMPORTANT. THE CDCS HAVE COMMUNITY DIRECTION AND ARE RESPONSIBLE, AND RESPONSIVE, TO THE NEEDS AND WISHES OF THE COMMUNITY AS THE MOST EFFICIENT AND EFFECTIVE MEANS OF ACHIEVING IMPACT. THE GOAL OF THE LEGISLATION WHICH ESTABLISHED THE SPECIAL IMPACT PROGRAM STATED THAT THE GOAL OF THE COMMUNITY ECONOMIC DEVELOPMENT PROGRAM WAS TO CAUSE "APPRECIABLE IMPACT" ON THEIR COMMUNITIES. THE CDCS HAVE BEEN TRYING TO MOVE IN THIS DIRECTION FOR TEN YEARS. BUT THEIR EFFORTS HAVE BEEN HAMPERED BY LACK OF ADEQUATE FUNDING, AS WELL AS A HOSTILE POLITICAL ENVIRONMENT.

THE SPECIAL IMPACT PROGRAM HAS BEEN CONSIDERED A DEMONSTRATION PROGRAM. WE HAVE SHOWN THAT OUR FORM OF ECONOMIC DEVELOPMENT CAN BE SUCCESSFUL IN MANY OF THE HARSHEST ENVIRONMENTS THIS COUNTRY HAS TO SUFFER WITH AS INDICATED IN THE ATTACHED SURVEY. WE FEEL THAT WE MUST NOW COME OUT INTO FULL OPERATIONAL STATUS SO THAT WE CAN SHARE THE BOUNTY OF INFORMATION WE HAVE GATHERED OVER THE LAST DECADE. WE FEEL THAT THE LEVEL OF FUNDING WE ARE REQUESTING WILL ALLOW US TO MAKE THAT TRANSITION WITHOUT SEVERE DISLOCATION OF SERVICES OR OF ADMINISTRATION OF THE PROGRAM.

THE LAST FEW YEARS HAVE SEEN SEVERE FUNDING RESTRICTIONS ON THIS PROGRAM. OUR LEVEL OF FUNDING HAS REMAINED VERY LOW. WE ARE ATTEMPTING TO SERVE ALMOST 40 COMMUNITIES IN AMERICA ON A FUNDING LEVEL OF ONLY $48 MILLION. WE CANNOT INCREASE THE NUMBER OF FEDERALLY-FUNDED CORPORATIONS SIGNIFICANTLY WITHOUT A HIGHER LEVEL OF FUNDING. WE CONSIDER THAT A MINIMUM OF ONE CDC IN EACH STATE IS ABSOLUTELY NECESSARY. IN ADDITION, WE CANNOT EFFECTIVELY PROVIDE SUFFICIENT MONIES FOR REFUNDING OF PRESENTLY OPERATIONAL CDCS WITHOUT A HIGHER LEVEL OF FUNDING. AND WE CANNOT EFFECTIVELY SUPPORT THE PRESENT OPERATIONAL CDCS WITHOUT FUNDING FOR ASSISTANCE MECHANISMS.

THE ATTACHED STUDY SHOWS THAT COLLECTIVELY, THE 33 CDCS RESPONDING HAVE GENERATED OVER 6900 JOBS, WITH A CUMULATIVE PAYROLL FOR 1976 ALONE OF OVER $38,600,000 ON A SPECIAL IMPACT PROGRAM FUNDING LEVEL OF WELL UNDER $50 MILLION FOR ALL CDCS. THESE ARE LASTING, PRODUCTIVE JOBS, WITH ADDED BONUSES OF INCREASED TAX BASES, CASH FLOWS, INVESTMENT OPPORTUNITIES AND ECONOMIC WELL-BEING TO THEIR IMPACT COMMUNITIES. THESE DO NOT INCLUDE INDIRECT BENEFITS SUCH AS RAISED STANDARD OF LIVING,

SOCIAL/COMMUNITY DEVELOPMENT PROGRAMS, AND OTHER NON-PROFIT-ORIENTED OPERATIONS OF THE CDCS. FOR EXAMPLE, THE PRESENT MARKET VALUE OF REAL ESTATE GENERATED THROUGH CDC CONSTRUCTION AND REHABILITATION EFFORTS IS OVER $120,900,000, ALMOST AS MUCH AS THE TOTAL INVESTMENT FOR TEN YEARS IN THOSE 33 CDCS BY THE SPECIAL IMPACT PROGRAM, OF $172,000,000.

CDCS ALREADY USE MONEY EFFECTIVELY, THROUGH PROFESSIONALLY BUSINESS-LIKE PROCEDURES, INVESTMENT OPERATIONS, AND LEVERAGING OF EQUITY CAPITAL INTO LARGER FUNDING AMOUNTS FROM PRIVATE INSTITUTIONS AND INVESTORS. THE RESULT OF THESE BUSINESS AND LEVERAGING OPERATIONS IS THAT EACH FEDERAL DOLLAR PROVIDED IS MULTIPLIED, SOMETIMES FOUR OR FIVE TIMES, BEFORE IT IS EVEN USED. ONCE THE DOLLAR IS USED, THE INVESTMENT NATURE OF THE CDC OPERATIONS RESULTS IN FAR MORE ECONOMIC IMPACT TO THE POOR COMMUNITY, THAN THE INJECTION OF FUNDS INTO THE AREA THROUGH OTHER MEANS WOULD GENERATE. THE LEVERAGED FUNDS NEEDED TO ATTAIN THAT MARKET VALUE IN THAT REAL ESTATE WAS ONLY $78 MILLION. THUS THE MULTIPLIER EFFECT OF FUNDS PUT INTO POOR COMMUNITIES THROUGH COMMUNITY ECONOMIC DFVELOPMENT CAN BE DRAMATIC.

THE HISTORY OF THE FUNDING FOR TITLE VII IS AS FOLLOWS:

(IN MILLIONS)

| FY 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 |
|---|---|---|---|---|---|---|---|---|---|
| $1.9 | $12.0 | $36.5 | $36.0 | $27.0 | $36.0 | $36.0 | $61.0* | $46.5 | $48.1 |

* $14.5 MILLION WAS FOR A SPECIFIC SPECIAL PROJECT

IN LIGHT OF THIS FUNDING HISTORY AND THE NEEDS OF THE PROGRAM, THE LEVEL OF $30 MILLION REQUESTED BY PRESIDENT FORD IS UNACCEPTABLE TO US. THIS LEVEL WOULD PLACE US BELOW THE LEVEL OF ALL BUT THREE OF THE YEARS OF THE PROGRAM. THE RESULTS FROM THIS PROGRAM ARE SUFFICIENTLY HIGH IN POTENTIAL THAT THE LEVEL OF FUNDS PUT INTO OUR PROGRAM ARE AS VALUABLE OR MORE SO THAN MANY OTHER GOVERNMENT PROGRAMS WHICH SPEND HUNDREDS OF TIMES MORE THAN WE DO WITHOUT CORRESPONDING LEVERAGE.

THIS SPECIAL IMPACT PROGRAM IS THE ONLY PROGRAM WHICH INCLUDES EQUITY FUNDING AS PART OF AN OVERALL ATTACK ON THE ROOT CAUSES OF A PROBLEM, NOT JUST ITS SYMPTOMS. THE U.S. CONGRESS HAS SHOWN ITS UNDERSTANDING OF THE NEEDS OF THE PROGRAM BY REQUESTING AN INCREASE OVER USUAL PRESIDENTIAL REQUESTS FOR THE PROGRAM. LAST YEAR, THE SENATE OVERWHELMINGLY PASSED A FLOOR AMENDMENT ADDING $15 MILLION TO THE COMMUNITY ECONOMIC DEVELOPMENT FUNDING LEVEL. THIS SORT OF ACTION SHOWS A DEFINITE DESIRE ON THE PART OF THE CONGRESS FOR AN EQUITABLE AND EFFECTIVE FUNDING LEVEL.

THIS YEAR, ESPECIALLY, WE ARE CERTAIN OF A MORE EFFICIENT AND EFFECTIVE USE OF THESE MONIES. WITH THE CHANGE IN ADMINISTRATIONS HAS COME A NEW COMMITMENT TO EFFICIENCY, EFFECTIVENESS, ADVOCACY, AND UNDERSTANDING ON THE PART OF THE COMMITY SERVICES ADMINISTRATION. AFTER EIGHT LONG YEARS OF STARVATION AND NEGLECT, NOW WE WILL BE ABLE TO GAIN THE SUPPORT AND ASSISTANCE WE NEED TO PERFORM OUR TASK OF ERADICATING POVERTY, AND REVITALIZING COMMUNITIES IN AMERICA. WE FEEL THAT OUR REQUESTED LEVEL OF $85 MILLION CAN MOVE US WELL ALONG THE PATH TOWARD THIS GOAL THE CONGRESS LAID OUT FOR US IN THE ACT AT A PACE WHICH IS CONSISTENT WITH ORDERLY PLANNED GROWTH.

THE $85 MILLION FUNDING LEVEL WILL MAKE FUNDS AVAILABLE TO:

(1) INSURE THAT ENOUGH FUNDS ARE AVAILABLE TO ALLOW COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATIONS (CDCS) FUNDED UNDER THE SPECIAL IMPACT PROGRAM TO MOVE TOWARD THE GOALS THE U.S. CONGRESS SET FORTH FOR THEM IN THE ACT. SPECIFICALLY, IT WILL ALLOW SUFFICIENT FUNDS TO ALLOW THOSE CDCS COMING UP FOR REFUNDING TO RECEIVE FUNDS TO CARRY OUT THEIR PROJECTS FOR THE NEXT TWO YEARS. THERE IS A NEED TO MAINTAIN ALL OF THE EXISTING PROGRAMS SO THEY CAN MATURE AND DEVELOP THE CAPACITY TO MAKE "APPRECIABLE IMPACT," AS DEFINED BY THE ACT.

(2) ALLOW THE SELECTION AND IMPLEMENTATION OF TEN ADDITIONAL NEW PLANNING GRANTS FOR THOSE BLIGHTED AREAS OF OUR COUNTRY WHICH HAVE NOT YET BECOME SERIOUSLY INVOLVED WITH COMMUNITY-BASED ECONOMIC DEVELOPMENT. A CDC IN EACH STATE IS CONSIDERED AN ABSOLUTE MINIMUM. WE PRESENTLY HAVE NINETEEN STATES WITHOUT OPERATIONAL SPECIAL IMPACT PROGRAM CDCS. WE NEED ADDITIONAL PLANNING GRANT MONIES TO INSURE THAT EACH STATE HAS THE CAPABILITY TO DETERMINE WHETHER A CDC IS NEEDED, AND IF SO, HOW TO ESTABLISH THAT CDC.

(3) PROVIDE OPERATIONAL FUNDS FOR THE THREE REMAINING PLANNING GRANTS GIVEN IN 1976 AND 1977. THESE NEW CDCS HAVE DEMONSTRATED THEIR CAPABILITY AND POTENTIAL, HAVE BEEN PROMISED FUNDS, AND SHOULD NOW DEVELOP INTO OPERATIONAL CDCS SO THAT THEY MAY CARRY OUT THEIR DEVELOPMENTAL PROGRAMS. WE, AND THE COMMUNITY SERVICES ADMINISTRATION, HAVE DEMONSTRATED THAT A MINIMUM OF $1.5 MILLION IS NEEDED FOR CONVERSION AND FIRST OPERATIONAL FUNDING FOR EACH NEW CDC FROM A PLANNING GRANT.

(4) ALLOW US TO BEGIN THE INNOVATIVE IDEA OF FUNDING RURAL COOPERATIVES THROUGH THIS SECTION OF THE ACT. THIS SECTION HAS NEVER BEEN FUNDED BEFORE. THESE COOPERA-

TIVES HAVE SHOWN THAT THEY CAN OPERATE WITHIN THE CONCEPT OF COMMUNITY-BASED ECONOMIC DEVELOPMENT, AND NEED THIS SORT OF FUNDING TO MORE EFFECTIVELY IMPACT ON THEIR COMMUNITIES.

(5) DEVELOP AND TEST THE EVEN MORE EFFICIENT FORM OF FUNDING THESE PROGRAMS THROUGH RECYCLABLE LOAN FUNDS. THIS CONCEPT, WRITTEN INTO THE ACT, ALSO HAS NEVER BEEN IMPLEMENTED BEFORE, BUT PROMISES SAVINGS IN PROGRAM COSTS TO THE TAXPAYERS WHILE CONTINUING THE HIGH LEVEL OF EFFICIENCY AND EFFECTIVENESS WHICH THESE PROGRAMS HAVE SHOWN IN THE PAST. WE NEED SUFFICIENT FUNDS TO DEMONSTRATE THIS NEWER FORM OF FUNDING MECHANISM.

(6) FUND SUPPORTIVE PROGRAMS WHICH HAVE BEEN SHOWN TO BE ESSENTIAL TO ASSISTING THE COMMUNITY-BASED ECONOMIC DEVELOPMENT ORGANIZATIONS THROUGHOUT OUR COUNTRY TO CARRY OUT THEIR TASKS AS DEFINED BY THE ACT. THESE SUPPORTIVE PROGRAMS INCLUDE EXPERIMENTAL DEVELOPMENTAL FINANCE CORPORATIONS, AND TECHNICAL ASSISTANCE ORGANIZATIONS. THESE ORGANIZATIONS ARE AN INTEGRAL PART OF THE SUPPORT MECHANISMS NECESSARY TO COMPLY WITH THE GOALS OF THE ACT.

(7) ADMINISTER THE PROGRAM. DUE TO INSUFFICIENT STAFF, THE OFFICE OF ECONOMIC DEVELOPMENT HAS BEEN SEVERELY OVERWORKED. ACCORDING TO ONE STAFF MEMO, EACH PROGRAM ANALYST IS REQUIRED TO PERFORM 313 MAN-DAYS OF ACTIVITY PER YEAR, AS OPPOSED TO REGULAR GOVERNMENT WORK LOADS OF ONLY 260 MAN-DAYS. THIS LEVEL OF FUNDING WILL ALLOW MODERATE INCREASES IN STAFFING AS REQUIRED BY THE PROPOSED REORGANIZATION PLAN ACCEPTED BY THE OFFICE OF MANAGEMENT AND BUDGET.

THE TABLE ON THE FOLLOWING PAGE ILLUSTRATES IN MORE DETAIL THE REQUESTS WE HAVE MADE:

FISCAL YEAR 1978

| | | MILLIONS |
|---|---|---|
| PART A: | SPECIAL IMPACT PROGRAM | |
| 1. | OPERATIONAL CDCS REFUNDING CYCLE | $ 62.0 |
| 2. | CONVERSION OF PLANNING GRANTS | 4.5 |
| | | $ 66.5 |
| PART B: | SPECIAL RURAL PROGRAM | |
| 1. | RURAL CO-OPERATIVES | $ 2.0 |
| | | $ 2.0 |

| | | |
|---|---|---|
| PART C: | DEVELOPMENT LOAN MECHANISMS | |
| 1. | COMMUNITY DEVELOPMENT LOAN FUND | $ 4.0 |
| 2. | RURAL DEVELOPMENT LOAN FUND | 1.5 |
| | | $ 5.5 |
| PART D: | SUPPORTIVE PROGRAM | |
| 1. | TRAINING & TECHNICAL ASSISTANCE | $ .5 |
| 2. | RESEARCH | 1.0 |
| 3. | EVALUATION | 1.0 |
| 4. | OPPORTUNITY FUNDING CORPORATION | 1.0 |
| 5. | SO. COOPERATIVE DEVELOPMENT FUND | 1.5 |
| 6. | DEVELOPMENTAL FINANCE CORPORATION (PART C) | 2.0 |
| 7. | FUNDING OF TEN PLANNING GRANTS | 1.5 |
| | | $ 8.5 |
| ADMINISTRATION | | 2.5 |
| | | $ 2.5 |
| | TOTAL | $ 85.0 |

I WOULD LIKE TO CLOSE WITH A REMINDER THAT THE SPECIAL IMPACT PROGRAM IS THE ONLY FEDERAL PROGRAM WHICH IMPACTS ON MANY OF THESE COMMUNITIES, WHICH CAN BE THE HARSHEST THIS NATION HAS TO OFFER. OVER THE LAST TEN YEARS, WE HAVE SHOWN THAT THIS PROGRAM CAN WORK, EFFECTIVELY, AND EFFECIENTLY, TO CREATE JOBS, OPPORTUNITIES, HOPE AND NEW ECONOMIC VITALITY IN MANY OF OUR NATION'S WORST POVERTY-STRICKEN AREAS. I ENCLOSE FOR THE RECORD A COPY OF OUR NCCED SURVEY OF 33 COMMUNITY-BASED ECONOMIC DEVELOPMENT CORPORATIONS WHICH ILLUSTRATES THIS POINT OF IMPACT IN MORE DETAIL.

THE $85 MILLION LEVEL OF FUNDING FOR FY 1978 IS ABSOLUTELY ESSENTIAL FOR THE CONTINUED SUCCESSFUL OPERATION OF OUR PROGRAM. THE INCREASE IS MODEST, AND REPRESENTS THE MINIMUM WE FEEL NECESSARY TO CONTINUE OUR ACTIVITY TOWARD THE GOALS THE U.S. CONGRESS SET OUT FOR US IN THE ACT.

I WOULD ALSO LIKE TO ADD THAT WE AGREE WITH THE LEVEL OF FUNDING PROPOSED BY OUR COLLEAGUES ON THIS PANEL FOR THE COMMUNITY SERVICES ADMINISTRATION AS A WHOLE. WE FEEL THAT THEY NEED AN INCREASE IN SECTION 221 FUNDS, AND FULLY SUPPORT THEM IN THEIR WORK.

THANK YOU FOR THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY, AND ALL OF US ON THIS PANEL WOULD BE HAPPY TO ANSWER ANY QUESTIONS.

# Special Impact Program Funding Data

The tables below indicate the distribution of Special Impact Program funds directly by OEO/CSA for the fiscal years 1968–1976. Dollar amounts listed here represent SIP grants made public as of October 1976. The figures do not represent funds received from other sources, such as Section 232 of Title II, for purposes similar to that of the SIP, nor do they include SIP funds granted by other agencies before OEO/CSA took full control of the program in FY 69. Supplemental grants have been included in the appropriate column. FY 76 extends from July 1, 1975 to Sept. 30, 1976.

All data published in these tables are official public information from CSA documents. Figures published previously by CCED are superseded by these data.

**Allocation of Special Impact Program (Title VII) Funds to Urban Programs (in thousands of dollars)**

| | FY 68–70 | FY 71 | FY 72 | FY 73 | FY 74 | FY 75 | FY76 | Total |
|---|---|---|---|---|---|---|---|---|
| Hough, Cleveland, Ohio[1] | 3,140 | 1,998 | 2,673 | — | — | 1,500 | 49 | 9,360 |
| Bedford Stuyvesant, N.Y. | 11,984 | 10,000 | 100 | 11,500 | — | 9,000 | 3,702 | 46,286 |
| United Durham, N.C. | 900 | — | 900 | — | 1,300 | — | 377 | 3,477 |
| Harlem Commonwealth, N.Y. | 1,400 | 2,631[2] | 900 | 2,000 | 3,500 | — | 7,000 | 17,431 |
| Union Sarah EDC, St. Louis, Mo. | 1,200 | 900 | 25 | 1,000 | — | — | 1,500 | 4,625 |
| ICBIF, Detroit, Mich. | 1,000 | 800 | — | term. | — | — | — | 1,800 |
| Pyramidwest, Chicago, Ill. | 2,500 | 2,104 | 5,000 | 1,200 | 3,000 | — | 4,500 | 18,304 |
| PIC/PDC Washington, D.C. | 775 | 750 | — | — | term. | — | — | 1,525 |
| Denver CDC, Colo. | 125 | 1,200 | 18 | — | 500 | 687 | 1,355 | 3,885 |
| East Boston CDC, Mass. | 300 | 1,300 | — | 1,000 | — | 1,500 | — | 4,100 |
| Greater Roxbury Dev. Corp., Boston, Mass. | 301 | 900 | — | 700 | 160 | — | 1,550 | 3,611 |
| UIC, Seattle, Wash. | 102 | 50 | term. | — | — | — | — | 152 |
| ECCO, Columbus, Ohio | 900 | — | — | term. | — | — | — | 900 |
| N.J. Dept. Comm. Affairs[3] | 2,140 | — | — | — | — | — | — | 2,140 |
| Bergen-Greenville Dev. Corp., N.J.[3] | 360 | — | — | — | 1,000 | — | term. | 1,360 |
| N.Y. Off. Comm. Dev. (FIGHT, Rochester) | 750 | 75 | term. | — | — | — | — | 825 |
| Memphis Area Chamber of Commerce (GMUDC), Tenn. | 1,000 | — | — | term. | — | — | — | 1,000 |
| CDC of Kansas City, Mo. | 1,117 | — | 700 | 1,000 | — | — | 1,000 | 3,817 |
| CAO (Black Dev. Fdn.), Buffalo, NY. | — | 560 | 500 | — | term. | — | — | 1,060 |
| Hunts Point CLDC, S. Bronx, N.Y. | — | 135 | 50 | 1,000 | — | 1,000 | — | 2,185 |
| CEDC of Nassau Co., N.Y. | — | 100 | 1,236 | — | 1,000 | — | 1,700 | 4,036 |
| MAUC, San Antonio, Tex. | — | 125 | 1,300 | 900 | 3,000 | — | — | 5,325 |
| TELACU, East Los Angeles, Calif. | — | 124 | — | 1,000 | 2,000 | 2,500 | 1,525 | 7,149 |
| SRC, Racine, Wis. | — | 50 | 1,300 | — | 2,000 | — | term. | 3,350 |
| San Juan CDC, P.R. | — | — | — | — | 500 | — | 1,550 | 2,050 |
| Anacostia EDC, Washington, D.C. | — | — | — | — | — | 150 | 1,500 | 1,650 |
| Chicanos Por La Causa, Phoenix, Ariz. | — | — | — | — | — | 150 | 1,500 | 1,650 |
| Black People's Unity Movement EDC, Camden, N.J. | — | — | — | — | — | — | 150 | 150 |
| TOTAL URBAN | 29,994 | 23,801[4] | 14,702 | 21,300 | 17,960 | 16,487 | 28,958 | 153,203 |

[1]Grantees are listed in chronological order of funding.

[2]Only $2.28 million of this total was used by HCC itself. The remaining $351,000 was used by El Barrio Economic Development Corporation, funded as a delegate agency of HCC. El Barrio was terminated as a delegate agency in FY 1973.

[3]A total of $2.5 million was granted in FY 1970 to the New Jersey Department of Community Affairs, which in turn funded 5 CDCs, one of which, Bergen-Greenville Development Corporation, received $360,000. Bergen-Greenville also received a SIP grant of $1 million in FY 1974 and thus is listed separately in this table.

[4]Figures in this table may not add up to total because of CSA rounding.

**Summary: Allocation of Special Impact Program Funds (in thousands of dollars)**

| | FY 68–70 | FY 71 | FY 72 | FY 73 | FY 74 | FY 75 | FY 76 | Total |
|---|---|---|---|---|---|---|---|---|
| Field Programs | | | | | | | | |
| Urban Programs | 29,994 | 23,801[2] | 14,702 | 21,300 | 17,960 | 16,487 | 28,958 | 153,203 |
| Rural Programs | 12,563 | 7,470 | 9,803 | 13,893 | 13,950 | 22,031 | 20,804 | 100,514 |
| Total Field Programs | 42,557 | 31,271 | 24,505 | 35,193 | 31,910 | 30,968 | 49,762 | 253,717 |
| Support Programs | 2,157 | 2,258 | 1,569 | 605 | 1,969 | 1,307 | 1,944 | 11,809 |
| Special Categories[1] | 4,400 | 1,633 | 35 | 45 | 746 | 3,580 | 1,920 | 12,359 |
| CSA Administrative Overhead | 1,800 | 700 | 700 | 700 | 1,000 | 1,250 | 7,150 | |
| TOTAL | 50,914 | 35,862[2] | 26,809 | 36,543 | 35,625 | 44,405 | 50,876 | 285,035 |

[1]Unlike the programs listed as Field Programs, all of which are funded under Part A of Title VII, Central Coast Counties Development Corporation is funded under Part D of Title VII and thus is listed here under Special Categories. However, this is an operating field program with a defined impact area, and thus the true amount allocated to field programs is understated.

[2]See prior note re rounding.

## Allocation of Special Impact Program (Title VII) Funds to Rural Programs (in thousands of dollars)

| | FY 68-70 | FY 71 | FY 72 | FY 73 | FY 74 | FY 75 | FY 76 | Total |
|---|---|---|---|---|---|---|---|---|
| ECCO, Ga.[1] | 581 | 754 | 1,187 | — | 500 | — | term. | 3,022 |
| HELP, N.M. | 1,121 | 701 | 20 | 1,000 | 1,500 | — | 59 | 4,401 |
| Kentucky Highlands Inv. Corp., Ky. | 368 | 1,003 | 17 | 1,200 | — | 3,200 | 42 | 5,830 |
| SE Alabama CDC | 370 | 570 | — | 200 | 800 | — | term. | 1,940 |
| SW Virginia CDF | 1,048 | 800 | 15 | 1,924 | — | 3,350 | — | 7,137 |
| New Communities, Ga. | 128 | term. | — | — | — | — | — | 128 |
| NE Oklahoma CDC | 875 | 50 | 2,500 | — | term. | — | — | 3,425 |
| Las Colonias, Tex. | 97 | — | term. | — | — | — | — | 97 |
| Westside Planning Group, Fresno, Calif. | 100 | 150 | 1,160 | 500 | 1,200 | 500 | 3,350 | 6,960 |
| Adela DC, Utah | 100 | — | 995 | — | 1,500 | — | — | 2,595 |
| Delta Foundation, Miss. | 1,288 | — | 1,058 | 600 | 3,400 | — | 4,000 | 10,346 |
| SEED Co., Fla. | 800 | — | — | 1,000 | — | 1,358 | — | 3,158 |
| CEDC, Alaska | 1,187 | 2,650 | 38 | 2,369 | — | 3,000 | 5,000 | 14,244 |
| Lokahi Pacific Corp., Kihei, Hawaii | 1,000 | — | — | 1,000 | — | 1,700 | 50 | 3,750 |
| Delta Area Developers, Ark. | 500 | 792 | — | 1,200 | — | 400 | — | 2,892 |
| Impact Seven Inc., Wisc. | 650 | — | — | 1,000 | — | 1,200 | — | 2,850 |
| Midwest Minnesota CDC | 750 | — | 870 | — | 550 | 2,250 | — | 4,420 |
| Standing Rock Industries, N.D. | 1,100 | — | 150 | 500 | — | term. | — | 1,750 |
| Lummi Indian Tribal Ent., Wash. | 500 | — | 1,711 | 600 | 2,500 | 3,373 | 1,000 | 9,684 |
| TENCO, Tenn. | — | — | 82 | 800 | 1,500 | 750 | 32 | 3,164 |
| Tri-Island EDC, V.I. | — | — | — | — | 500 | — | 1,000 | 1,500 |
| Anthra-Penn CDC, Pa. | — | — | — | — | — | 150 | — | 150 |
| Campesinos Unidos, Calif. | — | — | — | — | — | 150 | 96 | 246 |
| Dineh Cooperatives, Ariz. | — | — | — | — | — | 150 | 1,525 | 1,675 |
| Natchitoches EDC, La. | — | — | — | — | — | 150 | 1,500 | 1,650 |
| Northern Cheyenne CDC, Mont. | — | — | — | — | — | 150 | — | 150 |
| Northern Community Investment Corp., Vt. | — | — | — | — | — | 150 | 1,500 | 1,650 |
| Zavala County | — | — | — | — | — | 50 | 1,650 | 1,700 |
| TOTAL RURAL | 12,563 | 7,470 | 9,803 | 13,893 | 13,950 | 22,031 | 20,804 | 100,514 |

[1] Grantees are listed in chronological order of funding.

## Allocation of Special Impact Program Funds to Other Categories (thousands of dollars)

| SUPPORT PROGRAMS | FY 68-70 | FY 71 | FY 72 | FY 73 | FY 74 | FY 75 | FY 76 | Total |
|---|---|---|---|---|---|---|---|---|
| Research & Evaluation | | | | | | | | |
| Abt Associates | 771 | 952 | 14 | 90 | term. | — | — | 1,827 |
| CCED | 249 | 274 | 613 | 43 | 929[2] | 142 | 1,591 | 3,841 |
| INED | — | 53 | 332 | 422 | 209 | 439 | 54 | 1,509 |
| NHEDLP | — | 197 | 356 | — | 630 | 669 | — | 1,852 |
| Westinghouse | 357 | — | — | — | — | — | — | 357 |
| Bokonon | — | — | — | — | 100 | — | — | 100 |
| Washington State Board for Community College Ed. | — | — | — | — | — | — | 152 | 152 |
| Subtotal R&E | 1,377 | 1,476 | 1,315 | 555 | 1,868 | 1,250 | 1,797 | 9,638 |
| Training & Technical Assistance | | | | | | | | |
| Boise Cascade[1] | — | 456 | 143 | term. | — | — | — | 599 |
| Harbridge House | 571 | 155 | term. | — | — | — | — | 726 |
| NCCED | — | — | 50 | 50 | 101 | 57 | — | 258 |
| PMM & Co. | 209 | 150 | term. | — | — | — | — | 359 |
| Other TA | — | 21 | 61 | — | — | — | — | 82 |
| National Training Institute for CED | — | — | — | — | — | — | 47 | 47 |
| Employment Dev. Dept. of Calif. | — | — | — | — | — | — | 100 | 100 |
| Subtotal Training & TA | 780 | 782 | 254 | 50 | 101 | 57 | 147 | 2,171 |
| Total Support Programs | 2,157 | 2,258 | 1,569 | 605 | 1,969 | 1,307 | 1,944 | 11,809 |
| SPECIAL CATEGORIES | | | | | | | | |
| Other Grants | | | | | | | | |
| Assn. of Western Spanish-speaking CDCs, Washington, D.C. | — | — | — | — | — | 42 | — | 42 |
| OFC, Washington, D.C. | 3,900 | — | — | — | 46 | 738 | 120 | 4,804 |
| CCCDC, Calif. | — | — | — | — | 200 | 300 | 300 | 800 |
| SCDF, La. | — | — | — | — | 500 | 2,500 | 1,500 | 4,500 |
| Subtotal Other Grants | 3,900 | — | — | — | 746 | 3,580 | 1,920 | 10,146 |
| Interagency Transfer | | | | | | | | |
| OIC, Brooklyn | 500 | 1,500 | term. | — | — | — | — | 2,000 |
| Transfers to D.O.C. | — | 133 | 35 | 45 | — | — | — | 213 |
| Subtotal | 500 | 1,633 | 35 | 45 | — | — | — | 2,213 |
| Total Special Categories | 4,400 | 1,633 | 35 | 45 | 746 | 3,580 | 1,920 | 12,359 |
| TOTAL OTHER CATEGORIES | 6,557 | 3,891 | 1,604 | 650 | 2,715 | 4,887 | 3,864 | 24,168 |

[1] The Boise Cascade contract was transferred to Marshall, Kaplan, Gans & Kahn in March 1972.

[2] Represents two-year funding.

# THE CDC MODEL:
## A Development Vehicle in Poverty Communities

### HIGHLIGHTS

The following highlights of this paper are presented to give a quick overview of its contents:

- According to a recent Congressional Budget Office Report, one in every four families in the U.S. requires some form of transfer payment to remain above the federal poverty level.

- CDCs work against staggering odds. They deliberately take on development tasks where standard economic strategies have failed and local residents, public officials and business leaders have thrown up their hands in frustration.

- Community development corporations (CDCs) are supported by Title VII of the Community Services Act of 1974 in a few severely depressed communities to break the cycle of poverty by developing local skills and talents, owning and controlling land and other resources, starting new businesses and industries, increasing job opportunities, sponsoring new community facilities and services and improving the physical environment. They rejuvenate and create processes and infrastructures--a developmental environment--that permit and foster economic self-reliance and growth.

- Although community economic development is a hybrid that blends aspects of both the business and public sectors, its approach differs substantially from each.

- CDCs are unique because they:
  --are committed to a long-term and comprehensive

development process, and

--establish partnerships with and mobilize resources from an array of private and public institutions, and

--are conceived and governed by residents of the communities in which they operate, yielding flexible and adaptive strategies to fit the diverse and peculiar needs of each impact area.

° CDCs have impact:

| | |
|---|---|
| 33 | CDCs responding to NCCED survey (19 rural, 14 urban) |
| 6,940 | jobs in ventures, CDCs, and co-ops at December 1976 |
| $38,600,000 | generated in payroll January 1976 through December 1976 by ventures, CDCs, and co-ops |
| $78,100,000 | CDC and leveraged funds used for construction and rehab as of December 1976 |
| $24,200,000 | Estimate of the portion of above construction and rehab costs which are direct labor costs |
| $120,900,000 | Market value of real estate developed through CDC construction and rehab efforts |
| $33,900,000 | Funds CDCs placed and leveraged as loan capital to area residents and business January 1976 to December 1976 |
| $61,100,000 | Funds CDCs placed and leveraged which was in place as equity capital in operating ventures December 1976 |

The last full-scale, independent evaluation of the concept of community economic development was completed by Abt Associates in 1973. Abt found that:

> Overall, the experience of the Special Impact Program validates the key concepts of the approach. Particularly the critical element of community

> control and participation has been found to be effective in increasing the development impact of the CDC. Using business ventures for pursuing social objectives has no, or a slightly positive, effect on business performance measured in traditional terms. The overall efficiency of the average CDC is therefore increased by the comprehensiveness of the development approach.[1]

INTRODUCTION

America is becoming a nation of dependents.

That might be one conclusion from a recent Congressional Budget Office finding that one of every four American families needs some form of government subsidy to remain above the poverty level. Welfare and related outlays grew from $77.2 billion in 1965--when President Johnson launched the War on Poverty--to $286.5 billion in 1975.[2]

In many urban and rural communities, the existing institutions and economic bases have failed to reverse the downward spiral of social, physical and economic deterioration. In these areas the development problems are not affected by traditional, piecemeal solutions. For example, investment tax credits are of no use in the absence of an industrial base. When funding ends for public works and public service employment, so do the jobs. Industrial sites and business loan programs are of little assistance when workers are unskilled, and manpower training programs are not useful if no jobs are available.

The Congress did provide a tool for addressing the causes of poverty in a comprehensive, long-term fashion when it authorized and funded the Special Impact Program under the Economic Opportunity Act.[3] Community-based economic development corporations (CDCs) are supported with this Act to break the cycle of poverty by developing local skills and talents; owning and controlling land and other resources; starting new businesses and industries; increasing job opportunities; sponsoring new community facilities and services; and improving the physical environment. Currently 40 CDCs are employ-

ing this federal resource in severely depressed areas.

THE PROBLEMS CDCs ADDRESS

CDCs deliberately take on development tasks where standard economic strategies have failed and local residents, public officials and business leaders have thrown up their hands in frustration.

- For example, the Community Economic Development Corporation of Alaska works in an area covering half a million square miles with more than 200 villages and a population of 165,000. Average per capita income in 1970 was $2,352, and rural residents rely heavily on subsistence activities for economic survival. Average unemployment in some villages is over 30 percent. Most employment needs are for seasonal and unskilled workers. Because most businesses are owned by nonresidents, few profits are returned to the local economy, and there is a lack of capital for starting new ventures or expanding existing ones. In addition, typical rural problems such as difficulty of transportation and communication and lack of development expertise are even more pronounced in rural Alaska where costs are much higher.
- In the nine Appalachian counties of Southeastern Kentucky where Kentucky Highlands Investment Corporation is located, unemployment is estimated at 28 percent. Seventy-one percent of all adults have not gone beyond the eighth grade, and 41 percent of all families are below the poverty line. The area has suffered from a lack of developmental institutions, limited employment opportunities, and transportation and communication problems.
- The Delta Foundation faces a poverty rate of 80 percent among the black population of its 14 rural Mississippi-delta counties.

- Development problems complicated by a federal "hand-holding" mentality have persisted for decades on Indian reservations such as the Lummi in Washington State (unemployment of 60 percent prior to CDC results) and the Navajo in Arizona (67 percent of families below poverty level).
- But urban CDCs face no prime conditions either. The East Los Angeles Community Union's impact area population of 114,000 is located in just an eight square-mile section of the city, and 90 percent are Spanish surnamed. The unemployment rate is more than 17 percent.
- Likewise, the 3.2 square-mile impact area of Cleveland where Hough Area Development Corporation is located has an unemployment rate nearing 20 percent. Most of the population is non-white and average education is below the high school level. Private businesses continue to leave the neighborhood, taking jobs and dollars with them and speeding deterioration.
- While New York City continues to lose businesses and residents, the Bedford-Stuyvesant Restoration Corporation is challenged to attract them back to what some consider the worst part of the city.

These examples illustrate the range and severity of development problems facing deteriorated communities or Special Impact Areas (SIA).

THE CONCEPT OF CDCs

CDCs are unique because they:

- are committed to a long-term, comprehensive development process, and
- establish partnerships with and mobilize resources from an array of private and public institutions, and
- are conceived and governed by residents of the communities in which they operate, yielding flexible and

adaptive strategies to fit the diverse and peculiar needs of each impact area.

Other federal programs such as those of the Small Business Administration, the Economic Development Administration and the Office of Minority Business Enterprise are useful weapons in the CDC arsenal but do not, in themselves, encourage wide community participation and self-determination. Both SBA and OMBE focus on assisting individuals and small businesses by providing loans and some technical assistance, but small business is just one area needing attention in deteriorated communities. EDA and the regional commissions (such as the Appalachian Regional Commission) do address area-wide economic problems and fund public works as well as industry, but they work primarily with local governments and established businesses rather than with residents and new businesses. Further, their projects are oriented mostly toward physical development and handled on a project-by-project basis. None, then, are coordinated, comprehensive development strategies that address the range of problems and roadblocks encountered in special impact areas.

While community action agencies share a berth with CDCs in the Community Services Administration, their focus and strategies differ substantially. Community Action Programs deal with the social causes of poverty by bringing together low-income persons, elected officials and other citizens to mobilize resources and guide the delivery of services.

Although CDCs often find that they must address social concerns, they are directed toward changing fundamental economic and structural factors that perpetuate the cycle of poverty in depressed communities.

THE DEVELOPMENT PROCESS

Special impact areas are depressed because of a whole set of interrelated, negative conditions. For example, only poor

people live in delapidated housing, and they spend little. The merchants in turn move away, and the tax base declines, draining funds for essential community services. Job opportunities leave with businesses, increasing welfare dependency. Breaking this vicious cycle requires a coordinated attack at many levels, following a comprehensive, step-by-step plan that may take many years to implement. The process is expensive and requires more than mere injections of capital.

Two examples will illustrate the longer range and comprehensive nature of CDC approaches to economic and social problems.

- One approach is taken by The East Los Angeles Community Union (TELACU) which is trying to replace employment opportunities that have moved to surrounding parts of the city. In a three-phased planned approach to this need--expected to take at least 15 years to complete--TELACU has undertaken the following types of tasks (among others):
  - PHASE I addresses the establishment of institutions and developmental processes necessary for the following ten years.
    --Using funding from non-CSA sources (such as EDA, state and county), TELACU is studying a wide range of problems and alternative solutions for its SIA.
    --A Community Thrift and Loan (similar to a credit union) attracted $500,000 of capitalization in addition to the $750,000 of Title VII funds used to initiate it, and with deposits of $549,000 has made loans of $815,000.
    --The TELACU Manpower Division is providing job training and placement services for SIA residents.

°° PHASE II will identify and establish much larger business and industrial ventures with a wider and more lasting impact.

--TELACU is currently purchasing 50 acres with a $5 million foundation loan and has obtained tentative commitments from EDA to finance preparation of this industrial site.

--The TELACU Investment Company was formed, has a financing capacity of $3.5 million, and has made several investments.

--Efforts will be intensified to locate and finance new business ventures to employ area residents.

°° PHASE III will:

--allow TELACU to become self-sufficient and well-financed enough to undertake needed neighborhood physical improvements, and

--expand the ventures established in Phase II.

° Another approach is taken by Central Coast Counties Development Corporation (CCCDC). In a comprehensive approach to the goal of ownership of productive resources by farmworker families, CCCDC has brought together all of the necessary ingredients:

°° CCCDC organized cooperatives as the most practical method for increasing income and employment opportunities. 1976 sales were $3.5 million, with 150 families participating.

°° Since neither standard education nor training programs provided the training necessary before farmworkers could manage the entire farming process (in this case strawberry production), CCCDC built the Agricultural Training Center.

°° The 150 co-op member families received financial and management assistance from CCCDC

utilizing grants from EDA, CETA, HEW, the State of California, and Title VII.

- Although initially reluctant to deal with these cooperatives, local banks have since loaned $2.7 million.
- Since adequate housing for cooperative families is not available, CCCDC is now embarking on an innovative housing cooperative by assisting 50 farmworker families to secure a $1.2 million loan to purchase and rehabilitate a former prisoner of war camp.

These examples illustrate the variety of means that a CDC can utilize to develop a long-range, comprehensive approach to solving the area-wide problems of its SIA. In each of these cases the CDC is required to look much further into the future than one or two years, and in order to deal with the myriad social and economic problems it must develop an overall plan of attack focusing on causes rather than symptoms of poverty.

RESOURCE MOBILIZATION

CDC experience has shown that the success of the developmental process depends on the creation and strengthening of a framework--CDCs call it an infrastructure--of economic institutions that will provide a healthy environment for growth and stability. Planning competently, backing new businesses, and finding jobs for residents are certainly key elements, but many times it involves much more.

CDCs also play enabling and mobilizing roles by introducing required skills and expertise into the area, purchasing and improving real estate for industry, upgrading residents' educational and vocational abilities, "prying" money from local banks or establishing new credit sources, constructing or repairing housing and providing other essential human services. Section 2 of the Economic Opportunity Act of 1964 (as amended through

° The Kentucky Highlands Investment Corporation and its business ventures have received financing from eleven different sources, including federal and state programs, foundations, banks, and over $250,000 from individual investors. The business ventures alone have negotiated $5.2 million in financing, compared to KHIC's investment of $1.6 million of Title VII funds.

° The Delta Foundation has "borrowed" six man-years of professional executive talent from the Cummins Engine Company.

° The Bedford-Stuyvesant Restoration Corporation has received aggregate income of $105 million, less than half from federal grants. Bedford-Stuyvesant worked with IBM to achieve location of a plant which will employ 500 people in the community. This CDC has also negotiated over $53 million in private financing (primarily from banks) for residential and commercial physical development.

° Lummi Indian Tribal Enterprises has obtained $2.8 million from EDA for technical and financial assistance for their business ventures.

° TELACU has worked with OMBE and SBA to package $17 million in bank loans to 200 minority businesses. In addition, the CDC has mobilized $37.2 million for various developments such as $10 million obtained from HUD for a public housing project.

1976) states that the purpose of the legislation is to "strengthen, supplement and coordinate" federal and private efforts in the elimination of poverty. CDCs utilize the people and financial resources of the public and private sectors in pursuing their varied development strategies.

° The Denver Community Development Corporation formed The Greater Denver Local Development Corporation which utilized $440,000 in financing from SBA, local banks

and other private sources to build a facility for a DCDC-financed manufacturing company.

° CCCDC negotiated $2.7 million in bank financing for its co-ops.

FLEXIBILITY

A CDC's goals and priorities are determined by its board of directors, which represents all segments of a special impact community. Using its board, a CDC extends its planning and implementation capabilities by involving various sectors of the community in deciding what will be done and how. The board is able to assist in negotiating with local banks, forming local development corporations (to access SBA financing), locating and purchasing industrial sites and, in general, mobilizing community resources for CDC development strategies. Abt Associates concluded that this extension of the CDC into the community increases the chances for success.[4]

This responsiveness of CDCs to their environments is central to their effectiveness in the many diverse SIAs. Here are a few examples of the wide variety of CDC activities and operating philosophies:

° CEDC of Alaska operates through financing village cooperatives.

° Bedford-Stuyvesant is heavily involved in physical development.

° Northern Community Investment Corporation is financing the growth of old-line industries to stem the flow of manufacturing businesses from its rural area of New Hampshire and Vermont.

° TELACU has a current emphasis on manpower programs and financial institution building.

° Lummi Indian Tribal Enterprises actually directs and controls its business ventures, whereas Kentucky Highlands Investment Corporation makes venture capital investments

(with less than 50 percent ownership) in independently-managed companies.

But flexibility and responsiveness also mean the ability to adjust to changing conditions within a CDC's own impact area or to strengthen a weak strategy.

° Siete del Norte in New Mexico began to pursue economic development through investing in agricultural opportunities. However, the decline of the agriculture industry in its area was so severe (a decrease of 70 percent in agricultural employment in 10 years) that the CDC could not reverse it and several ventures failed. Siete maintained its economic development goals, but shifted its strategies and is now successfully investing in new manufacturing ventures.

° TELACU was unsuccessful in its early business investment strategies because the infrastructure necessary to support business operation did not exist. TELACU then prepared a long-term plan, has dealt with infrastructure problems in the past five years and is now successfully reinstating its business investment activities.

Due to their flexibility, CDCs can be more than business investment vehicles creating profits, jobs and construction. At times, in a depressed community where workers are unskilled, competent entrepreneurs and managers are difficult to find and banks may be uncooperative, ventures must be planned to operate at a loss for an extended period while these problems are addressed. Moreover, in many CDC communities housing stock is often deteriorated, the lack of child care may keep single-parent families from jobs, and human services are inadequate. Therefore, CDCs must take on various community development activities to achieve the physical and social infrastructure required to support economic development.

° The Lummi CDC operates several sea product ventures that began in 1970 as major research and development

projects. After some initial false starts, the ventures are now fully operational and are expected to reach breakeven in 1980. This 10-year development period allowed the Lummi's to operate production worker training programs and a shadow management strategy where eight Lummi management trainees work one-on-one with temporary non-Lummi managers. The additional costs of training, duplicative management, and the three-year lead time required before shellfish crops can be harvested account for the long time to achieve break-even.

- TELACU was instrumental in planning, developing and implementing the construction of 500 units of public housing containing a section with recreational and nutritional facilities.

THE IMPACT

In the foregoing discussion, examples were presented of how different CDCs have met the diverse challenges of their special impact areas. Specific examples were chosen to illustrate activities relating to (1) the long-range, comprehensive process of economic and social development, (2) the mobilizing of federal, state and local, and private resources to achieve the CDC's goals, and (3) to show the flexibility and adaptability of a CDC to the needs of its constituency.

In what follows, data gathered from 33 responses to a mail survey conducted by NCCED are compiled to show some of the overall impacts achieved by CDCs. Since the techniques and goals of CDCs tend to be as diverse as their impact areas aggregation of specific areas of achievement (while possible) is difficult and does not adequately illustrate the total scope of community economic development. Moreover, not all CDCs are involved in all areas of the survey, so not all areas have 33 responses. For this reason, the number of responses

is indicated for each survey subject.[5]

A total of about 6,940 jobs--3/4 of them full-time--were created by the 29 CDCs responding to this question, through business ventures, non-profit ventures and cooperatives. Included were 621 jobs in the CDCs themselves which primarily employ community residents. Total 1976 payroll for these jobs came to $38.6 million. Based upon expansion or initiation of business ventures, CDC-generated employment generally promises permanence, unlike jobs in public works and public service employment programs.

The 19 CDCs responding to the physical development portion of our survey invested and leveraged over $78.1 million for residential and commercial construction and rehab projects, generating $24.2 million in payroll.[6] Estimated current market value of the properties is over $120.9 million. Due to high deterioration rates in some of the impact areas, market values were sometimes lower than cost of construction, particularly in residential development, illustrating the downward spiral problem that CDCs must address.

Of the 33 CDCs responding to the NCCED questionnaire, 25 provided information on activities meeting the critical need for capital availability in their communities. In 1976, 21 CDCs placed or leveraged $33.9 million of capital into their local economies through such vehicles as direct business loans, bank financing, small business investment corporations, revolving loan funds and credit unions. Another $61.1 million of CDC and/or leverage capital was reported by the 25 CDCs as equity in place in operating businesses.

Some examples of impacts of CDCs in individual communities:

° Bedford-Stuyvesant Restoration Corporation's business ventures have had cumulative sales (from date of CDC investment) of over $47.3 million and a payroll of over $18.8 million (through June 30, 1975). Wages earned by

manpower placements made by Bedford-Stuyvesant exceeds $23.5 million.

- In 1976, CEDC of Alaska's 33 ventures, primarily fisheries and retail outlets, grossed $14 million with an aggregate net profit of $230,000 and a payroll of $2.5 million.
- Kentucky Highlands Investment Corporation has financed eleven new enterprises since 1970 that have had cumulative gross sales of $15.1 million, profits (net of all losses) of $907,000 and payrolls of over $4.4 million. Title VII funds invested in these ventures are less than $1.6 million.
- Lummi Indian Tribal Enterprises has quadrupled the value of fish caught by tribal members since 1968 and has created over 100 new full-time jobs on the reservation with a 1976 payroll of $1.25 million.
- The business ventures of CEDC, Inc. of Nassau County, New York, employed 303 persons as of December 31, 1976, generating a 1976 payroll of $2.4 million. With the 1.5 income multiplier used and suggested by the Nassau County government, the total impact of the payroll is estimated at $3.6 million.
- The Delta Foundation in rural Mississippi has created 348 jobs in business ventures with a 1976 payroll of nearly $1.9 million.

But the full impact of a CDC cannot be measured just by developmental statistics like those above. What is the impact of CDC achievements on the rate of alcoholism on an Indian reservation? The incidence of gang war in East Los Angeles? Or the break-up of families in Bedford-Stuyvesant? These questions were not addressed in the NCCED survey, but must be answered before the total impact of a CDC can be measured, or appreciated.

SUMMARY

CDCs have planted the seeds for a comprehensive long-range process attacking economic deprivation in poverty communities. Low-income and other disadvantaged residents are the primary participants in and direct beneficiaries of community economic development, but it is not a welfare program. Its effects are permanent and based on the principles of development and self-reliance.

The last full-scale independent evaluation of the concept of community economic development was completed by Abt Associates in 1973. Abt found that, compared with other anti-poverty efforts, the CDC tool has been largely successful:

> Overall, the experience of the Special Impact Program validates the key concepts of the approach. Particularly the critical element of community control and participation has been found to be effective in increasing the development impact of the CDC. Using business ventures for pursuing social objectives has no, or a slightly positive, effect on business performance measured in traditional terms. The overall efficiency of the average CDC is therefore increased by the comprehensiveness of the development approach.[7]

Community development corporations have accepted immense challenges. Some have failed. This report does not ignore that fact, but it is not an evaluation of the Title VII program. Rather, it highlights and illustrates the achievements and capabilities of CDCs to show that the basic concept of community economic development can be implemented to achieve development results in some of this nation's most depressed communities.

Appendix A

SELECTED CDC PROFILES

Given the wide variety of CDC structures and Special Impact Areas, there is no typical profile. Rather, the respondents to our survey reflect the ability of the CDC model to contour itself to a wide range of demographic and social settings.

- 19 CDCs are located in predominately rural areas. The smallest area in this group is 887 square miles, the largest 586,000 square miles (the state of Alaska

minus Anchorage, Juneau, and Fairbanks). The majority are multicounty and two are located on islands. Population ranges from 2,000 to 255,000.

- the 14 urban CDCs responding range from less than 2 square miles to 365, with target populations ranging from 33,000 persons to 424,000.
- black, white and hispanic communities are approximately equally represented in our sample and, in addition, three CDCs serve American Indian populations.

Unemployment is often a prime CDC concern, though the problem is much more severe in some areas. Rates range from a high of 60% in a northwestern rural CDC area to 9% in an eastern urban Special Impact Area.

Underemployment, the earning of an income too small to support the individual and dependents, is of equal, if not more, concern to the CDCs, for it is indicative of the low-skill/low pay cycle of poverty. In our sample 23 to 66% of impact area families lived below the federally designated poverty line. Average annual family incomes ranged from $3,600 on a tribal reservation to $9,870 in an eastern urban area. In general, average rural incomes are $3,500 lower than urban.

Also linked to low pay and the barriers to local business development is the lack of formal schooling held by the area residents. Again, the Indian CDCs display the lowest figure with average years of schooling completed of 3.9. The figures in our sample went as high as 9.8 years in an industrialized urban setting.

To more graphically display the different methods by which CDCs address their different development tasks and the scope of their operations, the following "snapshots" of several CDCs are presented. They were selected for their demonstration of the operations and achievements of CDCs with different characteristics, such as years in operation, geographic and ethnic factors, level of funding, and other demographics.

Bedford-Stuyvesant Restoration Corporation
(Bedford-Stuyvesant)
Brooklyn, New York

The Bedford-Stuyvesant Restoration Corporation is addressing the economic and social problems of a 5½ square mile area of Brooklyn with a population of 400,000. The community is 85 percent black and 12 percent Hispanic, with over 50 percent of the population subsisting below the federal poverty line.

Due to the interlocking nature of the social, economic, and physical problems, Bedford-Stuyvesant has designed a comprehensive development program. With New York City virtually bankrupt and business and residents leaving, Bedford-Stuyvesant is challenged to attract them back to what some consider one of the worst parts of the city.

Over the past 10 years Bedford-Stuyvesant has demonstrated that its approach works. Since inception in 1967 (as of June 30, 1975 except as noted):

| | |
|---|---|
| • Total Federal grants received (12/31/76) | $51,336,000 |
| • Physical and business development financing, primarily from banks | $53,190,000 |
| • Residential and commercial construction (at cost, 4/30/76) | $20,142,000 |
| • Cummulative business venture sales | $48,300,000 |
| • Business venture, construction and CDC Payroll | $41,335,000 |
| • Federal tax payments generated | $11,607,000 |

In 1976 Bedford-Stuyvesant and its ventures employed 801 people with a 1976 payroll of $6,833,000. In addition to Federal grants, as of December 31, 1976 Bedford-Stuyvesant has received $53,640,000 from foundations, contracts, rentals, investment income, and other sources.

The New York Times recognized the achievements of Bedford-Stuyvesant with an editorial on January 11, 1977:

(EDITORIAL)

NEW YORK TIMES January 11, 1977

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*

ARTHUR OCHS SULZBERGER
*Publisher*

JOHN B. OAKES, *Editorial Page Editor*
FRED HECHINGER, *Assistant Editorial Page Editor*

A. M. ROSENTHAL, *Managing Editor*
SEYMOUR TOPPING, *Deputy Managing Editor*
ARTHUR GELB, *Assistant Managing Editor*
PETER MILLONES, *Assistant Managing Editor*
JACK ROSENTHAL, *Associate Editor*

CHARLOTTE CURTIS, *Associate Editor*
CLIFTON DANIEL, *Associate Editor*
MAX FRANKEL, *Associate Editor*
TOM WICKER, *Associate Editor*

# Throwing Money in the Proper Fashion

One of the successes of the Nixon Administration was that it gave trying a bad name: that is, it indiscriminately applied the slogan "throwing money at problems" to efforts to attack the roots of poverty and urban decay. The slogan became cliché, and the cliché became shorthand for the dogma that the Great Society had failed entirely. But facts, such as the quiet but considerable accomplishments of the Bedford-Stuyvesant Restoration Corporation, have a way of intruding even on the most effective slander.

Just a few of the statistics generated by the ten years of the program's activity, as recently reported in The Times, gives a sense of the hope brought by the corporation to one of the nation's largest and most devastated black communities.

- It brought to the community $63 million in public and private funds.
- It developed 660 new or rehabilitated housing units.
- It established a mortgage pool and granted 1,100 loans totaling more than $21 million to local residents.
- It placed almost 7,000 local residents in jobs or job training programs.

The achievements of the Restoration Corporation have by no means erased all of the blight in Brooklyn's "Bed-Stuy" nor can it even be asserted that they have reversed the process of erosion. But they have generated both hope and activity which hold out some promise for the future in a community that could otherwise have been left for dead.

As Franklin Thomas, president of Restoration through its entire life, said recently: "There are still serious problems out here, but before we got started, no banks were willing to make loans, no private companies were willing to invest here, few people were willing to restore private property and there were no young people willing to work to fix up the community. All of these elements are at work in a constructive way here now."

The Bedford-Stuyvesant effort is providing a model for what it will take to regenerate the decaying portions of American cities, and it is very much on the Great Society design. Federal money was earmarked, within general guidelines but without rigid constraints, to generate private money and concerted local attempts to solve problems in Bedford-Stuyvesant. A broad local coalition was put together by the late Senator Robert F. Kennedy that included street radicals, community business people, politicians and Wall Street bankers. That coalition not only began the program, but has held with it for a decade.

The distinctive lessons of the Bedford-Stuyvesant program are that the "place for coordination is not at the start of the pipeline, but at the end of it in the community," as Mitchell Sviridoff of the Ford Foundation put it; that the local effort should be given enough latitude to evolve in its own way and, as Franklin Thomas says, that any attack on these problems must be seen as a "multi-decade struggle."

The secret of the Bedford-Stuyvesant achievement was that it provided broad definition and stimulus for local effort without overbearing direction from Washington. In picking their way between the dangers of too much and too little Federal concern, the Bedford-Stuyvesant managers and their Washington sponsors managed to tap the last great resources for urban revitalization: the energy, the ingenuity, the talents and the aspirations of the local residents. It is a lesson for the new Administration to study with care.

CENTRAL COAST COUNTIES DEVELOPMENT CORPORATION (CCCDC)

Aptos, California

CCCDC's target group is primarily the 46,000 low-income, Spanish-surnamed farmworker population of three rural counties. The average income for the unskilled Mexican-American migrant farmworker in 1969 was $3,852. Agribusiness in California is highly dependent on seasonal farm labor and unemployment rises to 15% in the off season. This problem is perpetuated by a lack of training programs and the inaccessibility of resources to the farmworking community.

CCCDC's primary goal is economic impact on the target population through immediate income improvement, increased employment opportunities, the building of alternative economic enterprise structures, physical development (housing), and increased ownership of economic ventures by farmworkers. To complement this strategy, CCCDC is also operating a public service component to deal with immediate training and employment needs with the goal of promoting an enabling environment that fully develops human resources.

CCCDC has organized and worked extensively with six strawberry producing cooperatives, which are among the largest in California. With CCCDC assistance, these cooperatives have leveraged $2.7 million in private sector loans from local banks, grossed $3.5 million in sales in 1976, and generated $1.75 million in 1976 in payroll and income benefits (to co-op members).

CCCDC has built the Agricultural Training Center and initiated Project AWARE to provide on-the-job training work experience and permanent job placement to the unemployed and economically disadvantaged population. Project AWARE serves approximately 400 clients annually.

CCCDC is also impacting upon the physical development of the community by assisting 50 farmworker families in establishing an innovative housing cooperative in the Salinas Valley. They are currently negotiating a $1.2 million loan to purchase and rehabilitate a former prisoner-of-war camp.

CCCDC's major internal problem has been the difficulty in recruiting staff who are trained and experienced in the field of community development. In addition to Title VII, CCCDC has utilized financing from various sources including the State of California, EDA, DOL/CETA and HEW. Title VII funds received by CCCDC as of September 30, 1976 total $800,000.

COMMUNITY ENTERPRISES DEVELOPMENT CORPORATION OF ALASKA
(CEDC, ALASKA)
Anchorage, Alaska

CEDC, Alaska has an impact area population of 165,000 people spread out over 200 villages covering 586,000 square miles with an average per capita income in 1970 of $2,352, and unemployment in some villages exceeding 30%. The magnitude of the economic and social problems is enormous. Most villages have no economic base, and basic community infrastructure relative to housing, water and sewer, electricity and community facilities do not exist in rural Alaska.

The goal of the CDCs activities is to provide local people the opportunity and necessary tools to achieve economic self-reliance. It's strategy is to provide technical and financial assistance to businesses owned by low income, rural communities. CEDC utilizes its administrative staff and venture capital to start businesses that provide jobs, income, and services, reduced prices to local consumers, and development of business skills. CEDC's business ventures include fish processing, retailing, tourism, real estate, and timber. Due to lack of business skills in villages, the

CDC provides substantial technical assistance and management training and support.

CEDC, Alaska has faced difficulties concerning CDC control versus local control, since it operates on the premise that local residents must initiate and participate in the development and operation of their venture. CEDC can assume management controls over the ventures only after its profitability is affected. CEDC, in the past, watched ventures become hopelessly mired in their problems before any action could be taken. Then CEDC had to assume control over venture operations to prevent further financial problems. Some decisions of long-term benefit to the venture may be unpopular on the village level.

In 1976 alone, CEDC's ventures had an aggregate sales volume of over $14 million and a net profit in excess of $230,000, with salaries of over $2.5 million for 1,080 full and part-time employees. Total value of real property and equipment in place was $5.6 million. As of December 31, 1976, CEDC has spent $9.8 million of CSA funds (including $3.3 million in investments).

CEDC, Incorporated
(CEDC of Nassau)
Hempstead, New York

CEDC's target population is the 28,000 minority and or low income families of Nassau County, with unemployment rates estimated at 20%-30%. Three major problems addressed by CEDC are: flight of businesses from depressed areas; disinvestment of local banks; and general movement of youth and middle class population out of the community.

CEDC's strategy for alleviating these conditions requires a socio-economic approach rather than one limited strictly to business development. This is due in part to CEDC's hybrid nature, since it is the economic tool of Nassau County's Community Action Agency (CAA). The CAA generally addresses the social problems but it overlaps with CEDC in impacting on the community. CEDC concentrates on business development, the establishment of credit resources, and development of minority management capabilities.

CEDC capitalized a small business investment company, partially with OED venture capital and partially with other public and private funds. This investment company currently has a total financing capacity of $2 million, and has financed several ventures.

CEDC's Federal Credit Union was established as a source of personal credit to the target community residents. It has grown to an active membership of 450 persons and a net worth of $142,214. It has the capacity to grant loans up to $9,000, and recently signed an agreement with SBA permitting it to participate in the loan guarantee program.

To stem the increasing deterioration of the Roosevelt business district CEDSHOP 1 was opened. This is a wholesale food market that employs 30 persons and has sales of $52,000 per week, $3,000 short of break-even. Although planned to reach a profitable sales level, the visible change in the communities' main street, the positive impact on nearby retail stores, the added jobs and resultant taxes, and the money flow into the local economy, more than outweighs the subsidy currently needed to operate.

CEDC is committed to develop minority leadership and management from within the impact communities. This includes its Board of Directors, staff, and a special Management Trainee project, as well as on-the-job training within ventures. The recent loss of two management trainees, both of whom had gained better than two years of education, training and experience and then left CEDC for greener

pastures, was a painful disappointment. Staff turnover is high and minority talent with which to replace it is scare, thus keeping CDC from reaching an optimum level of excellence, and impacting negatively on venture profitability.

CEDC of Nassau's business development strategies have resulted in 303 full and part time jobs with a 1976 payroll of over $2.4 million. The CDC has also rehabilitated over 780 units of housing with a current market value of over $15.6 million, leveraging funds from various sources in the process.

CEDC of Nassau had, as of December 31, 1976, expended $2 million in Title VII funds (including $750,000 in investments).

DELTA FOUNDATION, INC.
(Delta)
Greenville, Mississippi

The Delta Foundation was created in 1969 to promote economic development in 14 counties of the Mississippi Delta Region. The population of this 3,000 square mile area is 250,000, 60% black, the 1970 median income was $4300 ($2,611 for blacks) and the poverty rate is 43% (80% for blacks).

Delta's goal is to create employment and ownership opportunities for the poor mostly black residents of the community through the development of permanent income producing businesses. Delta has used the venture capital approach (less than 50% ownership of entrepreneurially initiated ventures) and has initiated and financed wholly owned subsidiaries.

Delta has achieved the following results:

- invested in 27 ventures which achieved $7.2 million in sales in 1976
- negotiated venture financing of $2.9 million from private sources
- venture employment of 343 as of December 31, 1976, with a 1976 payroll of $1.9 million
- constructed $950,000 of residential and $667,000 of commercial facilities (at cost)
- founding investor in the Southern Agriculture Corporation recently capitalized at $2.3 million to achieve increased productivity and ownership opportunities for small farmers in the South.

One of the major internal problems Delta has faced in rural Mississippi has been the difficulty in hiring and retaining individuals with the level of professional skills and experience required. To mitigate this problem Delta established a partnership arrangement with the Cummins Engine Company that has resulted in, among other things, an executive loan program through which Delta has received 6 man years of professional management assistance. Cummins has since worked with several other CDCs.

As of December 31, 1976, Delta had expended $7.5 million of Title VII funds (including $4.5 million in investments).

DENVER COMMUNITY DEVELOPMENT CORPORATION (DCDC)
Denver, Colorado

DCDC operates in an area of Denver where, according to a recent survey, the unemployment rate was 17.7% (22% for the approximately 60,000 Chicanos), 41% of the families earn less than $6,000 per year. The area is deteriorating as local commercial and manufacturing firms move away, jobs are lost, local purchasing power declines, and retail outlets go out of business.

The main thrust of DCDC's strategy is business development to meet the need for stable employment among residents. As a result, 213 full-time jobs have been retained and created in the SIA with a direct 1976 payroll of $1,937,000. DCDC has purchased 3 supermarkets which were about to leave the area, two of which are operating profitably, thus essential goods and services remain in the community as well as jobs and income.

In addition to pursuing business development goals, DCDC was instrumental in the formation of the Greater Denver Local Development Corporation that obtained SBA funds for rehabilitation of commercial and industrial structures, including the restoration of a facility for Mountain High Yogurt, a recent venture investment that will employ up to 150 people.

As of December 31, 1976 DCDC had expended $2.7 million of Title VII funds (including $1.3 million in investments.)

THE EAST LOS ANGELES COMMUNITY UNION (TELACU)
Los Angeles, California

TELACU's Special Impact Area (SIA) consists of 114,000 residents of whom 90% are Spanish surnamed, concentrated into eight square miles in unincorporated East Los Angeles (ELA). The unemployment rate in the SIA is 17.3% with a poverty rate of over 23%.

TELACU's goal is to create the economic and business infrastructure needed for attaining economic impact in ELA. They have come to two conclusions about their economic development effort: (1) it will take a prolonged effort before any appreciable impact on ELA will be discernable; and (2) given the level of CSA funding, relative to the magnitude of the task, TELACU must leverage additional resources to accomplish its goals. Thus, the CDC has developed a 15 year plan, base year 1971, with 3 major phases.

Phase I is aimed at formulating policies and plans to impact the serious problems of the community. In tandem, TELACU has developed organizations to implement these plans. A total of $673,000 was committed to this effort from non-Title VII sources and $63,000 was provided by TELACU. Phase I results include a Business Development Organization which has packaged loans of $17 million to small businesses in ELA. In addition, TELACU Manpower Division has placed over 4,000 people from ELA and surrounding areas in jobs generating wages of $10.8 million since its inception.

In Phase II, TELACU will concentrate on becoming financially independent and will initiate industrial enterprises bringing large scale employment to ELA residents. The CDC established TELACU Investment Company (TIC) which has leveraged original CSA funds 2.8 times and has invested in several industries, such as Atlas Aquariums, which was losing money, but showed a net after tax profits of $26,000 after TIC's investment. TELACU is negotiating to purchase 50 acres adjacent to East Los Angeles with a $5,000,000 loan from a private foundation and has tentative commitments from EDA to finance preparation of this industrial site.

Phase III will include achieving self-sufficiency of TELACU and the building of a sufficient asset base to continue development

programs in ELA, bringing jobs and income to the community residents. TELACU is equally committed to providing unmet Social Services to the ELA community, and has created Nutrition Programs (480 to 500 people per day) for senior citizens, and for-profit food stamp distribution centers handling 288,000 transactions per year, averaging $90.00 each with a gross flow of $26,000,000.

During their early stages, TELACU had a misplaced and unsuccessful emphasis on business development, due to the fact that the community did not possess the economic infrastructure needed for successful business ventures. TELACU corrected this situation by creating solid infrastructure consistent with their long range plan, and investing in manufacturing businesses.

TELACU had, as of December 31, 1976, expended $3.2 million in Title VII funds (including $1.9 million in investments). From all other sources, TELACU has mobilized $37.2 million

KENTUCKY HIGHLANDS INVESTMENT CORPORATION (KHIC)
LONDON, KENTUCKY

The nine mountain counties of southeastern Kentucky comprising KHIC's impact area cover an area of 3,500 square miles; 1975 population was 184,000; calculated unemployment is 28%; 71% of the population has completed less than nine years of schooling; 41% of the population lives below the Federal poverty level (according to state figures).

KHIC creates permanent job opportunities for area residents through initiating and investing in profitable manufacturing ventures. KHIC has a high concentration on venture profitability, yielding permanent results.

A second objective was set more than two years ago to achieve independence and continuity of KHIC as a community investment corporation. This entails financial independence from a sole funding source through the generation of adequate investment income to support KHIC's activities in the future without dependence on additional subsidization.

KHIC also develops social and industrial infrastructures necessary to support the increased business activity resulting from investments.

KHIC current investment portfolio contains eleven enterprises, with total KHIC venture financing of $1.6 million. These ventures have leveraged additional financing of $5.2 million, which equals $4.26 of total venture financing for each KHIC dollar invested. The ventures have had cumulative gross sales of $15.1 million, payroll of more than $4.4 million, profits (net of all losses) of $907,000 and presently employ 270 people. Venture employment currently comprises nearly 1 per cent of the total area work force, 20 per cent of one individual county's entire work force, and nearly 100 per cent of that counties total manufacturing jobs.

KHIC has created a substantial asset base with a net worth of over $4.1 million. Investment income ($165,000 in 1976), and unrealized capital gains (equal to 27 per cent annual return of equity), move KHIC toward its objective of financial independence and stability.

To develop the social and economic infrastructure, KHIC has obtained more than $250,000 in grants to pursue the establishment of a Health Maintenance Organization, and a program to promote resident entrepreneurship. Moreover, KHIC has purchased industrial site locations for portfolio companies and has invested in a local industrial development commission in partnership with SBA, Farmers' Home Administration, and a state agency.

The major obstacle to accomplishing KHIC's primary objective is the difficulty in identifying sufficient numbers of viable investment opportunities. Thus, many of KHIC resources (both staff time and dollars) are directed at generating a "flow" of entrepreneurially initiated or managed venture possiblities in which KHIC can invest. KHIC efforts have achieved results, as in 1976-77 they produced the largest number of entrepreneurial contacts in its history (more than 350).

KHIC had, as of December 31, 1976, expended $3.1 million of Title VII funds (including investments of $1.6 million).

LUMMI INDIAN TRIBAL ENTERPRISES (LITE)
Marietta, Washington

The LITE target population is the 2000 people of the Lummi Reservation. The average family income on the reservation prior to LITE was under $2,000, and unemployment was over 60%.

The economic deficiencies that LITE has attempted to impact on are: the lack of adequate price and market for fish caught by Lummi fishermen; lack of adequate supply of fish; lack of adequate production per fisherman due to inefficient fishing methods and gear; and a lack of interest by local institutions in supplying credit. These economic deficiencies relate to three prevalent social problems at the reservation: lack of adequate housing creating deteriorating health conditions on reservation; lack of education and failure of the Bureau of Indian Affairs (BIA) to live up to treaty promise; and the lifestyle of the fisherman exacerbated by long periods of idleness due to lack of fishing opportunities.

LITE's basic strategy is to create ventures addressing the social and economic problems plaguing the tribal community. They settled on two ventures: aquaculture of salmon and shellfish; and a seafood buying, processing, and marketing company. CSA capital of $500,000 created the fish hatchery, which has hatched over 12 million fish for Puget Sound and employs 14 full-time tribal members with a yearly operating budget of $300,000. EDA public works and technical assistance funds of $2.8 million were utilized to create Lummi tidal-flats for the production of shellfish, mainly oysters. The net financial worth of fish caught by tribal members before LITE was formed in 1968 was $250,000, and by 1976 the value was over $1 million per annum.

LITE Seafood Company was formed in 1973. Capital for the Seafood Company was obtained from CSA, EDA, DOL, and BIA. Sales volume of the Seafood Company has escalated from $300,000 in 1973 to $1,053,029 in 1976. In addition, they have helped eliminate the lack of adequate prices for Lummi Fish in the outlet market. Fish prices have risen from $.30 to $.60 in early 1970's to between $.60 and $2.00 in 1976.

The Aquaculture and Seafood Company ventures have created over 100 full-time jobs for LITE residents with 1976 salaries in excess of $1,250,000. The economic impact has been felt well beyond the reservation in terms of increasing the fish stock in Puget Sound, and providing other fisherman with equitable market outlets for selling fish.

As of December 31, 1976 LITE had expended $8.7 million in Title VII funds, all applied to their business ventures.

NORTHERN COMMUNITY INVESTMENT CORPORATION
(NCIC)
St. Johnsbury, Vermont

NCIC's area consists of 164,000 individuals who reside in the northern counties of New Hampshire and Vermont. 91% of the population is rural, and the average family income is 30% below the national average.

NCIC is attempting to alter the following conditions: a lack of

investment capital; net outflow of capital; an unemployment rate of 12%, lack of high skill, high wage jobs; and lack of infrastructure to achieve local self-reliance.

NCIC goals are geared toward developing NCIC as a viable capital investment and development organization, investing at least $4 million in the SIA with at least $4 million leveraged from other sources, and strengthening and broadening the economic base of the community.

NCIC, which was operationally funded in June of 1976 by CSA, made its first major investment in January, 1977, in Kearsarge Metallurgic Corporation, which had $2.8 million in sales in 1976, and projects sales of $3.6 million in Fiscal Year 1977. NCIC was able to leverage bank financing with FHA guarantees of $1,400,000 for expanding Kearsarge facilities to employ up to 300 people.

NCIC Revolving Loan Fund recently guaranteed a local bank loan to Northeast Kingdom Cooperative Cannery for funds to establish a canning center that will cut food costs for low-income residents. A $20,000 guarantee was made on a bank loan for Whitman Press, Inc., which employs 35 individuals and projects gross sales in 1977 of $824,000.

NCIC was the co-founder of the Wood Energy Institute, which will respond to the impending energy shortages and high costs facing both consumers and manufacturers in the area.

Since beginning its operating phase in June of 1976 NCIC has leveraged nearly $2 million dollars in outside investment funds into the area. NCIC has received $1.5 million of Title VII funds as of December 31, 1976.

Appendix B

List of Respondents

Adela Development Corporation
623 South 200 East
Salt Lake City, Utah 84111

Anacostia Economic Development Corporation
2041 Martin Luther King Avenue, S.E.
Washington, D.C. 20020

Bedford-Stuyvesant Restoration Corporation
1360-90 Fulton Street
Brooklyn, New York 11216

Central Coast Counties Development Corporation
265 Center Avenue
Aptos, California 95003

Community Enterprise Development Corporation of Alaska
1011 East Tudor
Anchorage, Alaska 99503

Community Economic Development Corporation of Nassau County
106 Main Street
Hempstead, New York 11550

Desert Enterprises, Incorporated
620 North 10th Street
Brawley, California 92227

Dineh Cooperatives, Incorporated
Post Office Box 569
Chinle, Arizona 86503

East Boston Community Development Corporation
144 Meridian Street
East Boston, Massachusetts 02128

East Los Angeles Community Union
1330 South Atlantic Boulevard
Los Angeles, California 90222

Harlem Commonwealth Council
215 West 125th Street
New York, New York 10027

Hough Area Development Corporation
7016 Euclid Street, Suite 336
Cleveland, Ohio 44103

Hunts Point Community Local Development Corporation
384 East 149th Street
Bronx, New York 10455

Delta Area Developers
204 North Washington Street
Post Office Box 1229
Forrest City, Arkansas 72335

Delta Foundation
819 Main Street
Post Office Box 588
Greenville, Mississippi 38701

Denver Community Development Corporation
4142 Tejon Street
Denver, Colorado 80211

Lummi Indian Tribal Enterprise Incorporated
Post Office Box 309
Marietta, Washington 98268

Mexican-American Unity Council
2300 West Commerce Street
San Antonio, Texas 78207

Midwest Minnesota Community Development Corporation
U.S. 59 South
Post Office Box 376
Mahnomen, Minnesota 56557

Natchitoches Economic Development Corporation
310 Highway 1 South
Post Office Box 944
Natchitoches, Louisiana 71245

Northern Community Investment Corporation
Post Office Box 396
St. Johnsbury, Vermont 05819

San Juan Community Development Corporation
5 Guayana Street
Post Office Box 2111
Hato Rey, Puerto Rico 00919

Seminole Employment & Economic Development Corporation
Post Office Box 2076
Sanford, Florida 32771

Siete del Norte CDC
216-B Riverview Drive, N.E.
Espanola, New Mexico 87532

Southwest Virginia Community Development Fund
401 First Street, N.W.
Roanoke, Virginia 24016

Impact Seven, Incorporated
Post Office Box 335
Turtle Lake, Wisconsin 54889

Kentucky Highlands Investment Corporation
Post Office Box 628
London, Kentucky 40741

Lokahi-Pacific Corporation
Post Office Box 767
Kihei, Maui, Hawaii 96753

Tenco Developments, Incorporated
1198 Madison Street
Post Office Box 368
Shelbyville, Tennessee 37160

Tri-Island Economic Development Corporation
No 2 Dronnigens Gade
St. Thomas, U.S. Virgin Islands 00801

UDI Community Development Corporation
Post Office Box 1349
Durham, North Carolina 27702

Union Sarah Economic Development Corporation
4731 Delmar Boulevard
St. Louis, Missouri 63108

West Side Planning Group, Incorporated
1476 North Van Ness Avenue
Fresno, California 97328

Appendix C

NOTES

1. Abt Associates, An Evaluation of the Special Impact Program, Vol. 1, Washington, D.C., December 1973, pg. 26

2. Congressional Budget Office Background Paper No. 17, Poverty Status of Families Under Alternative Definitions of Income, Washington, D.C., 1977, pg. 1 and 9.

3. In 1968 the Community Services Administration's predecessor, The Office of Economic Opportunity received from the Department of Labor a year-old program that channeled federal development dollars into urban--and later rural--areas. The Special Impact Program that has evolved is now authorized under Title VII of the Community Services Act of 1974

4. Abt, loc. cit.

5. In the current Title VII program, Part A, there are 30 established CDCs, 6 newly operational CDCs, and 3 planning grants. One CDC (Central Coast Counties) is funded under Part D of Title VII. The response to our survey includes 27 established CDCs, 4 newly operational CDCs, 1 planning grant, and the 1 Part D CDC. The responses therefore represent 82% of the operating CDCs. The respondents have received $172.5 million from Title VII in the last 10 years, or 68% of the total funds granted to CDCs under Title VII.

   While we have used information from the Bedford Stuyvesant Restoration Corporation in portions of this paper the data was not comparable to that collected in our mail survey and is therefore not included in any aggregate statistics.

6. Utilizing a national ratio of .31 in wage costs per dollar of total costs. Drawn from "The Input-Output Structure of the U. S. Economy, 1967" appearing in the Survey of Current Business, February, 1974, in Table 2. Direct Requirements Per Dollar of Gross Output.

7. Abt, loc. cit.

STATEMENT OF JAMES M. OLIVER

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, I HAVE BEEN INVOLVED WITH THE ANTI-POVERTY EFFORT FOR OVER A DOZEN YEARS. MY EXPERIENCES AS DIRECTOR OF THE COMMUNITY ACTION AGENCIES IN DETROIT AND YOUNGSTOWN AND MY CURRENT INVOLVEMENT WITH POVERTY PROGRAMS IN NEW YORK CITY HAVE PROVIDED ENOUGH REWARDING MOMENTS TO LAST A LIFE TIME.

IN THE EARLY DAYS OF THE WAR ON POVERTY AMERICA WITNESSED AN OUTPOURING OF INDIVIDUAL COMMITMENT THAT HAS NOT BEEN EQUALED BY PROGRAMS BEFORE OR SINCE.

UNION LEADERS, RELIGIOUS LEADERS, BUREAUCRATS, CONGRESSIONAL

MEMBERS, ITELLECTUALS, MEMBERS OF THE CIVIL RIGHTS MOVEMENT ALL JOINED HANDS WITH THE POOR EQUALLY IN AMERICA'S ATTEMPT AT ELIMINATING THE POVERTY CONDITIONS THAT SURROUND SO MANY MILLIONS OF AMERICANS.

I CAN ASSURE YOU THE COMMITMENT TO SUCCEED IS STILL THERE.

RECENTLY, PRESIDENT CARTER SELECTED DR. GRACE OLIVAREZ TO HEAD THE COMMUNITY SERVICES ADMINISTRATION.

TO THE MANY OF US WHO KNOW HER, WE ARE CONFIDENT SHE WILL BRING THE NECESSARY LEADERSHIP TO THE COMMUNITY SERVICES ADMINISTRATION AND WILL HELP RESTORE THAT AGENCY INTO THE PRACTICAL, EFFICIENT AND INNOVATIVE INDEPENDENT AGENCY IT SHOULD BE.

COMMUNITY ACTION AGENCIES ARE NOT ASKING FOR FUNDS TO CREATE A SUPER BUREAUCRACY. WE ARE NOT ASKING FOR FUNDS SIMPLY BECAUSE WE EXPECT A HAND OUT.

INSTEAD THE COMMUNITY ACTION AGENCIES IN AMERICA BELIEVE THEY HAVE DONE AN EFFECTIVE JOB AND WILL ALWAYS CONTINUE TO DO SO.

IN THE UPCOMING WEEKS, MEMBERS OF CONGRESS WILL BE RECEIVING REPORTS FROM THEIR CONSTITUTENTS ABOUT THE IMPORTANT ROLE COMMUNITY ACTION AGENCIES PLAY IN THEIR AREA.

WE ARE CONFIDENT THE RENEWED SPIRIT ENCOMPASSING COMMUNITY ACTION TRANSLATES INTO A MAJORITY OF THE MEMBERS IN CONGRESS.

A WARRIOR FROM ANOTHER TIME, ANOTHER PLACE ONCE TOLD AMERICA, "GIVE US THE TOOLS AND WE WILL FINISH THE JOB." TODAY COMMUNITY ACTION ASKS CONGRESS TO GIVE US THE TOOLS SO WE CAN FINISH THE JOB. WE WILL WIN THE WAR ON POVERTY.

THANK YOU.

MASSCAP EFS PROJECT
36 CONCORD STREET
FRAMINGHAM, MASS. 01701

March 28, 1977

Hon. Warren Magnuson, Chairman
Labor-HEW Appropriations Subcommittee
U.S. Senate
Washington, D.C. 20510

Dear Senator Magnuson and Committee Members,

The active participation of the Massachusetts Community Action Agencies in the Community Food and Nutrition Program (CFNP) has been instrumental in increasing participation in the federal food programs within our state. Through CFNP we have also begun a longer range program of encouraging food self-help projects within our relatively non-agricultural state.

We believe that state-wide planning and coordination has given us the strength necessary to progress toward our objectives. This planning and coordination has been made possible by the use of CFNP funds. Our federal food program participation rates compared quite favorably to other states, but we need an increase in our funding level to reach higher objectives.

You will soon be examining the CFNP budget for Fiscal Year '78. We ask that you support a funding level of $50 million.

CFNP has made it possible for us to prepare a needs assessment and to create strategies to meet the needs uncovered in the assessment. Where we have found common needs around the state, we have been able to gather resources to work on the problem in order to move toward solutions. However, there are many more needs defined than we are able to address at our current funding levels.

By your supporting and obtaining a higher funding level, we would be able to expand our activities to cover areas in which we now can only hope to cover adequately involving information and referral activities. We would like to be involved in monitoring and evaluating additional programs, then researching and developing models for community groups to utilize. By drawing all concerned agencies together we could address the quality problem across the board, i.e., create and implement a state-wide nutrition policy.

For your information, we are asking the Manpower and Poverty Subcommittee of the Human Resources Committee to write legislation so that the Community Food and Nutrition Program could create and implement a National Food and Nutrition Policy. Only through quality nutrition education will we be able to maximize the value of the tax dollars which have been allocated to federal feeding programs.

So that you may have an idea of activities occurring within Massachusetts, the last five issues of our state-wide newsletter, TABLE SCRAPS, are enclosed.

If we may be of any assistance to you, please let us know. We are looking forward to a strong Community Food and Nutrition Program in the future.

Sincerely,
Clifford Walton

Clifford Walton
EFS Director

FINANCIAL NEEDS

Mr. HEYMAN. We appreciate the opportunity to discuss with you the financial need of the Community Services Administration. It is the response to those needs which we hope to reflect in the Community Services appropriation, specifically 1978.

As you have indicated, I am Frank Heyman and I am the executive director at Allen County Opportunity Council in Fort Wayne, Ind.

You have met the other members.

My purpose in this short time is to give an insight into the 1978 appropriation needs of the Community Services Administration, and therefore, the local community action agency.

Please recognize that the comments I make here today come from a single director, although I have had several years experience in administration and the poverty agencies and have had hundreds of discussions with colleagues——

Senator EAGLETON. Are you a State director now?

Mr. HEYMAN. No, sir. I run a local agency.

Senator EAGLETON. Where?

Mr. HEYMAN. Fort Wayne, Ind.

Senator EAGLETON. You run the local CAP agency in Fort Wayne? What do you do, sir?

Mr. OLIVER. I have a local community agency in east Harlem in New York City.

Mr. LIZARRAGA. I am president of a community development corporation.

Senator EAGLETON. That is different than the CAP? OK.

Mr. LOPRESTI. I am president of the National Community Development Corporation——

Senator EAGLETON. You have to sort out for me what CAP does that is separate and distinct from the community development, so I have it all stored away.

Mr. HEYMAN. The history of the OEO/CSA is familiar to all of us. I will just briefly mention, the war on poverty declared by President Johnson back in March of 1964 has not been won. The focus by this Government toward eliminating poverty gave way to a more pressing war, Vietnam. The millions of poor in our Nation were soon to find out that the drain of Federal resources to Southeast Asia would thwart the efforts of the U.S. Government to wage and win a war on poverty. Lyndon Johnson, the creator of the "Great Society," was to become of necessity an absentee father of America's war on poverty.

Later, the transfer of 11 OEO programs to other agencies in 1973 as part of President Nixon's all-out effort to dismantle the Office of Economic Opportunity was not only unsuccessful but, with the help of Congress, the poor of this Nation told our executive branch that they too will have a voice in our Government.

We were pleased when both President Ford and then candidate Carter pledged their support to an active, revitalized, and independent Community Services Administration.

The cause remains just and the great needs continue. Now is the time to renew the full-scale war on poverty.

Recent Government figures show a startling increase in the number of poor in America. To those who doubt America's poor deserve this renewed commitment, I challenge anyone to ride the streets of a south Boston, a Roxbury, or an east Chicago and proclaim "America's war on poverty is over."

To win this war, the vehicle must be the Community Services Administration. It is the only agency in the Federal Government whose mandate is to eliminate poverty in America. It is the only agency whose legislation allows enough proper flexibility to respond to the many changing crises our poor face each year.

Specifically, community action needs the following appropriations for fiscal year 1978.

Items of local-initiative funding. We are requesting a 15-percent increase in local-initiative funds, raising the dollar amounts from $330 million to $379.5 million.

Section 221 of the Community Services Act——

Senator EAGLETON. Assistant secretary in what department has jurisdiction over the community services operation?

Mr. HEYMAN. Community Services Administration remains an independent agency in the executive branch. President Carter has indicated the nomination will be forthcoming for Mrs. Grace Olivaras to head up that Agency.

Senator EAGLETON. She reports directly to the President?

Mr. HEYMAN. The Office of the President. The whole initiative funding, section 221 of the Community Services Act, authorizes Federal funding of community action agencies. This agency—this community action agency is the key structure for administering a flexible and wide range of programs to combat poverty at the local level.

Over the past 12 years these community action agencies—CAA's or CAP's—have been the primary coordinators and operators of all Federal antipoverty programs. A network of almost 900 CAA's, working through over 5,000 neighborhood centers, both rural and urban, are serving over 20 million poor persons with programs funded by CSA, HEW, DOL, HUD, and various other State and local sources.

These CAA's administer over $1.6 billion worth of antipoverty programs nationwide, with a staffing totally of about 110,000——

Senator EAGLETON. Are you going to read the whole statement?

Mr. HEYMAN. I can read it quickly or eliminate it.

Senator EAGLETON. I think we can put the statements in.

Mr. HEYMAN. That is fine.

In essence what we are requesting is the two points of view. One, the specific dollar amounts we feel are crucial, in my mind; more important, rationale for why the dollar amounts are necessary.

A key factor to consider this year is the recognition that in the past 6 years there has been literally no increase in funding in the only flexible and hopefully responsible antipoverty program funded by the Federal Government.

In the last 6 years we have lost, in fact, nearly 35 percent or more of our dollar value in terms of providing programs because of inflation.

This agency and the local community action agencies continue to do a highly respectable job, particularly at the local level. There is no question but what there are enormous problems in operating

CSA. The staffing level is down from over 2,000 to about just exactly 1,000 people. It is very, very difficult for the agency to be operating at such a low-funding level, trying to maintain the same programmatic level in the field.

Senator EAGLETON. Who hires you? Did you say Fort Wayne?

Mr. HEYMAN. Yes. I have a local board of directors. Community action agency, as you may be aware, has established a private non-profit corporation with a local board of directors, one-third of whom who are public officials, one-third the private sector, service-oriented sector, and one-third the poor themselves.

My board engaged me in about 1975, I guess.

Senator EAGLETON. Does practically all of your funding come via the Federal Government?

Mr. HEYMAN. Yes.

Senator EAGLETON. You get inkind——

Mr. HEYMAN. In terms of my cash funding, the vast majority is Federal money one way or the other. Much of it is grants directly from a Federal department, and 30 percent is through a contract passed through a State board of instruction or health, but it is originally Federal dollars.

Senator EAGLETON. So State input is usually office space?

Mr. HEYMAN. Our inkind commitment from either State or local sources are at best—they are office space. At best they are some delegated or detailed manpower.

Generally the inkind, the agencies which I worked in, the agencies I have operated, is really a nickel-dime affair, and far too often the inkind situation is—of necessity is a bureaucratic operation you must go through simply to satisfy the guidelines.

I think the inkind requirement is an important one, but at the oppressive levels in the current legislation, which is 40 percent, it is really a shell game.

Senator EAGLETON. The total payroll nationwide of all community action people is 1,000?

Mr. HEYMAN. That is in terms of headquarters staff. Headquarters and regional office staff.

In terms of the number of people employed by local community action agencies, it is in the neighborhood of 110,000 people. On the actual Federal payroll there are 1,000 people.

Senator EAGLETON. In the budget document I have for Community Services Administration, the 1977 appropriation, according to these figures, is $436 million.

The Ford budget asked for $336 million, and the Carter budget for $380 million.

In terms of local initiative, the figures are the same right across the line, $330 million. There are some deletions and subtractions.

Well, a whole bunch of things are deleted. Senior opportunities and services, $10 million stays the same.

State equal opportunity offices, $12 million. That is the same.

Community food and nutrition, $27.5 million. That is the same.

Then we get down to emergency energy conservation services. That is deleted. $27 million.

Then we just added $280 million, I am told, in the supplemental. But we deleted the $27 million. That is an interesting shell game there.

National youth sports program, $6 million, deleted in the Ford and Carter budget.

Summer youth transportation program, $17 million. That is reduced to $1 million, it looks like.

Oh, Migrant—I cannot make heads or tails out of this budget. That is why I am a good chairman to hear it, I guess.

In any event, the bottom line is a drop from $436 million in the Carter figure of $380 million.

Mr. HEYMAN. That is correct. While the brick and mortar here is that initial level, that $330 million, it has been a long, hard fight on the part of those in the community action to keep it at $330 million.

The previous administration, it was proposed to go down to $2.5 million. Then down to 260, which I would have been in impossibility.

If you add in the 282, that would put in the supplemental, then the drop is all the greater.

Senator EAGLETON. Let's try to get some justification on this. Even at the Carter figure, $442 million, which is even for the Federal Government a decent amount of money——

Mr. HEYMAN. There has been a fairly detailed study from the White House transition time headed by Mr. Joseph Oregon.

Senator EAGLETON. You are next, sir.

Mr. OLIVER. Mr. Frank talked to you more specifically about the kind of——

Senator EAGLETON. You are in Harlem?

Mr. OLIVER. East Harlem. I would like to talk now about a little bit of the background of the 12 years of experience in community action in the world and also the reason why we feel commitments should be continued of the Federal Government toward the poor of America.

I have been involved in the direct poverty effort through OEO for close to a dozen years. I have been the director of the Detroit CAP and also the CAP in Youngstown, Ohio, and I am currently involved in programs for poor people in New York City, in east Harlem, as I mentioned.

Of course, in each of these areas of work I have gained quite a bit of experience and thoughts on just what should be happening in terms of eliminating poverty in America.

I just want to indicate that early in the war on poverty there was really a tremendous outpouring of individuals and groups and organizations who are really concerned about trying to bring to bear the total resources of America on this particular kind of problem.

Union leaders, religious leaders, and bureaucrats and congressional and intellectuals right down the line. We are working hand-in-hand with the poor in this effort.

Unfortunately there has been somewhat of a stoppage of that with the kind of attitudes that have crept into the whole governmental commitment to the elimination of poor in this country.

So, as a consequence of that, we now feel with the selection, the possible nomination of Dr. Grace Olivaras, there probably is a new type of spirit in America, and we think under her leadership she will bring the kind of efficiency to the organization and restore it, rather, that has been there before.

Senator EAGLETON. What was she doing before she was tapped for this job?

Mr. OLIVER. She had worked early on as one of the poverty directors in Arizona. I am not sure what her most recent job was prior to being selected for this position, but I know she has quite a lot of experience on the war on poverty. She worked back in 1959 in a program called LEAP.

Mr. HEYMAN. State planning director, also, I believe.

Mr. OLIVER. Essentially what we are saying, if I go back and think of one of the writers in 1968 that really looked at the war on poverty, and said for the first time we in America had the opportunity to wipe out poverty—resources, the will, and the commitment—but what happened, we got distracted in terms of what the job really was.

If we looked at it at that early date we could have discerned that those that would have been helped most in the first 5 or 8 years would have been those persons who were most qualified and persons who have had training and background, and knew really what the opportunity called for.

I think if we turn our attention to the next number of years, first 5 or 7 years, if we would turn our attention to that, whether it would be another 5 years or whatever, with the same kind of commitment we would have been able to understand that the work on hard-core poor would have taken just a little more effort and tenacity——

Senator EAGLETON. Do you think we promised too much?

When I say "we," I mean Lyndon Johnson, Great Society. Do you think the promises were so extravagant that we could never achieve them as quickly as the then-President said he could.

Mr. OLIVER. I think it was unrealistic to assume that the poor would come out of poverty immediately. If we looked at the poor in America, at that time in 1964, the disadvantages, also ethnic and health disadvantages, they did not have the opportunity to move in. We can conceptualize that in the form of an iceberg. We just took the top of the iceberg.

As you know, an iceberg is much larger in depth under the surface than on top. If we would have done that, we would have been able to do a much better job.

I do not think the commitment was unrealistic. I think it could have been more planful in terms of what would have been necessary at the time, at the time that we were working on this kind of action; but certainly not unrealistic in terms of our expectations. I go back again to the fact that I think we had the resources. It was just whether or not we could apply them in the way that would have been most effective to eliminate poverty in America.

Mr. LIZARRAGA. Thank you, gentlemen, and thank you, Mr. Chairman and members of the committee.

I am David Lizarraga, chairman of the board of directors of the National Congress for Community Economic Development, a national trade association of organizations involved in community-based economic development.

Many of our members are funded through the special impact program of the Community Services Administration. The special impact program is listed as the community economic development section of the CSA budget, pursuant to the Community Services Act, title VII.

I am also the president of the East Los Angeles Community Union of East Los Angeles, Calif., a special impact program-funded, community-based economic development corporation, or CDC.

I would ask that my full statement be submitted for the record, as I have only a brief statement I would like to make today. I include as part of the statement, a survey completed last month by the National Congress for Community Economic Development of 33 CDC's funded under the special impact program.

On behalf of all of those involved in the community-based economic development program, I am here to request a fiscal year 1978 funding level of not less than $85 million. This level of funding represents a moderate, balanced growth of the program over the last several years. While we have requested this level for several years, we have never received the full amount.

We feel that this year we can utilize this money efficiently and effectively to move forward in our attempt to revitalize our Nation's poverty-stricken communities.

Senator EAGLETON. You are asking for 85. This current fiscal 1977 is 48 million, and the Ford and Carter budgets both have 30 million.

Mr. LIZARRAGA. That's correct.

In the first year of the new administration, with what we feel is a new commitment to our Nation's poor, we can move to a new and effective position of improving the economic imbalances which exist in many of our urban and rural areas.

The community economic development program stands on the threshold of a new era, in this 10th year of its existence. We have existed as a demonstration program, at a mere subsistence level for 8 years. We have not had sufficient funding or support to actively shift from a demonstration format to a fully operational status. This $85 million funding level for fiscal 1978 is one way to help to move, with this new administration, to a concentrated and effective attack on the root causes of poverty.

Senator EAGLETON. Does the CDC program operate in one area of the country?

Mr. LIZARRAGA. In the entire United States, but not every State.

Community-based economic development is a concept which dates back to the early American colonial trading companies. In its present state, CED is one of the most efficient and effective tools to enable low-income areas to break the cycle of poverty which grips them. CED works by focusing resources on one or two crucial links in the poverty cycle of each community.

CDC's, the usual practitioners of CED under the special impact program, have shown that they can effectively mobilize non-Federal resources on a massive scale, if the initial Federal seed money is available. The survey which is to be read into the record illustrates some examples.

If I may quote a few relevant figures, the impact of the CDC leveraging of small amounts of Federal dollars becomes apparent. I will quote a few figures here.

The market values of real estate, generated solely through CDC construction and rehabilitation efforts, is over $120 million.

Senator EAGLETON. Is this the same Miss Olivaras? Is this part of her shop, too?

Mr. LIZARRAGA. That's correct. This is all under her shop.

Senator EAGLETON. Where are you from?

Mr. LIZARRAGA. East Los Angeles.

Senator EAGLETON. You are director of the CDC out there?

Mr. LIZARRAGA. Yes.

Senator EAGLETON. What kinds of things do you do in East Los Angeles that maybe this CAP guy does in Los Angeles?

Mr. LIZARRAGA. Our attack on poverty is an attack on the economics of that community. For example, we have received to date, in the last 4 years, $3 million in capital. Those $3 million have been used to invest in businesses that can be relocated in that community, that are owned by the community board of directors. Those $3 million are utilized to leverage private money.

As much as $6 million has been allocated to create jobs. The cost of the jobs is approximately $3,500 to $4,000. If you compare that, public works—talking about permanent jobs—$10,000 per job is what it costs for public works for one job for 1 year, with no permanency whatsoever.

We are talking about building an economy. Our values, our reservations, and our ghettos—private industry has escaped them. They have left; they have left them behind to become deteriorated and devastated. We look at our own——

Senator EAGLETON. Give me an example of the type of business you got going last year with the $3 million that attracted $6 million in private capital.

Mr. LIZARRAGA. We put together a small business investment company called Nesbic. We utilized our capital and were able to get private participants matching money, and increased the base to $3 million. We began to invest in companies outside of the impact area that were viable but needed to grow, and asked them to grow in our community.

Senator EAGLETON. Did you open another plant or whatever?

Mr. LIZARRAGA. That is correct. One plant. We have one plant that makes aquariums. It is the largest aquarium employer in the State of California and employs 325 people. And——

Senator EAGLETON. This aquarium guy was somewhere else to start with.

Mr. LIZARRAGA. He was going out of business because he was a technician. He knew how to make aquariums, but not how to run a business. We saved the business by bringing management techniques.

Senator EAGLETON. Who are the management techniques guys?

Mr. LIZARRAGA. We are. We happen to be one of the CDC's that is very effective in this way.

Senator EAGLETON. You and some of your colleagues have some academic training in business management?

Mr. LIZARRAGA. I don't. My staff did. I come out of the war on poverty, through CAPS, and I am president of this corporation and I have hired people to train people to have this kind of expertise.

We are just beginning to get our people out of the colleges and universities, and they have the business expertise necessary to run these companies. We also run a bank. The bank is a community bank, community people are stockholders in that bank. I don't have any stock options. I work at a salary and I could be hired or fired by that community board.

Senator EAGLETON. Where did you get the capital for the bank?

Mr. LIZARRAGA. Out of the same pool of $3 million. We were able to capitalize it at $750,000, and we brought in another $750,000. This is another strategy. This didn't create jobs. This creates money in our community——

Senator EAGLETON. Lending opportunities?

Mr. LIZARRAGA. Lending opportunities in a redline community. It is just like a lot of the underdeveloped nations of the world; we have the same balance of trade problems, export of dollars and manpower and nothing coming in. We need to revitalize those communities and it is economic and it is also social. It is social, because the jobs that are created are given to people in that community. It is social, because the multiplier effect of dollars changed in that community increases from one out to one bank in, and it circulates, 3, 4, 5, 6 times in that community.

It creates a job we think at a very low cost to the Government.

Senator EAGLETON. How many jobs do you estimate that your operation generated last year?

Mr. LIZARRAGA. Just with its own capital, we generated 720 jobs. That is the equivalent of $7,200,000 in public works money. We did that with $3 million.

Now, remember that those $3 million also included our administration, which is 15 percent. Then we have training and supportive services for our board and the other costs and the rest of it is venture capital.

We have a very good ratio of benefit for the buck. We worked very closely with our local CAP over there, so we can coordinate social services to that community. Creating an economic base takes time. Private industry will not come back to our reservation and our ghettoes, unless they get the incentives, unless they do. How can we be expected to turn an economy around in the first, second, or third year? I wish we could have the same minds that are sent to Bangladesh, that are sent to Latin America, through our AID programs to develop nations, so we can have that same idea sent back to devastated communities, with that same commitment because they can be revitalized; they can grow. But we need——

Senator EAGLETON. Why do you think the Carter administration holds your program—I won't say low esteem—but they are cutting the program to $38 million.

Mr. LIZARRAGA. We hope that may change. I don't know. However, we think it has happened because we have had successes and we have had failures.

Senator EAGLETON. I guess we hear more of the failures.

Mr. LIZARRAGA. We admit the failures. Remember one thing, we have existed for very difficult years when our program was being dismantled. When CSA was being dismantled when we went through nine directors in 9 years. That shows something about commitment. Also we went through some very difficult times.

Businessmen in our community, in the country as a whole had an 80-percent failure. We also suffer from the same effects of an economy that is barely beginning to take a rise and had very tough years, but we have proven the concept works. If out of 30 CDC's and only 5 or 7 work, we should look at what made it work and duplicated that over and over and over again, because as a demonstration project, it has succeeded.

You can see it. You can touch it. You can smell it. People are working and profits are being made in those companies and those profits put back into the businesses. OK? So insofar as a demonstration program is concerned, we have proven that the demonstration works. We are asking now for that commitment, that very same commitment that is afforded to foreign countries to be afforded to ourselves and the full understanding of the developmental concept.

Also, one more thing, Senator, the law that exists on the books is a good law, but has never been fully implemented, only one part of it. We have A, B, C, and D in that law. Only one part of it has been implemented. We ask that the law, as it stands there, it is a good law, to be implemented to its fullest and we will be able to do things in rural communities, through the cooperative concept, as well as urban communities through the urban concept that we have.

It is an exciting thing. Anybody that sees it comes back very excited over what they saw, because it is an opportunity to participate in a sense in a capitalistic society, in the free enterprise system.

Mr. LoPresti. I have a couple of remarks. This program is a small program——

Senator Eagleton. Where do you operate, sir?

Mr. LoPresti. In Washington. I am the national representative for all the CDC's.

Senator Eagleton. You are the Washington representative. How big a staff do you have?

Mr. LoPresti. Five.

Senator Eagleton. Who pays you?

Mr. LoPresti. We survive on dues alone. No Federal grants whatsoever.

Senator Eagleton. Who pays the dues?

Mr. LoPresti. CEC's.

Mr. Lizarraga. We raise the money and keep an office here.

Senator Eagleton. How?

Mr. Lizarraga. Through private sources. Profits.

Senator Eagleton. Like out of the aquarium?

Mr. Lizarraga. Yes.

Mr. LoPresti. This program really goes at the cause of the poverty. Most of the testimony here today are all measured for the band aid. They are important sources. But the point is economic investment goes to why people are poor. This program is the insight that years ago on the war of poverty that you went out with investment capital, to find out why people are poor.

In the community, we are talking about there was no jobs. One of our CEC's made four jobs right in the middle of Appalachia where there is no opportunities. It is the investment of capital in communities, so you can recycle the money and make the community rich again. A CDC makes it possible for entrepreneurs to work. We present an effort in making poor communities richer, or at least getting a headstart, going after the causes.

We know about the balance of payments, about profits and what it costs for jobs. But more important, we know how and why to go after really the cause of poverty. It has to be a comprehensive plan. You have a CDC in Missouri, in Kansas City, and Union Sarah.

Senator Eagleton. What is it called?

Mr. LoPresti. Union Sarah.

Senator Eagleton. In Saint Louis?

Mr. LoPresti. Correct.

Senator Eagleton. Even though I know the streets in Saint Louis, I am not familiar with the Union Sarah CDC. Is there one in Kansas City?

Mr. LoPresti. Yes., In Kansas City. That is Velcott identified with the black economic front.

Senator Eagleton. Do you know who heads up the Union Sarah?

Mr. LoPresti. Nesby Moore.

Senator Eagleton. Do you know who heads up the one in Kansas City?

Voice. Don Maxwell.

Senator Eagleton. I am not familiar with what they are doing. I confess to it.

Voice. This is the third time we have been requesting $85 million. Because we know with planned growth, it's a small program, but it works. The real reason they only gave us $30 million, it's another shame, where the Government doesn't know how economic development works. The reason for it, they know the CDC's have resources available to them.

For example, the CDC's are the only programs that used to get cash dollars with their grant. They didn't get the letter of credit because they are capitalized. That is what they are. They take the money and invest it in minority banks and they get funded for 2 years, where the CAPS only get funded for 1 year, so half of it is for the next year, anyway.

They are always on us and saying, You have other resources you haven't used. That is the system. Nobody will talk to you if you don't have money in the bank.

Mr. Lizarraga. We can't go into a bank. The banks, to start with, closed the doors to us. When we have the capital in hand, we are able to negotiate, get their participation. That's all they understand.

Senator Eagleton. Where is the line drawn between what you do and——

Mr. LoPresti. We are interested in equity, ownership, or control of businesses in the community. SBA provides assistance to businessmen. The program he mentioned is part of an SBA program. The point is, the SBA is, right now in America, used predominantly by banks in going through that system.

Mr. Lizarraga. We are involved in institution building. We want to create an institution. We are ready to build the institutions to create the money and create jobs. We are in the process, with the help of EDA, in taking over a 50-acre industrial park. EDA submitted $2 million to help do it.

What happened there, they picked the plant and opened it in Mexico. That is what happened in a community that has over 20 percent unemployment.

We need to create the businesses that provide the jobs. We use the investment dollar to do that. We have been successful. Some of the investments have been good; and like any other business, some have been bad. We are building right now the expertise within the

community. And up until now we have been buying that expertise, with the best people we can find.

When we put together a bank, I don't get my general counsel to put together a bank; I get the best attorneys that are available to help me put that together. However, now that the bank is going, we have a shadow concept of management training, where we train our people with the existing staff that is there, to take over the jobs that are available there at this time. And you see upward employment and upward mobility.

Senator EAGLETON. I came over today to hear the Labor Department budget, but they have thrown a couple of extra on me. I don't mind.

You have an acting administrator; it makes our job all the more difficult. You can appreciate that. Yet nobody's to hold accountable. It's hard to get information. We have to think out a way of making an analysis. I wouldn't know what to recommend to the full committee. It would be a total guess on this.

Well, $380 million is less than you think you need. Even if your testimony—I wouldn't have the foggiest idea what to recommend to my committee.

Mr. HEYMAN. One final comment I would like to make. It's very understandable. To some extent, it involves the whole system; not yours——

Senator EAGLETON. This sort of falls between the cracks.

Mr. HEYMAN. What happened, the antipoverty effort has been this kind of crack in the system for so long. It's time to recommit resources and dollars, and recommit, more importantly, the talent; and mandate of the Government that they do care about poor people. That's all I care about.

Senator EAGLETON. It happened back in 1963 or 1964. It had some appeal. LBJ was running around, eliminate poverty, and Sargent Shriver said we would do it overnight. Then the bottom fell out. Because when you are dealing with disadvantaged people, you aren't going to have a 100-percent success ratio.

That is why Job Corps, for instance, costs a lot more money to operate than other jobs. You are dealing with some very tough social problems. You are not happy about it and I am not, either.

If I had a choice of investing my money in the Chase Manhattan Bank and your bank in Los Angeles, I probably would have to put it in Chase. Some of their investments aren't so good, like New York City, and so forth. As the mistakes became publicized, I read them, you read them—we all know about them—then the bloom went off the rose.

Mr. HEYMAN. What's interesting about that, they continued to be in my own agency and hundreds of others. People were making $5,800, $6,200, who come to work every day, and they still care about poor people. They don't know about the failure here and there, but they are doing their job.

Commitment on the local level is, by and large, there. We have lost the partnership between the Federal commitment and the people doing the job on that level. That is what we are asking about.

Senator EAGLETON. I assure you, we will pay more attention to this section of the budget than we have up to now. You are entitled to that kind of consideration. I may agree with your figures; I may not.

Mr. HEYMAN. We will provide any assistance we can provide in helping.

PREPARED STATEMENTS

Senator EAGLETON. We have written statements from the American Civil Liberties Union and the Association of Media Producers which will be included in the record.

[The statements follow:]

## STATEMENT OF JOHN SHATTUCK AND ELLEN LEITZER

John Shattuck is an attorney and the director and Ellen Leitzer is staff counsel to the Washington Office, American Civil Liberties Union, a non-profit organization of approximately 275,000 members wholly devoted to the protection of rights and liberties under the Constitution.

The American Civil Liberties Union opposes the inclusion of the Hyde Anti-abortion language of the fiscal 1978 Labor-HEW Appropriations bill. Unless the Hyde language is deleted from the Appropriations request, poor women dependent upon medicaid would be denied reimbursement for abortion except where the woman's life is endangered by the pregnancy. Thus, the bill would effectively prevent indigent women from exercising their constitutional right to an abortion. The ACLU's position is bottomed on an awareness of the adverse legal, medical and social consequences which will necessarily result if the Hyde restriction is allowed to stand.

In 1973 the United States Supreme Court handed down two landmark decisions affirming a women's right to abortion, Roe v. Wade, 410 U.S. 113 and Doe v. Bolton, 410 U.S. 179 (1973). The Court in Roe and Doe expanded the privacy doctrine to include the right of a woman, in consultation with her physician, to choose whether or not to terminate a pregnancy. This right to privacy is virtually absolute up until the third trimester (24 to 28 weeks) when the state may proscribe abortion to protect the state's interest in thepotentiality of human life. However, abortion prohibitions must make exception for the preservation of the woman's life and health, including her mental health. The Supreme Court strongly reaffirmed its holdings in Roe and Doe more recently in Planned Parenthood of Central Missouri v. Danforth, _____ U.S. _____ (1976); 96 S.Ct. 2831 (1976).

Numerous federal courts have held that it is unconstitu-

tional to restrict Medicaid payments for elective abortions in cases concerning state restrictions of Medicaid reimbursement for abortion on privacy and equal protection grounds. Klein v. Nassau County Med. Ctr., 347 F.Supp. 496 (E.D.N.Y. 1973), vacated and remanded for reconsideration in light of Roe and Doe, 412 U.S. 924-25, remand decision 409 F.Supp. 731 (1976), appeal docketed No. 75-1749 (May 27, 1976); Wulff v. Singleton, 508 F.2d 1211 (8th Cir. 1974), aff'd in part, rev'd in part, 44 U.S.L.W. 5213 (1976); Doe v. Rose, 499 F.Supp. 779 (D. Utah 1973); Roe v. Norton, 408 F.Supp. 660 (D. Conn. 1975), prob. juris. noted 44 U.S.L.W. 3761 sub. nom. Maher v. Roe.; Doe v. Westby, 402 F.Supp. 140 (D.S. Dak. 1975), on remand from 420 U.S. 968, supplementing 383 F.Supp. 1143 appeal docketed. No. 75-813 (Dec. 8, 1975); Doe v. Myatt, No. 43-74-48 (D.N. Dak. Oct. 30, 1975); Smith v. Tinder, No. 75-0380 CH (S.D.W. Va. Aug. 8, 1975); Doe v. O'Bannon, No. 4-74-Civ., 189 (D. Minn. Aug. 1, 1975); Doe v. Rampton, 366 F.Supp. 189 (D.Utah 1973); Planned Parenthood Assoc. v. Fitzpatrick, 401 F.Supp. 544, 581 (E.D.Pa. 1975), vacated and remanded on other issues sub nom Beal v. Franklin, 44 U.S.L.W. 3758; Doe v. Wohlegemuth, 376 F.Supp. 173 (W.D.Pa. 1973), aff'd sub nom Doe v. Beal, 523 F.2d 611 (3rd Cir. 1975), cert. granted 44 U.S.L.W. 3761 (July 6, 1976); Doe v. Bowen, Civ. No. 1P74-187-C (N.D. Ind.). Indeed, the Hyde Amendment to the fiscal 1977 Labor-HEW Appropriations bill enacted by the 94th Congress has been enjoined by a federal district court. An appeal in that case, McRae v. Mathews, is pending in the U.S. Supreme Court. The lower federal courts have consistently ruled that the constitutional guarantee of Equal Protection mandates the reimbursement of expenses of women who choose to terminate their pregnancies by abortion when the medical benefits system in question pays the expenses of women who choose to terminate their pregnancies by childbirth. Moreover, the refusal to provide Medicaid reimbursement for abortion creates an invidious classification between

women who can pay for abortions and poor women who cannot; a classification not tolerated by the constitutional guarantee of Equal Protection. Furthermore, the purpose of the Labor-HEW Appropriations bill is to equalize health and education services. Thus, a prohibition in the bill against a particular service, in this case abortion, which is available to higher income women is a direct denial of such equalization.

Another compelling argument for the deletion of the Hyde anti-abortion language from the fiscal 1978 Labor-HEW Appropriations bill rests on the First Amendment guarantees of religious freedom. In Roe v. Wade, the U.S. Supreme Court recognized the inherently religious nature of the abortion controversy, and took note of the significance of religious background in determining attitudes towards abortion, and the conflict among religious groups over the questions raised by abortion. Because religion and attitudes toward the regulation of abortion are so intimately tied together, Congress' restriction of abortion by denying Medicaid reimbursement for poor women disturbs the balance struck in Roe between legitimate and illegitimate state interests in abortion, thereby running afoul of the Establishment and the Free Exercise Clauses of the First Amendment. Indeed, the District Court in enjoining enforcement of the Hyde Amendment in McRae v. Mathews considered the profound religious implications of the Amendment. The Court stated:

> "It is undeniable that [the Hyde Amendment] expresses a strongly and widely held disapprobation of lawful abortion. The view is profoundly rational and espoused with religious fervor. It is neither purely sectarian nor identifiable with any political allegiance. But on this issue fundamental philosophical beliefs are in direct conflict. What some regard as denigration of the sanctity of human life others regard as involving no such matter, for the definition of human life is itself in debate (cite ommitted) and visualize opposition to lawful abortion as both inhumane and callously indifference to the tragic lot of the unwanted child. Divisions between sober and God-fearing people so deep and equal deny to civil authority any power to intervene by direction or indirection, either to compel abortion as a measure of population control or to deny medical assist-

> ance to the needy who act on their own beliefs. When the power of enactment is used to compel submission to a rule of private conduct not expressive of norms of conduct shared by the society as a whole without substantial division it fails as law and inures as oppression."

There are also strong medical and social reasons why abortion should remain accessible to poor women. The Courts have recognized that restricting public funding of abortion clearly cannot be justified as a means of protecting or promoting the health of women. The costs of prohibition such as the Hyde Amendment exacts in terms of the life and health of women are appalling. Poor women denied abortions, which they and their physicians believe appropriate, are forced to either bear the substantially increased risks of disability and death associated with childbirth and delivery, or the substantially increased risks associated with late abortions obtained after a difficult search for charitable care, or the grave risks of death and disability associated with "kitchen table" abortions. (Statistics indicate that 80% of the women who died from illegal abortions in 1974 were non-white and poor.)

Nor is it tenable to argue that should Medicaid payments for abortion be denied, poor women would stop seeking abortions; clearly a result intended by the passage of the Hyde Amendment. The plain fact is that no statute can ever prohibit abortion. Poor women sought abortions in vast numbers when abortion was <u>not</u> legal, and will continue to seek them even if access to safe, medical abortion is denied. (Authorities estimate that approximately 70% of all abortions performed legally last year would have been performed regardless of the legalization of abortion.) Poor women will continue to get pregnant, will continue to have conflicting interests and will continue to have abortions. When they do, they should be entitled to the bona fide medical attention available to higher income women.

STATEMENT OF THE ASSOCIATION OF MEDIA PRODUCERS

1978 LABOR-HEW APPROPRIATIONS

The Association of Media Producers is the national trade association which represents producers and distributors of educational audio-visual materials.

Audio-visual media are more important today than ever before in the educational system. Today's youth are in contact daily with television, radio and audio recordings. They are audio-visually oriented when they enter the classroom, and they are surrounded by this media when they leave school each day. Not only is media part of their everyday experience, but students have demonstrated gains when the technology they're used to is brought into their classroom environment. Audio-visual media have been instrumental in solving one of the greatest problems faced by classroom teachers: each student learns differently and responds to different stimuli; media can reach students on their own terms.

Unfortunately, the current fiscal problems faced by the education community have had a serious economic impact on schools' ability to acquire necessary instructional resources. As the demand for instructional media increases, teachers and library/media specialists are faced with a cruel fact: the property tax base on which our educational system largely relies has reached a limit. Rising school operating costs, coupled with increasing local taxpayer inability to shoulder a heavier school tax burden, are stripping schools of the means of acquiring the very instructional tools they require in a balanced educational system.

It is widely known that when school budgets must be slashed, the first reductions occur in the area of "controllable" expenditures--that is, "things." As energy costs increased and salaries escalated, budgets for instructional materials were reduced accordingly. This is amply illustrated by the results of NEA's latest teacher opinion poll, which surveyed a nationwide sample of public school teachers. When asked, "If

cutbacks have been made, in what ways have they occurred?," 64% of the teachers (the largest percentage) indicated a decrease in teaching materials. Teachers said that the lack of instructional materials had an adverse effect on their work. Given the unusually harsh winter recently endured by this country, and the skyrocketing fuel costs which accompanied it, it is logical to anticipate even further reductions in instructional materials budgets as schools struggle to meet unexpected utility costs.

And yet, a national survey of 24,000 teachers revealed that instructional materials structure 95% of classroom time and 90% of homework time. These instructional materials, however, represent less than 1% of the total education budget, or one-sixth of the annual expenditure for dog food in the United States.

The Association of Media Producers believes that increased Federal support for the School Library Resources Program (ESEA IV-B) is essential if the needs of teachers and students are to be met. In the past, with Federal help, the percentage of elementary schools without library/media centers was reduced from 70% to 20% between 1965 and 1975. However, there remains much more to accomplish. The National Center for Educational Statistics has indicated that only about 10% of all high school library/media centers meet national standards established by the American Association of School Librarians and the Association for Educational Communications and Technology. The prolonged recession has particularly affected state and local budgets. During the past year, forty-four states were obliged to reduce the percentage of per pupil expenditures devoted to instructional materials. With state and local educational agencies cutting back their acquisitions of instructional materials, some LEAs have expressed concern not only about meeting regional accrediting requirements for library resources, but also about meeting standards established by their own state agencies. In addition, there are still 20% of all elementary schools without library/media centers. The Carter administration submitted its 1978 budget in February 1977. For school library programs, Carter requested no increase in the 1978 appropriation. The 1978 school library

resources funds will not be released until the 1978-79 school year. It is astonishing that the Carter administration can request, in Fiscal 1977, no increase in library funds for Fiscal 1979 and still expect the school library program to provide the same services it now provides.

Increased funding in the 1978 Labor-HEW appropriation is urgently needed. In 1973, Federal funds for ESEA II (school library resources) and NDEA III (equipment and minor remodeling) totaled $150 million. Since 1973, the Consumer Price Index has risen more than 28%. Congress, however, appropriated only $154.33 million for 1978 to fund not only the former ESEA II and NDEA III, but also to fund the guidance counseling and testing portion of ESEA III, all of which were consolidated under ESEA IV-B. Inflation alone makes this appropriation insufficient to continue ESEA II and NDEA III at the same level as in previous years. The additional guidance component, which includes salary increases due to inflation, makes the enacted appropriations for Title IV-B even more unrealistic. When one considers that in 1967 ESEA II and NDEA III received $190 million and that the Consumer Price Index rose 75% since that time, it would require an appropriation of over $700 million just to equal the 1967 buying power for those two programs, excluding guidance.

Therefore, the Association of Media Producers strongly urges the Congress to renew its commitment to the school library resources program and to appropriate $197.33 million for that program in the 1978 appropriation.

The addition of $43 million is essential, because the fiscal problems of the states and local school districts are compounded by the fact that manufacturing costs of audio-visual materials have skyrocketed. Costs of paper, petrochemicals, labor, etc., have risen 40% to 50% in the past two years. Nevertheless, the educational market place, even in the best economy, is very inelastic, and the current financial problems have meant that producers simply have had to absorb their additional costs. For example, the Consumer Price Index has increased 28% during the last four years. But even with the 40% to 50% manufacturing cost increases, producers have only raised prices of films and filmstrips an average of 15%. Even these

increases, which are well below the Consumer Price Index rise occurring during that time, have diminished the capacity of schools to acquire instructional materials because of declining local educational agency resources. And, this in turn diminishes the capacity of producers to develop new materials for special education and job training programs.

During 1976, in certain larger segments of the industry the dollar decline in sales of audio-visual materials was as much as 22% below 1975 sales. This decline does not take into consideration the inflation factor which makes the decline even greater. Obviously, this leaves little room for investment in new products. This is a dangerous situation.

Investments in new materials are made possible by returns from traditional markets such as those supplied by local school districts. Unless schools have the funds to buy the materials they need, there will not be enough revenue generated to permit producers to invest in new products. We are already seeing the effects of reduced purchasing in the reduced production of new materials.

In a sample of twenty-two producers of educational media, 78% of the companies reported that in 1976 they reduced their budgets for new product development by an average of 35%. Fifty-five percent of the companies projected that their 1977 product development budgets would be reduced by 45%. The impact of these reductions will not really be felt until 1978 and 1979, due to the lead time needed to produce and market new materials. A severe impact can be expected in the area of special education. There is today a great lack of appropriate multimedia/multisensory instructional materials essential in teaching handicapped children. There are about 6 million handicapped children who must be served under The Education for All Handicapped Children Act (P.L. 94-142). We estimate that schools will have to purchase about $40 million of materials for these children, but right now the materials they need aren't available. In the NEA opinion poll, teachers were concerned about mainstreaming of handicapped children in regular classes because they lack appropriate materials. Normally, inventories of materials for special education programs would be built up

over several years. However, if those materials are to be available by 1978 or 1979, production will have to proceed about three times more rapidly than normal. Accelerated production of the necessary materials would require an estimated investment of about $15 million--money which can only be generated through sales of existing materials, which schools need but cannot afford.

In addition to special education program needs, the addition of thousands of new job training slots in the Comprehensive Employment and Training Act (CETA) will require new materials. Audio-visual training materials are an important component of these programs. CETA subcontractors in the Washington, D.C. area have indicated that in training large numbers of unskilled individuals, non-print materials are vital. So is individualized instruction, which with large classes can only be accomplished with such tools as 8mm film loops, for example, which run only a few minutes and actually show one segment of a skill over and over again.

The importance of continued production of training materials is amply illustrated by our experience during World War II, when millions of young men and women were trained in the shortest possible time to perform duties that were quite foreign to them beforehand. This training was accomplished largely through audio-visual instruction. If hundreds of thousands of individuals are to be trained and employed in an effort to stimulate the economy, the absence of appropriate training materials will impede the progress toward economic recovery. However, at this time we believe there are insufficient materials to accommodate a sudden influx of CETA students; funds to produce them come from sales of materials currently available in other markets.

A 1978 appropriation of $197.33 million for school libraries is urgently needed to permit schools to acquire the materials teachers use to teach and students use to learn, and to encourage continued production of media necessary to meet the special needs of handicapped children and CETA program participants.

It would be folly to pretend that commercial producers of instructional materials do not have a vested interest in securing adequate funding for school library resources; obviously they do. However, the Association of Media Producers believes strongly that media are vital to the achievement of excellence in education. Such excellence can only be achieved by providing the instructional resources necessary to accomplish the task.

SUBCOMMITTEE RECESS

[Whereupon, at 1:40 p.m., Monday, April 4, the subcommittee was recessed, to reconvene at 3 p.m., the same day.]

(AFTERNOON SESSION, 3 O'CLOCK, MONDAY, APRIL 4, 1977)

## NONDEPARTMENTAL WITNESSES

### COALITION FOR HEALTH FUNDING

**STATEMENT OF JOHN SHERMAN**

**ACCOMPANIED BY:**

**MARY MULLANE, AMERICAN ASSOCIATION OF COLLEGES OF NURSING**

**FEDERICO WELSCH, ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES**

**MIKE GEMMELL, NATIONAL ASSOCIATION OF COUNTIES**

### OVERVIEW OF 1978 BUDGET

Senator BROOKE. The subcommittee will come to order.

This afternoon we will have public witness testimony relating to the various health programs.

Our first witness is Dr. John Sherman and the Coalition for Health Funding, and people representing 60 other organizations.

Dr. Sherman will give us an overview of the 1978 fiscal budget.

We are pleased to have you here. I am going to ask you to abbreviate your testimony. Unfortunately we have several appropriations going on at the same time and we have to shuttle back and forth. I apologize for even this much delay.

We are very much interested in what you have to say. We do have to get it in the record and your full statement will be printed in full in the record.

You may proceed, Dr. Sherman.

Dr. SHERMAN. Thank you. I have here with me this afternoon Dr. Mary Mullane on my immediate right, Mr. Welsch on her right, and Mr. Gemmell.

We appreciate the opportunity to meet with you today. We appreciate having the opportunity to meet with you today to discuss our views on the fiscal year 1978 funding levels for discretionary health programs.

The coalition for Health Funding is comprised of over 50 nonprofit health-related organizations which are interested in funding levels for health.

The coalition has annually made recommendations to Congress on funding levels for the past 5 years. The coalition formulates its suggestions through a several-month process which assesses funding needs and compromises the desired amounts of funding to create the complete proposal.

PUBLICATION

The coalition publication, entitled "Appropriation Recommendations for Federal Health Programs Fiscal Year 1978, An Alternative to the President's Proposal," presents our recommendations in detail and in addition contains information to justify those requests. I would lke to submit a copy of our booklet for the record.

Senator BROOKE. Yes, it will be placed in the record.

[The document follows:]

# APPROPRIATION RECOMMENDATIONS for FEDERAL HEALTH PROGRAMS FY 1978

## An Alternative to the President's Proposal

The Coalition for Health Funding

A group of representatives of health-related organizations met in 1970 to discuss how interested groups could be kept informed of developments in Federal health budgets (and later, impoundment of appropriated funds) and how the Congress, the press and the public could be made aware of Federal health budget alternatives. The result of that meeting was, ultimately, the formation of the Coalition for Health Funding.

Representing over 50 organizations, the Coalition combines the dedication and expertise of its members to monitor the development of the Federal budget, the Congressional budget process, appropriations process, supplemental money bills, rescissions and deferrals of budget authority, and the overall status of health financing. The Coalition annually publishes this analysis of the President's health budget, including carefully developed alternative recommendations. This document, the seventh of its kind, addresses the FY 1978 budget recommendations of President Carter. The document is being distributed to members of Congress, as well as to the media and interested groups and individuals.

The Coalition for Health Funding Bylaws state that the goals of the organization are:

1. To identify inadequacies in existing and proposed levels of support for all health programs administered by the Department of Health, Education and Welfare and selected health programs from other departmental budgets;
2. To establish priorities for increased funding of the various health programs;
3. To communicate the need for adequate national expenditures for specific health programs to the public, the press, the Administration and to the Congress;
4. To prepare and present documentation of the financial needs of each of the Federal programs involved, stressing what could be accomplished if appropriate funding were made available;
5. To seek Congressional support for specific appropriation levels as is determined to be necessary;
6. To seek expenditure of all appropriated funds.

The Coalition confines its activities to the Congressional Budget and Appropriations process and limits its recommendations to controllable health programs. The Coalition attempts to provide assistance to portions of the Administration and the public by distributing information on its analysis of the health funding process. The Coalition takes no partisan political positions, nor does it attempt to influence authorizing legislation.

Membership in the Coalition is open to any non-profit organization with a demonstrated interest in funding for health programs, including professional associations, health professional education groups, higher education organizations, health providers, independent research institutes, voluntary health organizations and consumer groups.

Board of Directors

President, John F. Sherman, Association of American Medical Colleges
Vice President, William M. Samuels, American Society of Allied Health Professions
Secretary-Treasurer, Constance Holleran, American Nurses' Association
Member, Mike Gorman, Citizens for the Treatment of High Blood Pressure
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American Nurses' Association
American Optometric Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Allied Health Professions
American Speech and Hearing Association
Arthritis Foundation
Association of American Medical Colleges
Association of Independent Research Institutes
Association of New York Neighborhood Health Centers
Association of Schools and Colleges of Optometry
Association of Schools of Public Health
Association of University Programs in Health Administration
Citizens Committee for the Conquest of Cancer
Citizens for the Treatment of High Blood Pressure
City University of New York
Council of State Administrators of Vocational Rehabilitation
Council on Social Work Education
Cystic Fibrosis Foundation
Endocrine Society
Federation of American Societies for Experimental Biology
Group Health Association of America
Human Growth Foundation
National Association of Community Health Centers, Inc.
National Association of Social Workers
National Coalition of Hispanic Mental Health and Human Services Organizations (COSSMHO)
National Committee Against Mental Illness
National Council of Community Mental Health Centers
National Foundation/March of Dimes
National Health Education Committee
National League for Nursing
National Medical Association
National Student Nurses' Association
Pediatric Pulmonary Association of America
Planned Parenthood/World Population
Society for Investigative Dermatology
United Auto Workers

## Introduction

The Budget Revisions submitted by President Carter to the FY 1978 Budget are indicative of the tone of this transitional year. The Carter Administration has been able to identify a few priorities for health funding that will become areas for concentration of effort in the next fiscal year. In addition, the new administration has attempted to restore some of the funding cuts that were incorporated into the original FY 1978 Budget. We understand that further analysis of the budget is taking place and more revisions to the budget may be submitted at a later date. In short, fiscal and public policy will continue to be dominated by the work of the former administration in FY 1978.

The Coalition understands the difficult adjustment the new government is confronting, but we cannot help but express disappointment in the revised budget for controllable health programs.

The Revised Budget increased FY 1978 Budget Authority by $26.8 billion, but health received only $0.4 billion, or 1.5%, of that increase. Of that increase, controllable-health programs received $200 million. The restorations in the controllable-health budget still do not bring the budget up to the level of current services adjusted for inflation for FY 1978. The Coalition applauds the administration's elimination of the proposed block grants to states and the Public Health Service reorganization which would have transferred most program management funds to the office of the Assistant Secretary for Health. The new initiatives in child health care and immunizations are commendable, but the need for biomedical research funds, more active health services programs, and health manpower development has not been adequately met in this budget.

The Coalition has based its recommendations on its professional assessments of health care needs. In spite of an unpredictable future for many expiring health programs, and the as yet undefined new directions for the Department of Health, Education, and Welfare, the Coalition has attempted to recommend and justify funding levels for controllable health programs in this Alternative Budget booklet.

## Legend for Narratives

Appropriation: Money appropriated by Congress to fund programs. Aggregate totals are used, derived from appropriation acts and, where applicable, continuing resolutions.

Authorization: Spending ceilings established by Congressional authorizing committees. Where "Open" appears, authorizing legislation calls for "...such sums as are necessary" to meet the statutory purpose set forth in a law. The word "Undetermined" appears for those authorizations which expire before the beginning of FY 1978.

President's Request: These budget authority levels are those submitted by President Carter in his Fiscal Year 1978 Budget Revisions in February 1977.

Coalition Recommendation: These figures represent, in the professional judgment of the member organizations, the amounts necessary to adequately fund the programs to meet public health care needs. For those programs whose authorization levels expire in FY 1977, the Coalition has made its recommendation based on the best estimate of need. Since those authorization levels are still unknown at the time this booklet goes to press, the recommended levels are marked with an asterisk (*) and may have to be adjusted at a later date.

## Food and Drug Administration

Appropriation
FY 1976 $209,600,000
FY 1977 $245,102,000

Authorization
Open

President's Request
FY 1978 $279,258,000

Coalition Recommendation
FY 1978 $307,434,000

During FY 1976 and FY 1977, the FDA has assumed an increasing burden for consumer protection. Disclosures before House and Senate Committees have shown a greater need for FDA to monitor preclinical and clinical testing of drug products, to research toxicological tests for food contaminants, coloring and additives.

Bills were introduced by the Senate Health Subcommittee to divide FDA into two agencies and give each greater authority to handle the demands placed on them. The House Health Subcommittee expressed great concern over drug safety, proposing to strengthen the Food, Drug and Cosmetic Act in several respects and to permit FDA to conditionally license certain drugs for use by specifically qualified practitioners for limited purposes. More than 45 special studies of FDA operations have been made in the last five years by the General Accounting Office. In the drug field, the GAO has testified that lack of resources and coordination has resulted in the failure of the FDA to impose sanctions.

On May 28, 1976, the Medical Device Amendments became law. To implement the provisions of P.L. 94-295 will require a surge of regulatory activity--writing regulations, training inspectors, developing enforcement policies, promulgating device standards, and classifying all medical devices and diagnostic products as required by the law. By the end of FY 1977 the agency will have increased the personnel of the Bureau of Medical Devices and Diagnostics from 140 to 320 persons plus a field service allocation of roughly 600 man-years. In addition, a reorganization of the new bureau is required and must await decisions by a new Commissioner and a new President.

FDA has grown from 4700 full-time personnel in 1967 to 7113 in 1976, and the agency still cannot satisfy the public and Congressional concern. Despite this growth in personnel, FDA finds it increasingly difficult to recruit adequately trained scientists and health professionals to do its work. There are presently a number of openings for medical officers that cannot be filled because salaries and working conditions are neither flexible nor attractive. In other areas, the FDA cannot attract competent non-physician expertise, such as clinical pharmacists who are qualified for FDA drug review activity, because Civil Service job descriptions have not kept pace with the changing abilities of health professionals. The initial salaries paid to pharmacists by the FDA are as much as 50% lower than pharmacists' earnings in traditional dispensing situations. Given the difficult and important tasks the Congress has assigned to the FDA, the funds for properly trained staff should be appropriated.

The FDA's laboratory operation has shown a marked deterioration in scientific accomplishment in research concerning drug standards and specifications and food toxicology. One problem is that the laboratories are housed in inadequate facilities. The FDA building in central Washington which houses most of the labs is a converted office building and is in need of extensive renovation. FDA can hardly expect the regulated industries to comply with Good Laboratory Practice regulations if it appears that the agency itself is incapable of compliance because of its antiquated, archaic facilities.

In short, unless FDA is given the money it needs to do the job as consistently and thoroughly as the people of the United States have been led to believe, the Congress will perpetuate mediocrity, and examinations of agency failures will continue.

## HEALTH SERVICES ADMINISTRATION

### Community Health Centers

Appropriation
FY 1976 $196,648,000
FY 1977 $215,148,000

Authorization
FY 1977 $240,000,000
FY 1978 Undetermined

President's Request
FY 1978 $229,148,000

Coalition Recommendation
FY 1978 $250,000,000*

Community health centers are neighborhood clinics situated in medically underserved urban and rural locales. These centers provide quick attention to medical problems, accidents, and promote general health maintenance. Community health centers provide primary diagnostic, treatment and consultant referral services in general medicine, laboratory, X-ray, pharmacy, mental health, dentistry, physical and speech therapy, optometry, sickle cell anemia, lead poisoning and many other areas. As well, many provide a host of supplementary health services, including hospital, home health and extended care facility services, nutrition education and social services, pharmaceutical services, allied health, dental and vision services, and rehabilitation therapy.

Currently, more than 2.5 million previously underserved and unserved Americans receive family-oriented health care at 302 community and rural health centers. The centers have been in the forefront of developing innovative ambulatory service models in the provision of high quality care to the medically indigent in both urban and rural communities.

During FY 1976, the number of persons served by CHCs increased (from 1975) by 1.1 million (78%). Encounters increased from 6.6 million to 9.98 million (52%). Program efficiency reached an all time high with a further reduction in the annualized total cost per person served from $240 to $129--a reduction of 37%. It is highly significant that these community health centers can reduce health care costs some 37% when the increase in the medical care component of the Consumer Price Index is estimated at 10.3%. Third-party collections have increased from 22% to 27.5% of total operating expenses. Moreover, recent studies of CHC impact reveal a 34% lower hospitalization rate for community health center patients than the overall national average.

Demands throughout FY 1977 promise to be even greater. It is estimated that CHCs will actually serve in excess of 3.3 million people while making every effort to control and further reduce costs.

Perhaps most important is the fact that there are still in excess of 44 million Americans residing in 8,259 urban and rural areas defined by DHEW as medically underserved. Characteristic of these populations are a shortage of health care providers (especially primary care) and health facilities, and higher rates of disability and infant mortality. Many families have incomes well below the poverty level; all do not have access to adequate health care which has resulted in a lower life expectancy and a health status substantially below that of our general population.

Despite an increased demand for services and the program's proven effectiveness, the Administration's budget for fiscal year 1978 requests a funding level of $229,148,000. This level represents a $14 million increase over the FY77 appropriation, and is targeted for expanding family-oriented health services including family planning, pre-natal and post-natal care, and services to identify and provide care to high risk populations. Although these programs will improve care programs to this defined population, the funding level will not accommodate increased costs for items such as personnel, malpractice insurance, and supplies. It fails to recognize that some 25 states have either imposed or are considering reductions in their Medicaid programs. Such cutbacks would have disastrous results for affected centers. It still does not address the problems of some 44 million Americans who still do not have access to decent health care. The Administration's budget would result either in (1) a reduction in the number of health centers, (2) a reduction in services provided, or (3) closing doors to eligible individuals who lack the ability to pay in full or lack third-party coverage which would be contrary to the letter and spirit of PL 94-63. In any case, the people who are in most need of services would suffer.

With respect to those now residing in underserved areas, the CHC program has made great strides in extending care through the rural health initiative model. These "centers" have efficiently and effectively brought health care to areas which have been neglected for too long. But the need is both urban and rural.

Given this overwhelming need, it is imperative that community health centers be funded at $250 million for FY 1978. Such an appropriation level would enable the maintenance of existing services to an expanding number of patients and allow the program to begin to respond to the needs of millions of medically underserved Americans.

Health Revenue Sharing

Appropriation
FY 1976 $ 90,000,000
FY 1977 $ 90,000,000

Authorization
FY 1977 $110,000,000
FY 1978 Undetermined

President's Request
FY 1978 $ 90,000,000

Coalition Recommendation
FY 1978 $110,000,000*

State general health and mental health programs are eligible for comprehensive public health grants which can be used to fund service programs for the general population as well as programs designed for high risk populations such as alcoholics, cancer victims, and patients suffering from heart disease. Consultation services are provided by regional offices to State Health Agencies to further support these programs. Before grants are funded, states must supply detailed plans of how projects will be implemented and how the program integrates with the State Health Plan. The funding level for comprehensive health grants has been held at $90 million since 1971. In view of the expanded activities of the health planning process and the continued need for state supported health service programs, the Coalition advocates an increase in the funding level for these state grants.

Health Revenue Sharing - Hypertension Formula Grants

Appropriation
FY 1976 $3,750,000
FY 1977 $9,000,000

Authorization
FY 1977 $15,000,000
FY 1978 Undetermined

President's Request
FY 1978 $9,000,000

Coalition Recommendation
FY 1978 $30,000,000 *

The 1975 Health Services Act (P.L. 94-63) authorized $15 million in Fiscal 1976 and $15 million in Fiscal 1977, empowering the Secretary of Health, Education and Welfare to make grants to state health agencies for the purpose of establishing and maintaining programs for the screening, detection, diagnosis, prevention and treatment of high blood pressure.

The previous appropriation levels were inadequate in the light of figures from the National Center for Health Statistics that indicate that a minimum of 23 million hypertensives exist in the United States, and that only 30 percent of these are both aware of the disease and receiving adequate therapy. The other 70 percent is comprised of 29 percent who are unaware that they have the disease; 23 percent who are aware but receiving no treatment, and 18 percent aware but receiving therapy which does not control their high blood pressure.

It has been realized only since the Secretary of Health, Education and Welfare launched the National High Blood Pressure Education Program in 1972 that high blood pressure is the major causative factor in 65 percent of heart attacks and in 75 percent of strokes. Heart attack, stroke and other cardiovascular diseases account for over 53 percent of all American deaths annually. Doctor Theodore Cooper, formerly Assistant Secretary for Health, has stated on a number of occasions that, undetected and untreated, high blood pressure is responsible for over 200,000 deaths each year.

Despite these depressing statistics, it is impressive that the High Blood Pressure Education Program has achieved the following results, according to a recent release from the National Center for Health Statistics:

(a) Between 1973 and 1975, the death rate from hypertension alone declined 21 percent.

(b) Between 1973 and 1975, the death rate from hypertensive heart and renal diseases declined 14 percent.

(c) Between 1973 and 1975, the stroke death rate declined 9.6 percent.

These declines which have been achieved are dramatically effective in holding down our nation's medical care bill. For example, circulatory problems are commonly the result of prolonged high blood pressure and are responsible for 26 million days of hospitalization each year. Furthermore, data from the Social Security Administration state that high blood pressure and its consequences account for the largest single number of disability claims in the country.

Despite some impressive advances over the past four years, the High Blood Pressure Program is really just beginning to get off the ground. For example, in FY 1977, the formula grants to the states were extremely low; many states received from $20,000 to $30,000 in formula grants, with only two states -- California and New York -- receiving more than $500,000.

Since the immediate task is to detect between twelve and fifteen million Americans who are either unaware that they have high blood pressure or, if aware, whose high blood pressure is not controlled, the Coalition recommends $30 million in FY 1978 in formula grants to the states for high blood pressure control.

Maternal and Child Health

Appropriation
FY 1976 $319,408,000
FY 1977 $345,708,000

Authorization
FY 1978 $350,000,000

President's Request
FY 1978 $343,708,000

Coalition Recommendation
FY 1978 $350,000,000

For the fiscal year 1978, the Coalition recommends that the Maternal and Child Health Service be funded at $350 million, the maximum amount legally permissable at this time, in order to insure continuation and expansion of the Department's important programs. While health care for mothers and children has improved substantially during the twentieth century, the nation still has far to go before the optimal levels of care for women and children of all incomes will be reached. In 1975, for example, 15 developed countries had infant mortality rates that were lower than that of the United States--a shocking statistic considering that we are one of the wealthiest countries in the world. The figure is even more distressing in light of the fact that individual programs have proven to be clearly successful in lowering these infant deaths, yet are continually funded below the necessary workable levels. Clearly something must be done to reverse this trend. By directing more money to the Maternal and Child Health-Crippled Children's Programs' efforts to provide a medically safe and disease-free environment, we are investing in our most important resource--the children who will be our nation's future. Certainly it is the best possible expenditure of federal dollars.

A mandatory first step is to increase the grant to states monies from $317 million to $320 million. These formula grants are programs whereby states match federal dollars and translate them into services--highly effective service programs. Lower infant mortality rates, rates of hospitalization and complication rates from disease are directly related to these programs. For example, in-patient hospitalization rates decreased by 70% nationally between 1968 and 1973 due to Children and Youth Projects, and the length of hospital stay was down by 33%. With the additional funding the nine Improved Pregnancy Outcome Projects, which were established on local levels through FY 1976-77 allocations, will expand to statewide jurisdiction, working to reduce infant mortality and morbidity by providing an increased number of women with high quality prenatal care in the first trimester of their pregnancies. These programs significantly reduce the incidence of repeated adolescent pregnancies (and low birth weight babies), premature births and the numbers of women who conceive after age 35. An additional 10 local projects will be initiated in 1978 to further expand the Improved Pregnancy Outcome Program--but only if the additional funds are received.

Crippled Children's Programs are another crucial aspect of MCH services. The funds allocated to these programs are used by state agencies to locate handicapped children, provide diagnostic services and assure adequate and proper treatment. Currently the programs are treating only 6% of the approximately 9.5 million children who need care. With higher funding there will be treatment of new referrals, and integration of new diagnostic categories into the programs, such as diabetes, hemophilia, and congenital heart disease. Additional support services such as nutritional and psycho-social counseling and guidance to parents in matters of

ongoing care will assure that the medical correction is not delivered in a vacuum without consideration of the other needs of the handicapped child.

The Coalition also calls for an increase of $1.3 million for research and training programs, raising their budget figure to a total of $30 million. Approximately one out of every six children in the United States suffers from chronic pulmonary disease, including cystic fibrosis, chronic bronchitis and asthma. Currently there are only 11 regional Pediatric Pulmonary Centers treating less than 1% of this afflicted population. The 1974 Pediatric Pulmonary Progress report called for a minimum of 20 projects throughout the nation to treat these children; if we are to maintain the current 11 and establish even one more, research and training funds must not be diminished. More pediatric health professionals skilled in chronic pulmonary and genetic conditions are desperately needed; if the Pediatric Pulmonary Centers are funded at lower levels than in FY 1977, undoubtedly they will train fewer personnel. Similarly the numbers of health professionals trained in the care of multiply-handicapped children will also decrease if funds are cut, as will nurse practitioners. Specialty personnel are central to the effective treatment of our nation's afflicted children, and we cannot afford to have the necessary training centers close or reduce their programs.

Although two-thirds of American children basically receive adequate health care, the remaining third, approximately 20 million children, do not. Deliberate steps must be taken to remedy this situation. By allocating $350 million to the MCH Services, a strong base on which to build a better child health care system would be established. Although much more money is needed, $350 million to the MCH Service is a worthy commitment. Good health care during infancy and childhood is not only important, it is an essential prerequisite for a full, productive and healthy adult life.

## Sudden Infant Death Syndrome

Appropriation
FY 1976 $2,500,000
FY 1977 $2,000,000

Authorization
FY 1977 $3,000,000
FY 1978 Undetermined

President's Request
FY 1978 $1,716,000

Coalition Recommendation
FY 1978 $3,000,000

Much public attention is currently being directed to the tragedy of infant death referred to as Sudden Infant Death Syndrome. Although the increasing interest of the public and media in this disease is an encouraging step, an appropriate annual commitment of federal dollars is what is truly needed. The Coalition recommends an allocation of $3 million for the SIDS program for FY 1978.

Little is known about sudden infant death--the syndrome occurs without warning between 7,500 and 10,000 times annually in the United States. Often, because of the ignorance of authorities, the deaths are attributed to maltreatment in the home, and families are blamed or ostracized by their communities. Only minimal help has been available to these families in the past, further burdening them.

The SIDS program is working to make the disease more readily understood by the general public as well as by the medical community and authorities. In the 36 projects that are currently operating throughout the country, efforts are underway to gather, analyze, and disseminate information about the disease, as well as counsel those families in which a sudden infant death has occurred. The requested increase of $1 million for FY 1978 will insure the continued operation of these projects and support the development of five new ones, so that an estimated 1,950 families may be counseled. The funds will also assure continued close cooperation with the National Institute of Child Health and Human Development, the agency responsible for the research into the cause and prevention of this tragic disease.

For the past three years, the Administration has requested that no money be put into the SIDS program. Congress has generously funded the program in spite of the Administration's directive and has increased the financial commitment each year. The Coalition hopes that this will happen again, so that the SIDS program may continue to grow.

## Family Planning Services

Appropriation
FY 1976 $100,615,000
FY 1977 $113,615,000

Authorization
FY 1977 $122,500,000
FY 1978 Undetermined

President's Request
FY 1978 $123,615,000

Coalition Recommendation
FY 1978 $140,000,000 *

In FY 1977 the Congress increased funds for family planning services project grants under the Family Planning Services and Population Research Act for the first time in three fiscal years. The Coalition for Health Funding had urged successfully that the Congress increase the funds for family planning services so that programs could offset the inflation and curtailment of services and staff that had occurred due to the freezing of the funding level. After accomplishing this goal, however, there were only limited funds available for increasing the number of patients who could be served by the program during FY 1977.

It is estimated that currently there are 3.5 to 4 million women in the United States who are yet in need of subsidized family planning services, some seven years after the passage of the Family Planning Services and Population Research Act. Expenditures of approximately $500 million a year would be required if all these low and marginal income women were provided with family planning services.

Furthermore, there are an estimated two million sexually active teenage women who remain without access to effective birth control services. There are approximately one million teenage pregnancies each year. This results in teenage women experiencing more than 200,000 out-of-wedlock births (more than half the U.S. out-of-wedlock births); some 300,000 abortions (one-third of all U.S. abortions); 100,000 births occurring in marriages accomplished after discovery of pregnancy and 140,000 miscarriages. The rest are accounted for by births of children who were conceived following marriage. Teenage pregnancy, affecting 10 percent of the total teenage female population every year, is an "epidemic" by any recognized public health standard. Reaching all adolescents in need of birth control services would require an additional $200 million or more. Currently, federal expenditures for family planning services amount to approximately $200 million, including the $113.6 million for project grants and reimbursements under Medicaid and Title XX of the Social Security Act.

For FY 1978 maintenance of current service programs would require about $120 million (the current level of $113.5 million for project grants, plus an allowance for inflation). Undertaking a modest new initiative in the area of services to adolescents would require an additional $20 million. Therefore, the Coalition for Health Funding recommends an appropriation of $140 million for family planning services project grants for FY 1978.

## Health Maintenance Organizations

Appropriation
FY 1976 $18,612,000
FY 1977 $22,612,000

Authorization
FY 1978 $45,000,000

President's Request
FY 1978 $18,100,000

Coalition Recommendation
FY 1978 $45,000,000

The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) were signed into law October 8, 1976. They revised and extended the program for the establishment and expansion of health maintenance organizations. Loans under the law may now be made through September 30, 1980. Grants may now be made through September 30, 1979. The major effect of P.L. 94-460 was to relieve HMOs of many restrictive requirements placed upon them by the HMO Act of 1973. These restrictions had made it very difficult for an HMO to compete with traditional forms of indemnity health insurance. The new law will relieve HMOs of the burden of open enrollment and enable them to design specific health benefit packages to meet the demands and interests of health care consumers.

The law also reduced authorization levels for the program in each of fiscal years 1977, 1978 and 1979. Authorization levels were reduced from $85 million to $45 million for each of fiscal years 1977 and 1978; and to $50 million for fiscal year 1979. Because of the reduced and more realistic authorization levels; the commitment of the Carter Administration to solving the nation's health care crisis; and the importance of the health maintenance organization as a major component of

the nation's health care delivery system, funding of the HMO program at the full authorization level of $45 million is warranted.

Part of the solution to providing high-quality medical care on a cost-effective basis involves changing the pattern of our nation's health care delivery systems. HMOs represent a strong and viable attempt to do this. They are making an important contribution to the development of a pluralistic health care network while serving as an alternative to the traditional fee-for-service system. Recent studies conducted by the Social Security Administration and the Institute of Medicine of the National Academy of Sciences have shown the advantages of HMOs. A Social Security Administration study of 8,000 Medicaid families showed that HMOs delivered 340 days of hospital care per 1,000 persons compared to 888 days per 1,000 persons receiving care under the fee-for-service system. Group practice HMOs delivered 208 days of surgical care per 1,000 persons compared to 318 days for the fee-for-service control groups. A 1976 Institute of Medicine report on controlling the supply of hospital beds compared HMOs and fee-for-service providers on the basis of hospital days and cost. HMOs used 30 to 50 percent fewer hospital days and cost 10 to 30 percent less per capita than did traditional fee-for-service providers, according to the report.

Funding for the HMO program is recommended at the level of $45 million, including $35.3 million for grants, $6.7 million for program support, and $3.0 million for research and evaluation. There is a need to increase grant funds for the development of additional HMOs and to make supplemental grants to plans that have demonstrated they are worthy of such support. The HMO program is now unable to provide technical assistance which is needed by developing HMOs. A national HMO technical assistance program could help planners and also provide guidance to groups interested in developing an HMO. In view of the federal funds invested in development grants for HMOs, existence of a technical assistance program would be an economy. Funds are also needed for research and evaluation of the HMO concept. Very little effort is now being made to collect data regarding the experience of HMOs since there is not available funding for this purpose. Looking forward to a national health insurance program, an evaluation of the experience of the HMOs would be valuable.

## Migrant Health Centers

Appropriation
FY 1976 $25,000,000
FY 1977 $30,000,000

Authorization
FY 1977 $44,000,000
FY 1978 Undetermined

President's Request
FY 1978 $30,000,000

Coalition Recommendation
FY 1978 $52,500,000 *

Our nation's migrant workers who qualify for no state programs, and who enjoy limited constituency in the Congress, have always had minimal health care provisions. These hard working Americans and their families have nowhere to turn but to federal support for essential health services. The federally-funded Migrant Health Center (MHC) program provides the essential health care so desperately needed by these Americans. Located primarily in areas with the highest concentration of migrant and seasonal farmworkers and their families, MHCs provide diagnostic, treatment, and consultant referral services in general medicine, laboratory, X-ray, pharmacy, preventative dentistry, preventive vision services, and where appropriate environmental health services including the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal and rodent or parasitic infestation. Some centers are able to offer a range of supplemental services which may include hospital, rehabilitative, mental health, nutrition, and health education; however, in many cases, adequate funding is not available to support such services or prevention programs.

During fiscal 1976, MHCs actually served in excess of 400,000 people or 10,000 more than the preceding year. The number of encounters increased by 160,000 to 800,000. The annualized cost per person served was reduced from $100 in 1975 to $98 in 1976 and the cost per encounter went from $37 to $23. Despite these gains, much needs to be done. Statistics prove that the incidence of communicable diseases such as influenza, pneumonia and tuberculosis, accidents, infant mortality and need for hospitalization among migrant families far surpass similar incidences in the general population. Insufficient funds earmarked for migrant hospitalization benefits, and disincentives for medicaid participation have combined with low funding levels in the past to produce an unconscionable and intolerable situation in regard to migrant worker access to decent health care.

The fact remains that only 14.8% of migrant worker families eligible for services have been reached. Only one-tenth of 1% (3,125 persons) of the eligible population will be fortunate enough to receive hospitalization services. In addition, current funding levels are insufficient to allow centers to provide the required primary and supplemental health services under P.L. 94-63, which are to be offered to all eligible migrant workers and their families, regardless of their ability to pay.

Given the range of services required by law, the lack of third-party coverage for most patients, special health problems associated with this population group, the need for bi-lingual providers of health care and rising costs in general, the Administration's request for fiscal 1978 of $30 million is inadequate to support existing programs. Moreover, this level is totally inadequate with respect to addressing the needs of the other 2,000,000 migrants and seasonals and their families who are not receiving adequate health care. It is obvious this program has demonstrated both its effectiveness in terms of delivery of quality care and its ability to administer a program well in terms of controlling costs.

The Coalition recommends $52.5 million in appropriations to meet the urgent health needs of migrant workers. Of this amount, we would urge that a specified amount be earmarked for badly needed hospitalization services. Totally, though this amount represents a $22.5 million increase over FY 1977 funding, the lack of available health care to migrants, plus the expanded services which the centers must provide, make such an expenditure crucial.

National Health Service Corps

Appropriation
FY 1976 $15,000,000
FY 1977 $25,354,000
(continuing resolution)

Authorization
FY 1978 $47,000,000

President's Request
FY 1978 $37,599,000

Coalition Recommendation
FY 1978 $45,000,000

The National Health Service Corps (NHSC) is responsible for the recruitment and distribution of physicians, dentists, nurses, and other allied health professionals in communities designated as critical shortage areas by the Secretary.

This year the Coalition is supporting a large increase in the funding level for NHSC Scholarships. This program addresses the serious manpower shortage problems of both the urban and rural areas of the country, assists the development of community health services, and encourages health professionals to continue practicing in shortage areas. In view of health manpower needs and the larger budget the Coalition is supporting for NHSC scholarships, there is justification for increased funding of National Health Service Corps program management.

Genetics Program

Authorization
FY 1978 $30,000,000

President's Request
FY 1978 $0

Coalition Recommendation
FY 1978 $30,000,000

The provision of genetic services was authorized for the first time by the Genetic Diseases Act which became law on April 22, 1976. The Act authorizes $30 million to be appropriated during both fiscal years 1977 and 1978 for projects to establish and operate voluntary genetic testing and counseling programs and a program to develop and disseminate information and educational materials relating to genetic diseases, including sickle cell anemia, Cooley's anemia, Tay Sachs disease, cystic fibrosis, dysautonomia, hemophilia, retinitas pigmentosa, Huntington's chorea, and muscular dystrophy.

In the United States, one child in every 150 to 200 live births, or 15,000 - 20,000 infants per year, has a major genetic anomaly. It has been estimated that 12 million Americans carry true genetic diseases; 36 percent of all spontaneous abortions are caused by chromosomal defects; 40 percent of all infant mortality results from genetic factors; 80 percent of the incidence of mental retardation in this country is genetically related.

The costs - both economic and social - of genetic disease are enormous. The cost to society of caring for those suffering from Down's Syndrome, for example, which results in mental retardation and has an estimated frequency of one in 600 births, is approximately $1.7 billion annually. The estimated medical bill in the

case of a child with Tay Sachs disease ranges from $20,000 to $40,000 per year for the three to five year average life span of an affected child. Treatment for hemophilia can cost as much as $12,000 per year. The annual burden for the estimated 25,000 to 30,000 cystic fibrosis patients is over $150 million. Regardless of the financial costs of treating genetic disease, the emotional pressure on the family of an affected individual is staggering.

The reduction of genetic disease in most cases is primarily dependent on identifying carriers of genetic disease traits through positive family history and screening. A recently developed procedure, amniocentesis, can detect genetic conditions in the child before birth. Counseling subsequent to screening permits couples to make an informed decision regarding the risks of having a child and to prepare themselves for the care of an affected child. However, these services are not available to most of the population, especially those groups at high risk. Such services are not covered by Medicaid.

The Act requires that the programs be carried out in conjunction with other existing health programs including Maternal and Child Health Services (Title V). Each state should include in its plan for maternal and child health a component on genetics. It should include a provision for mass screening for phenylketonuria and certain other metabolic disorders for which relatively simple, inexpensive and accurate tests have been developed.

In addition, the state plans should make provisions for regional genetic service centers. It is estimated that as many as eighty centers would be required throughout the United States to provide testing and counseling services with the necessary diagnostic laboratory facilities. The services should include multidisciplinary clinical evaluation, prenatal diagnostic counseling and professional and public education. Both providers and the public should be fully informed as to the nature of these disorders and the availability of services to combat them.

For fiscal year 1978 the full $30 million is required to initiate these programs and also to provide the necessary staff positions in Washington and in the Regional Offices to properly administer them. The complex nature of the programs requires specialized personnel who must be recruited and retained if this program is to succeed.

Hemophilia Treatment

Appropriation
FY 1976 $3,000,000
FY 1977 $3,000,000

Authorization
FY 1977 $9,000,000
FY 1978 Undetermined

President's Request
FY 1978 $3,000,000

Coalition Recommendation
FY 1978 $5,000,000*

Hemophilia is a genetically transmitted blood disorder which prevents normal blood coagulation, resulting in excessive and sometimes fatal external and internal bleeding. In addition to the danger to which hemophilia sufferers are exposed is the attendant pain associated with blood pooling in organs, joints, muscles, bones and soft tissue areas. Minor trauma, such as a shallow fall, or minor surgery such as tooth extraction, can cause a hemophiliac to require massive transfusions and even prolonged hospitalization.

Though therapeutic methods have been developed, many hemophiliacs do not receive such treatment. Only 10% of hemophiliacs benefit from any home care whatever--primarily because the resources are not available to most hemophiliacs for home care and other advanced treatment. Fear of complications has traditionally confined hemophilia treatment to more expensive and less personal hospital treatment. Outpatient clinics, specializing in hemophilia, are very few--only 67 in 27 states and the District of Columbia--and many of these clinics cannot provide comprehensive services such as psychiatry, hematology and genetic counseling. The Federal government supports only 17 of these centers.

The traditional treatment for hemophilia has been whole blood replacement. Because this is both costly and painful, it is considered to be inefficient and unsatisfactory. Technology has been developed to remove from whole blood that substance (Factor VIII) which, in normal persons, permits coagulation. This process, known as cryoprecipitation--or blood separation--isolates Factor VIII and, when administered, rapidly checks bleeding and reduces pain. But this, too, is a costly procedure, estimated to cost patients an average of between $5,000 and $6,000 per year.

During 1975, the Health Services Act (PL 94-63) authorized a two-pronged attack on hemophilia. Diagnostic/treatment centers were established which must provide: a) comprehensive services; b) training of professional and paraprofessional personnel; c) outpatient treatment and services; d) cooperative programs, with nearby facilities to serve hemophiliacs near, but not close to the center; e) social and vocational counseling; f) creation of individual treatment programs. Also authorized were development and expansion of blood separation centers to make blood components and fractions more readily available. The Coalition recommends that $4 million be appropriated for the treatment centers and $1 million for the separation centers.

Home Health Services

Appropriation
FY 1976 $ 3,000,000
FY 1977 $ 3,000,000
(Continuing Resolution)

Authorization
FY 1977 $12,000,000
FY 1978 Undetermined

President's Request
FY 1978 $ 3,000,000

Coalition Recommendation
FY 1978 $12,000,000 *

Home health care is recognized as an increasingly important alternative to the confinement of patients to hospitals and nursing homes. Provision of coordinated home health services by nurses, physicians, various therapists, and home health aides, have proven to be cost effective. The reduced stress on the family, community resources, and financial support systems, tend to create an improved environment for rapid recovery by the patient. Medicare and Medicaid costs for in-hospital care continue to climb daily. Development of programs with services to avoid hospitalization and the application of fiscal restraints on institutional spending would result in benefits for both provider and consumer. Preliminary findings of research in home health care by HEW and other private groups lend continuing credibility to the efficacy of community based care.

The Coalition recommends a budget of $12 million for Home Health Services to be allocated in the following manner: $5 million to provide support for new start-up and expansion of existing home health agencies; $3 million for research and development of alternative care delivery models; $3 million for implementation of quality assurance programs (this would also include fraud and abuse control); and $1 million to provide revenue for training of new service providers and continuing education for professionals currently working in home health care.

In view of an anticipated system of nationalized health insurance, it is important for systems of home care and self care to be developed and to be integrated into existing health delivery patterns. Since these programs have been shown to be cost effective, it is imperative that further development of alternative outpatient systems be supported.

Quality Assurance

Appropriation
FY 1976 $52,769,000
FY 1977 $66,187,000

Authorization
FY 1978 Open

President's Request
FY 1978 $77,952,000

Coalition Recommendation
FY 1978 $80,000,000

The Coalition recommendation for the Bureau of Quality Assurance consists of $6,000,000 for the Medical Care Standards program and $74,000,000 for the Professional Standards Review Organizations (PSROs). The Bureau is responsible for assuring that recipients of Medicare, Medicaid, and Maternal and Child Health services receive high quality health care. This is accomplished through both the development of medical care standards and the day to day monitoring of services in acute and extended stay facilities. Contracts have been awarded for research and development of methods to insure quality care in ambulatory care settings, thus further expanding the program.

The Medical Care Standards program provides medical expertise to carry out the quality assurance provisions for Medicare and Medicaid. The mandated requirements are varied, including development of standards for long-term care facilities, certification of voluntary accreditation surveys for facilities participating in Medicare and Medicaid programs, and end-stage renal disease care. Responsibility for the Maximum Allowable Cost of Drugs (MAC) program has also been added to this Bureau.

The Professional Standards Review Organization (PSRO) program is a national system of local groups of physicians who are responsible for the proper use and assurance of quality of services provided to Medicare, Medicaid, and Maternal and Child Health beneficiaries. This system was authorized by the 1972 amendments to the Social Security Act. The system involves local physician groups, Statewide Councils, and a National Council which is supported and evaluated by the federal program. Although PSROs have not specifically demonstrated a real decrease in costs, they have been able to document areas for control and to present new methods of addressing quality assurance in health care. Many PSROs are working with non-physician health care providers by assisting their development of standards and criteria through which they will be monitored. Of the 203 designated PSRO areas, 106 are conditionally operating and 14 have planning status. The Coalition believes the upcoming report of a comprehensive evaluation of the program will provide new insight into the future operations of the PSRO. The increase of $14 million is recommended by the Coalition to support the present commitments for activity.

Patient Care and Special Health Services

Appropriation
FY 1976 $117,970,000
FY 1977 $128,209,000

Authorization
Open

President's Request
FY 1978 $137,152,000

Coalition Recommendation
FY 1978 $135,000,000

The Public Health Service hospitals primarily serve seamen, members of the Coast Guard, National Oceanographic and Atmospheric Administration, PHS Commissioned Corps personnel, and Hansen's disease patients. In the state of Hawaii, the Department of Health supports care for Hansen's disease patients and is reimbursed through this program. Services are also provided to beneficiaries of other Federal agencies, foreign seamen, and local communities on a reimbursable basis. An additional responsibility of the program is to survey and consult on the conduct of Federal employee occupational health programs.

The major change in the operations of this program over the FY 1977 level will be an increase in the number of patients to whom services will be provided. The Coalition recommends an increase in the FY 1977 funding level to support the increased patient load.

Emergency Medical Services

Appropriation
FY 1976 $37,025,000
FY 1977 $33,625,000
(continuing resolution)

Authorization
FY 1978 $77,500,000

President's Request
FY 1978 $33,625,000

Coalition Recommendation
FY 1978 $55,000,000

The Emergency Medical Services (EMS) Amendments of 1976 passed the 94th Congress on its last day in session. The Act authorizes grants and contracts for planning and feasibility studies of EMS systems. Assistance is also provided to study systems that want to improve the delivery of existing services, including the use of advanced life support techniques and improved delivery of services in rural areas. The Act further provides assistance for the establishment and initial operation of EMS systems; grants for expansion and improvement of existing systems; grants to public and private nonprofit agencies for research in EMS techniques, methods, devices, and delivery, with a special emphasis on rural areas; grants and contracts for research, training, and establishment of burn programs; and grants to train emergency medical technicians.

The Act authorizes $45 million for FY 1977, $55 million for FY 1978, and $70 million for FY 1979. Between three and five percent of the authorized funds for FY 1977 and FY 1978 are earmarked for planning and feasibility studies. At least 20 percent of the money authorized for FY 1977 through 1979 is to be used for the establishment and initial operation of EMS systems, and at least another 20 percent is for expansion and improvement projects.

The President's Budget recommends $33,625,000 for FY 1978. The Coalition recommends expanding EMS so that more citizens can be served, and research in

emergency medical techniques, methods, devices and delivery can be maintained. To carry on this program, and to keep alive our country's commitment to the health and safety of those citizens beset by immediately adverse or threatening conditions, the Coalition recommends $55 million for emergency medical services systems in FY 1978.

Indian Health Service

Appropriation
FY 1976 $350,425,000
FY 1977 $425,585,000

Authorization
FY 1978 Open

President's Request
FY 1978 $442,491,000

Coalition Recommendation
FY 1978 $594,844,000

The Indian Health Service (IHS) provides health care to more than 577,000 American Indians and Alaskan natives. There is almost an equal number of U.S. Indians without IHS assistance.

Following passage of P.L. 93-638, the Self-Determination and Educational Assistance Act, the Indian people are assuming control of their own programs. On September 30, 1976, President Ford signed the Indian Health Care Improvement Act, P.L. 94-437, designed to overcome the inadequacies of existing programs, to eliminate the backlog in health care services and to meet the health needs of the Indian people. For the first time since 1955, when the Public Health Service began providing this health care program, the laws will permit the Nation to adequately handle the health needs of the Indian peoples--if enough money is appropriated to do the job.

The Coalition for Health Funding requests a total of $594,844,000 for IHS programs. Of this amount $416,475,000 is for health services and $178,369,000 is for facilities. Included in both figures is a total of $145,257,000 to implement P.L. 94-437.

In reviewing the appropriation levels for the last two fiscal years, it is apparent that Congress is making great efforts to reconcile the health needs with financial resources. However, only 60-70% of the needs of the Indian people are being met, a situation that has existed for several years and is the reason that P.L. 94-437 was passed by the Congress.

The Coalition believes it is reasonable to begin funding these new authorizations if the Congress is to keep faith with the American Indian people. The history of broken treaties between the Federal government and the Indian people has created a situation requiring honest efforts to restore credibility. In addition to funding increases under the old laws, the following amounts are recommended for the Indian Health Care Improvement Act:

Title I. Indian Health Manpower, $7,850,000. Of this amount, $5,450,000 will permit scholarships to be given to Indian people and those who agree to serve Indians so that health professions may be learned.

Title II. Health Services, $14,025,000. Of this amount, $10,025,000 will be added to the current programs of patient care, field health, and other services, while $4,000,000 will permit the transfer of dozens of alcoholism programs from the National Institute on Alcohol Abuse and Alcoholism.

Title III. Health Facilities, $118,382,000. Of this amount, $67,180,000 is needed for hospitals, $6,960,000 for health centers, $1,242,000 for staff housing and $43 million for safe water and sanitary waste disposal.

Title IV. Access to Health Services. The services will be funded under the Medicaid/Medicare programs as the IHS Services are reimbursed under those appropriations. However, administrative costs to get this program started will require $800,000 in the first year.

Title V. Health Services for Urban Indians, $5,000,000. The funds will permit the IHS to begin serving Indian people who have moved off the reservation and find themselves in need.

Titles VI and VII will be funded under program management funds made available as in previous years.

In order to accommodate these newly defined directions for the Indian Health Service, the Coalition recommends that the appropriation consist of an inflationary adjustment to the FY 1977 funding level plus an increase for the new activities authorized in the Indian Health Care Improvement Act.

CENTER FOR DISEASE CONTROL

Center for Disease Control

Appropriation
FY 1976 $148,897,000
FY 1977 $175,228,000

Authorization
Project Grants
FY 1978 $ 95,000,000
Other Programs
FY 1978 Open

President's Request
FY 1978 $186,926,000

Coalition Recommendation
FY 1978 $221,500,000

The preventive health services activities of the Public Health Service are maintained by the Center for Disease Control. The Center has specific responsibility for preventing illness and maintaining scientific surveillance of communicable, chronic, chemical-induced and occupational diseases. The Coalition recommends $221.5 million for funding of these programs.

The concept of preventive health care has been widely acclaimed, although the success of CDC's efforts in this area has been hampered by the lack of adequate funds. The number of cases of measles is more than 60% greater than last year. Venereal diseases are still not under control, so the country is faced with a threatened spread of penicillin resistant strains of gonorrhea. The Coalition recommends that the funds for project grants in venereal disease control be restored to the FY 1975 level. Similarly, the demonstrated need for more childhood immunization programs supports the Coalition recommended increase of $10 million for immunization project grants. Important state and local preventive health programs are dependent upon this funding and these increases as well as maintenance of the grant programs for rat control and lead-based paint poisoning.

Disease surveillance activities include two new areas which deserve funding support. The first is fluoridation of public water supplies which has received the unqualified approval of major health organizations, the National Institutes of Health, and the World Health Organization. In those communities where the water supply contains recommended levels of fluoridation, the incidence of dental caries has been reduced by 50%. The economy of this safe and effective preventive measure is demonstrated by the fact that the annual cost of fluoridating a water system approximates 5 to 15 cents per person. Despite studies which estimate that between $30 and $50 could be saved in dental care costs for every dollar spent on fluoridation, less than one-half of the population are presently enjoying its benefits. Funds are needed to assist in the installation, initial operation and maintenance of fluoride dispensing equipment. A major program of public education should also be launched urging state legislatures, local government and public officials to give fluoridation a high priority in their disease control programs. The second surveillance program supports the use of amniocentesis to detect birth defects. An increase in funding would create a program designed to hasten the general acceptance of and judicious use of amniocentesis as part of obstetrical health care.

State public health laboratories will be assuming more responsibility for the certification or licensure of clinical laboratories in their States. These laboratories need direction and support to improve and expand their capabilities and competence. Greater resources are needed at CDC to assist the States in increasing their responsibilities.

The Coalition recommends $52 million for the National Institute on Occupational Safety and Health program. Expansion of occupational health training centers and the safety initiative begun in 1977, and an increase to a full operating level of the program directed toward the health and safety of working women are two major initiatives which would be funded by this increase.

Public Health Education programs are being funded primarily in the campaign against smoking. This program's activities involve several national information retrieval systems and other public health service programs. A continuation of these programs as well as increases for supplies, facilities maintenance, and salaries justify the overall Coalition recommendation.

NATIONAL INSTITUTES OF HEALTH

National Cancer Institute

Appropriation
FY 1976 $762,647,000
(Res Tng $18,163,000)
FY 1977 $815,000,000
(Res Tng $20,000,000)

Authorization
FY 1977 $1,073,500
FY 1978 Undetermined

President's Request
FY 1978 $818,936,000
(Res Tng $18,163,000)

Coalition Recommendation
FY 1978 $945,000,000 *
(Res Tng $26,000,000)

Passage of the National Cancer Act in 1971 lent added momentum to a publicly endorsed effort to lift the burden of cancer which weighs heavily on the American people. Thousands of scientists and physicians at hundreds of institutions situated across the Nation have been enlisted in the formulation and execution of the increased effort outlined during the planning of the National Cancer Program.

The efforts of the program are directed across a variety of scientific thrusts ranging from chemical carcinogenesis to rehabilitation, and are sustained by a number of funding mechanisms. Cancer patients and potential cancer victims have benefited from the program; continued progress will depend on continued impetus of the program. However, due to the pressures of inflation, the need for increased technical sophistication and diversity and the need for greater involvement of the public and the biomedical community, the need for increasing investments of time, people and money is evident.

Viewed in these terms, investment in the cancer program appears to be leveling off. Thus new findings, new opportunities and new innovations have been identified and exploited at a less than optimum rate. The momentum needs to be restored.

To illustrate, the role of environmental carcinogens, chemical, physical and biologic, needs to be further defined and the lessons learned applied, if increasing numbers of human cancer are to be prevented. This can be achieved only by screening a burgeoning number of potential carcinogens, determining how they act and how their effects can be avoided, modified or reversed.

The properties of early cancers, particularly as they occur in susceptible populations, need to be better defined so that improved techniques for early detection and accurate diagnosis can be developed and exploited. This represents a vital key to effective treatment.

Since we are still failing to prevent many cancers, the importance of treatment in dealing with cancer is paramount. All the elements are at hand to permit development of increasingly effective treatments: a clear appreciation of the systemic nature of most cancers at the time of diagnosis; increasing understanding of the rational bases for designing and exploiting multimodal systemic attacks on these diseases; increasing availability and access to widespread network of skilled professionals who, armed by an increasingly sophisticated technology, are collaborating to advance the art and science of cancer treatment.

Investigator-initiated, grant-supported, fundamental research in a multitude of disciplines continues to underlie more narrowly focused programs by replenishing and enhancing the scientific base from which practical advances are ultimately derived.

None of these vital areas can be allowed to lag or languish--nor can a variety of other efforts which underpin or lend focus to the efforts noted above. These efforts include the Cancer Control Program, the Cancer Centers Program, lay and professional educational programs and, of continuing importance, research manpower training.

The NCP in concept and in structure extends across a vast area of scientific thought and action, and is designed to serve ultimately cancer patients and the millions of people who may become victims. The problem of cancer remains so vast that it is not possible to consider retrenchment or a plateauing of effort. The essential ingredients of any successful disease-directed effort can be described in many ways. Stability in the provision of sufficient dollar resources and manpower resources is, however, of basic importance. Without this the vigor and effectiveness of important programs will be soon lost and not readily restored, and the burdens of diseases that exist today will be visited to an even greater degree on tomorrow's generations.

National Heart and Lung Institute

Appropriation
FY 1976 $370,347,000
(Res Tng $20,954,000)
FY 1977 $396,661,000
(Res Tng $21,988,000)

Authorization
FY 1977 $403,000,000
FY 1978 Undetermined

President's Request
FY 1978 $403,642,000
(Res Tng $19,954,000)

Coalition Recommendation
FY 1978 $461,000,000 *
(Res Tng $28,000,000)

As a result of legislative mandates in 1972 and 1976, the National Heart, Lung, and Blood Institute has initiated and planned a National Program of new and expanded activities in a number of areas to advance the National effort and accelerate the attack on heart, blood vessel, lung, and blood diseases and the management of our blood resources.

For more than fifty years, heart and blood vessel diseases have been the major cause of death in this country. They account for over 50% of all deaths annually, nearly three times the death rate of the next leading cause. An estimated thirty million Americans have one or more diseases of the heart and blood vessels which leads to an estimated economic loss of more than $58 billion annually. Each year lung diseases covered by the NHLBI mandate account for an estimated 150,000 deaths; cause 60 million days lost from work; 40 million days at bed-restricted activity; and cost the economy $19 billion. Almost exclusively limited to premature births, respiratory distress syndrome of the neonate, in addition, accounts for approximately 10,000 deaths annually; problems of the blood are intimately related to cardiovascular and pulmonary diseases. The cardiopulmonary complications of cystic fibrosis are usually the immediate cause of death in that disease. The impact of clotting and bleeding disorders is considerable. Arterial thrombosis causes or complicates a great variety of diseases in all parts of the body. Thrombosis may cause pulmonary embolism which is a disorder responsible for the hospitalization of about 300,000 persons annually, approximately one-sixth of which die. Hereditary diseases of the blood constitute a major national health problem. Approximately two million individuals, primarily black, carry the sickle cell trait. About one in every 400 black babies are born with sickle cell anemia. Twenty-five thousand Americans suffer from hemophilia.

The current budget proposal for 1978 is marked at a level similar to that for heart, lung, and blood research for 1977. This level represents a clear reduction in constant dollars and would have severe effects on the National Program, reducing the Institute's ability to support investigator-initiated research grants and manpower development programs as well as limiting any means of initiating any new program initiatives.

For the first time in a decade, the number of deaths from heart disease dropped below one million despite an overall growth in population. Despite the progress, however, heart attacks are still the leading cause of death; and more than 650,000 Americans are expected to die this year.

The Coalition budget would maintain four priority programs:

- Regular Research Grants would be awarded at close to 50% of the amounts recommended for approval by the National Heart, Lung, and Blood Advisory Council. It compares with 60% funded in 1976. The President's budget for 1978 would fund less than 15% of approved grants.
- National Research and Demonstration Centers of which the Institute has been able to support only 3, play an important role in bridging the gulf between fundamental research and application of research results in health care and disease prevention. During the past year, the NHLBI Advisory Council has reviewed the R&D Centers' Program and after careful assessment, recommended the establishment of twenty additional centers.
- Research Control Programs do not exist which are directed at seeking systematic knowledge of how best to accomplish effective and acceptable hypertension control at the community or work setting level. The NHLBI is planning in 1978 a study to devise practical and effective models of coordinated hypertension education and control programs in communities with high prevalence of high blood pressure.
- Research Training support in all areas of need would be maintained and possibly expanded in this budget. Over the past five years while the total of individuals trained by the Institute has remained level, the number of individuals trained in the heart and blood vessel area has dropped nearly 30%.

Other areas which should be given high priority at this funding level include:

- Development and expansion of a Collaborative Clinical Trial on the effects of anti-arrhythmic drugs on patients recovering from acute myocardial infarction. If it can be demonstrated that anti-arrhythmic drugs lower mortality rate in patients in this high risk category, for sudden death it would be a major step forward in the secondary prevention of coronary heart disease.
- Initiation of a Cooperative Study on the Clinical Course of Sickle Cell Anemia. This large study would identify the frequency of occurrence and concurrence of health related events in the clinical course of patients with sickle cell disease.
- A proposed program to stimulate the design and assessment of educational programs for children with asthma. Improved understanding of the nature of this disease, particularly appropriate actions to take, will cause a reduction in the child's psychosocial effects of disease and reduce the dependence on utilization of health care resources for care of asthmatic crisis.

This budget will also provide for a Clinical Trial on protecting the ischemic myocardium and minimizing infarct associated with acute myocardial infarction, a Clinical Study of intermittent positive pressure breathing, a task force on Pediatric Heart Disease and many more investigator and institute-initiated activities.

National Institute of Dental Research

| Appropriation | |
|---|---|
| FY 1976 | $51,427,000 |
| (ResTng | $ 5,497,000) |
| FY 1977 | $55,573,000 |
| (ResTng | $ 4,131,000) |

| Authorization | |
|---|---|
| FY 1978 | Open except Research Training |

| President's Request | |
|---|---|
| FY 1978 | $57,981,000 |
| (ResTng | $ 1,995,000) |

| Coalition Recommendation | |
|---|---|
| FY 1978 | $62,000,000 |
| (ResTng | $ 5,400,000) |

The National Institute of Dental Research has achieved an international reputation for its basic investigations into the causes of dental disease. The flow of knowledge which has resulted from the programs of the Institute has had a direct and beneficial impact on the public.

A primary goal of dental research is to increase the emphasis on the development of preventive measures in order to decrease dependence on more costly forms of reparative treatment. The degree to which this goal can be met depends almost entirely upon the ability of N.I.D.R. to fund research on causes and treatment of dental and oral facial diseases.

Through its National Caries Program, the Institute is conducting a vigorous research activity to reduce the incidence of tooth decay. A budgetary increase in the amount recommended would permit an expansion of those programs designed to: (1) increase the resistance of teeth to acid demineralization, (2) combat decay-inducing bacteria, (3) modify decay-promoting diets, and (4) improve the delivery and acceptance of caries preventive techniques.

Intensive efforts are also being made to better understand the causes of periodontal diseases and to develop more effective methods of prevention. Gum disorders as well as tooth decay are serious problems that affect virtually the entire population. The Coalition recommended increase will allow (1) initiation of studies to confirm preliminary findings that specific bacteria contribute to the onset of periodontal disease, and (2) the initiation of clinical research centers where applied studies of these findings can be conducted.

Another major area of research encompasses congenital malformations. The most common is malocclusion, which affects over one-third of the population. Emphasis is also placed on cleft lip/palate, which afflicts some 6,000 babies each year. New initiatives will include studies of acquired defects due to accidents or cancer surgery, which affect at least one million patients annually. The Institute believes that better diagnosis, control, and prevention of herpes simplex virus infections can be realized within a foreseeable period through more intensified research. Other oral ulcerations, such as aphthous stomatitis (canker sores), as well as oral cancer, are further concerns of the Institute.

Research, in conjunction with universities and the National Bureau of Standards, will be expanded to focus on the development of improved restorative materials, including implants. A more effective control of pain and anxiety associated with oral-facial conditions and with treatment is another 1978 goal.

The Institute is committed to a balanced program of research, extending from basic investigations to clinical trials and demonstrations when possible. An important aspect of this effort occurs at the five research centers which emphasize an interdisciplinary approach to the problems of dental disease. During FY 1978 the Coalition recommended funding level will support approximately 200 laboratory projects spanning a broad spectrum of oral health conditions.

The intramural research capability of the Institute is dependent upon a staff of well trained investigators. A minimum of 16 additional positions is required if the N.I.D.R. is to explore new directions of clinical research. These new positions would allow new programs in fluoride pharmacology to be initiated, in addition to the expansion of clinical research activities.

National Institute of Arthritis, Metabolism and Digestive Diseases

Appropriation
FY 1976 $179,801,000
(Res Tng $4,344,000)
FY 1977 $209,000,000
(Res Tng $9,646,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $216,961,000
(Res Tng $11,777,000)

Coalition Recommendation
FY 1978 $285,100,000
(Res Tng $15,000,000)

The National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD) is the most complex and varied of the research institutes at the NIH. It is responsible for research in ten categorical disease areas, encompassing much of the serious chronic diseases besetting Americans. Among the most prominent are arthritis, which afflicts over 20 million people, diabetes which is estimated to affect about 10 million people, digestive diseases, which are estimated to trouble 13 million Americans and diseases of the urinary tract and kidneys (8 million people). These diseases cause 160,000 deaths each year, inflict countless severe disabilities, including blindness, amputation of limbs and heart disease, and have an economic cost in billions due to direct medical costs and to lost income and tax revenue.

In fiscal year 1978, the program responsibilities of NIAMDD will be expanding in almost unprecedented fashion, primarily by Congressional mandate through specific legislation in the fields of diabetes and arthritis. The National Diabetes Act and The National Arthritis Act created a National Diabetes Commission and a National Arthritis Commission. The National Plans developed by the Commissions and submitted to the Congress call for greatly intensified efforts in basic and clinical research, in postgraduate, paramedical and lay education and in other specific activities intended to bring the fruits of research to the bedside with minimal delay. In 1977 NIAMDD is initiating programs to create multipurpose (comprehensive) centers in arthritis and research and training centers in diabetes, and is expanding research grant support in diabetes under the proposed FY 1978 budget. With the CHF budget for FY 1978, NIAMDD would expand support of arthritis research and begin selected, purposeful, applied programs which are spelled out in the respective National Diabetes and Arthritis Plans.

The legislation establishing National Advisory Boards for Arthritis and Diabetes also created a National Commission for Digestive Diseases. It is expected that this new Commission will prepare a national plan to combat digestive diseases that will require significant expansion of the institute's activities in this area as well. The increasing prominence of still another NIAMDD program responsibility, cystic fibrosis, is evidenced by a study which is underway to assess the state of the art in research and patient care and determine future directions in cystic fibrosis.

The proposed President's budget for FY 1978 shows an increase of approximately $8 million over the previous year, which will not begin to support the proposed expansion. In all programs areas but one, diabetes, there will be fewer new and competing projects supported than in 1976, despite specific Congressional directions to increase efforts in orthopedics, skin diseases including psoriasis, digestive diseases, nutrition and kidney disease. Without a very substantial increase in 1978, disease areas of great importance and impact upon our population, such as digestive disease, kidney disease, skin diseases and the fields of nutrition, orthopedics, endocrinology, metabolism and hematology face a dismal prospect.

In the NIAMDD, endocrinology research has plummeted in recent years. In FY 1975, for example, the percentage of funded new and competing regular research grants dropped from 56 percent, to FY 1976 levels of 38 percent, down to 28 percent in FY 1977. For such a vital area of basic research, this drop is nothing short of catastrophic. It should be noted that this very important field is only partially aided by increases for research in diabetes.

Funding for dermatology research has been adversely affected by that Institute's funding levels over the past several years. In 1975, the percentage of competing grants which were approved by the council and funded was 44 percent, and the same figure held for FY 1976. However, for FY 1977, the percentage has dropped down to 22 percent, which is the lowest of any research category in the NIAMDD, and perhaps in the NIH overall.

A very serious situation has arisen in this Institute with respect to personnel positions. NIAMDD's program responsibilities have been expanded significantly by Congressional action. The Institute's budget for diabetes has been greatly increased without addition of any of the staff required for implementation of the Congressional mandates. The Coalition is aware of this fact and strongly proposes remedial appropriations language which would add 89 positions to the Institute for FY 1978.

Funding at the level proposed by the Coalition ($285 million for FY 1978) will assure a reasonable beginning of implementation of the Congressional mandates with respect to diabetes and arthritis and strengthening of the scientific base needed in the other important categorical program areas of NIAMDD.

National Institute of Neurological and Communicative Disorders and Stroke

Appropriation
FY 1976 $144,707,000
(Res Tng $7,900,000)
FY 1977 $155,500,000)
(Res Tng $7,100,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $161,461,000
(Res Tng $6,572,000)

Coalition Recommendation
FY 1978 $201,000,000
(Res Tng $9,200,000)

The National Institute of Neurological and Communicative Disorders and Stroke is charged with the mission of coordinating and focusing a nationwide attack on diseases and disorders of the brain, the nervous system and human communication. Its work benefits the more than 40,000,000 Americans burdened by disabling neurological disorders and difficulties of hearing, speech, and language. More specifically, the Institute is concerned with research on stroke, epilepsy, multiple sclerosis, muscular dystrophy, slow virus and other degenerative neurological disorders, injury to the brain and spinal cord, hereditary diseases of the nervous system, developmental neurological disorders, tumors of the brain and spinal cord, Parkinson's disease, otosclerosis, and the many other communicative disorders affecting hearing and speech.

The President's FY 1978 budget fails to propose adequate funding for the important research supported and conducted by NINCDS. The budget constitutes a request of only $6 million more than the 1977 appropriation. A significant portion of these increases has been absorbed by mandatory expense increases such as pay increases and central service cost increases. Therefore the token increases proposed by the President fail to provide sufficient support to maintain prior levels of effort. Further, the President's budget provides for only 543 positions, two positions less than provided in the 1977 appropriation. This combination of facts will make it increasingly difficult to effectively capitalize on new research opportunities and to mount new initiatives aimed at improving health care related to those disorders.

The training programs supported by NINCDS were responsible for the development of academic departments, in medical schools and universitites, which now serve as national centers of teaching excellence. The decrease in funding for training programs provided in the President's budget will seriously affect the viability of further research and research training in these fields. New scientific advances point to the importance of such unusual and diverse areas of science as microbiology, biochemistry, and bioengineering to the understanding and treatment of neurological and sensory diseases. The support provided for training will barely meet the need to replace neuroscientists who are leaving research. It will allow very little funding for increased demands for traditionally prepared neuroscientists and will allow nothing for appropriate training in new areas of opportunity.

NINCDS-sponsored research on methods of testing hearing in very young children is important for early identification of hearing impairment and, therefore, mitigation of speech and language deficit. The level of support for such research is currently minimal ($103,796). Expanded funding of such programs should be a priority in fulfilling NINCDS' commitment to addressing problems of human communication. The etiology of the processes of human communication is not fully understood. Research now is devoted to detection and assessment. Once methods of identification are perfected, causes and development and assessment of treatment methods can be addressed. The need to know more about the etiology of human communication and evaluation of its disorders will require additional funds to train researchers in speech, language and hearing disorders.

Basic research on why and how the brain works, how its components are organized and related, and how the central nervous system controls the other organ systems of the body, is important to the attack on such problems as alcohol and drug abuse, emotional disorders and muscle disease, as well as the more traditional neurological and sensory disorders. The neurosciences are on the most challenging frontier of medical knowledge. If additional federal support and encouragement for continued basic research on this frontier is not forthcoming, advances in the diagnosis and treatment of epilepsy, multiple sclerosis, stroke, deafness, paraplegia, head injury, learning disorders, cerebral palsy, autism, mental retardation, muscular dystrophy, and other human afflictions will continue to be delayed.

National Institute of Allergy and Infectious Diseases

Appropriation
FY 1976 $127,163,000
(Res Tng $7,934,000)
FY 1977 $141,000,000
(Res Tng $8,081,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $153,442,000
(Res Tng $6,481,000)

Coalition Recommendation
FY 1978 $187,000,000
(Res Tng $10,000,000)

NIAID is the Institute with primary responsibility for research on (a) the immune system and its derangements and diseases including asthma and other allergies, as well as, (b) infectious agents and infectious diseases.

Research on the immune system includes study and characterization of its components, their interaction in normal functioning and the precise nature of their deficiency or derangement in immunologic disease. Research on infectious diseases encompasses the full gamut of infectious agents including bacteria, fungi, viruses and parasites such as protozoa, worms and insect-like organisms.

Specific allergic and immunologic diseases receive special attention through the activities of allergic and disease centers, clinical research projects and projects directed at the emerging area of clinical immunology. The immunological problems of organ transplantation and rejection and the inheritance of immune characteristics are the concerns of the broadened expanding field of immunogenetics.

Infectious disease research encompasses a triad of program areas: (a) microbial biology concerned with the identification, growth, transmission, structure, composition and characterization of infectious agents, (b) clinical research on specific infectious diseases including their diagnosis, epidemiology and treatment or clinical management as well as the substances such as antivirals and antibiotics used in treatment, and (c) specific disease prevention including targeted vaccine development and targeted evaluation of antivirals.

In the national interest it is important to maintain the momentum of currently supported high quality fundamental research in both immunologic and infectious disease research. But equally pressing is the need to explore the new opportunities for diagnosis, treatment and prevention provided by expanding knowledge on antivirals and the immune system; and to increase the level of effort on major public health problems such as sexually transmitted diseases, hepatitis and infectious gastroenteritis.

The Institute plans to expand the number of asthma and allergic disease centers from the present level of 16 to about 20 and to broaden their areas of concern by supporting infectious respiratory disease activities where appropriate. Additionally, three pediatric pulmonary centers, now receiving base support from another agency, will be supplemented for the intensive study of the natural history and pathogenesis of allergy and acute infections in the long term development of chronic respiratory tract diseases, such as sinusitis, bronchitis and

asthma. A clinical immunology centers program will be initiated for an interdisciplinary attack on the diseases of the immune system. Autoimmune diseases and genetic control of the immune system will be emphasized because they have such broad implications for medicine.

The new thrusts in infectious disease research will include clinical virology centers, development of new and improved vaccines and clinical evaluation of promising antiviral drugs such as interferon.

DNA recombinant research - a new and growing area of science exploring the potential of hybridizing completely unrelated species of organisms - will continue to receive research support, both directly and through the provision of resources such as improved and safer strains of organisms and biological containment facilities.

National Institute of General Medical Sciences

Appropriation
FY 1976 $187,388,000
(Res Tng $40,851,000)
FY 1977 $205,000,000
(Res Tng $43,851,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $219,896,000
(Res Tng $39,630,000)

Coalition Recommendation
FY 1978 $240,000,000
(Res Tng $57,200,000)

The NIGMS supports a wide spectrum of basic research that seeks elucidation of those life processes whose alteration or disturbance may lead to disease. The Institute develops and supports research on the cellular and molecular basis of disease and on certain clinical problems, the responsibility for which lies beyond the purview of the categorical Institutes. It offers regular research grants, center grants and contracts for directed studies. The funds for competing research grants for this Institute included in the President's Budget would pay only 40% of approved grants and those to a priority of 200, whereas it should be almost mandatory to pay 50% of approved grants and those to a priority of 250.

Institute consultants have advised strongly that emphasis be put on support of projects which focus on the genetic basis of so-called polygenic disease, a category that includes heart disease and diabetes. The genetics of these diseases has been very difficult to unravel for many reasons. They appear to be due to the combined effects of several genes, so that an analysis of pedigrees does not show an easily deciphered pattern as in cystic fibrosis or sickle cell disease. A further difficulty is the strong effect of environmental factors, such as diet, drugs, or life style. These factors may in fact determine whether an individual suffers serious symptoms or not. Once the complex genetic patterns of these diseases are understood better, it will become reasonable to offer genetic counseling both in the interest of prevention and specific treatment.

Many genetic diseases result from the absence or deficiency of one vital compound, such as insulin, antihemophilic factor, normal hemoglobin, or various enzymes. Most of these compounds are proteins and are typically subject to such rapid breakdown when ingested or injected that they do not reach the cells in which they act. NIGMS investigators are looking for ways to envelop the proteins or otherwise protect them from being broken down and are slowly making some progress. One of the barriers is the cell membrane itself, and a number of Institute biochemists are now analyzing cell membranes with a whole array of new techniques.

Another promising and very important research area is pediatric pharmacology. At a recent workshop sponsored by the Institute, leading pharmacologists with expertise in this field, from both the United States and abroad, highlighted research areas needing emphasis. It was pointed out that the chemical metabolism of some drugs was quite different in infants and adults. This is so because of different rates of maturation of various drug-metabolizing enzyme systems during infancy. As a result, a dose calculated on the basis of body surface or weight may seriously over- or underestimate the biologic effect of the drug, and the child may suffer from the toxicity of an overdose or, what is equally bad, from an ineffective dose. Other aspects of pediatric pharmacology were discussed, such as the need for data on how various childhood diseases affect drug action, how the limitations of small tissue samples for analysis, inability to communicate, and ethical and sociological considerations may be handled.

A vital thrust of the NIGMS mission is to ensure that well-trained, versatile biomedical scientists will be available in the future. The Institute has learned

from experience that progress in a scientific field may come to a halt if manpower with appropriate research training is missing. There is a special need for support of multidisciplinary training that can give the requisite breadth of background. A highly successful example of such training is provided by the Institute's Medical Scientist Program, which combines the rigor of graduate science training with the perspective and orientation of medicine.

National Institute of Child Health and Human Development

Appropriation
FY 1976 $136,573,000
(Res Tng $9,515,000)
FY 1977 $145,543,000
(Res Tng $9,745,000)

Authorization
FY 1978
Open, except Research Training and Population

President's Request
FY 1978 $155,761,000
(Res Tng $9,202,000)

Coalition Recommendation
FY 1978 $178,400,000
(Res Tng $12,600,000)

The National Institute of Child Health and Human Development (NICHD) seeks out opportunities for early prevention of disease and disability, using the tools of the biomedical and behavioral sciences, together with demographic, biometric and statistical techniques. These objectives are pursued based on the premise that the early phases of the human life cycle offer opportunities for prevention of disease, disorders, and social handicaps which may affect individuals at any point in their life spans. Thus, the Institute supports and conducts scientific investigations concerned with improved health for mothers and children and with family planning.

Research for mothers and children includes activities in pregnancy and infancy, developmental biology and nutrition, human learning and behavior, and developmental disabilities such as mental retardation. In the pregnancy and infancy area, NICHD addresses itself to the conditions which account for death and morbidity among mothers and their offspring, from the time of conception through infancy. The sudden infant death syndrome is still the leading cause of death of infants between one month and one year of age. Research continues to focus on the causes of the syndrome to identify infants at risk and to develop approaches to prevention. High risk pregnancy conditions such as diabetes mellitus and maternal immaturity are a major concern since they contribute heavily to the population of low birth weight infants and other babies who suffer lifetime disease and disability. Other emphasis areas include the initiation of labor, and neonatal adaptation. The NICHD will continue development of the Major Research Programs to concentrate effort on these major health problems of mothers and children. Adequate resources must be made available to continue this effort.

NICHD also supports and conducts research on congenital defects, developmental immunology, developmental disorders such as dyslexia and hyperkinesis, nutrition, human genetics, and human intellectual and social development. Through increased emphasis in these areas we can comprehend and subsequently alleviate the developmental diseases and disorders encountered later in life.

Mental retardation is a multidisciplinary problem, and it is the NICHD's special assignment to pursue research on both its biological and social aspects. Early identification of children at risk for faulty development is necessary to assure their timely treatment. Acceleration of this and other efforts toward amelioration and or prevention is essential in dealing with the nation's six million mentally retarded individuals. At least 10-20 percent of the retarded population have significant hearing impairments -- three-to-four times the "non-retarded" population. Forty-to-seventy percent of America's handicapped are estimated to have significant speech problems. And almost all retarded individuals have language deficits. In order to prevent or mitigate the speech and language deficits, more research must be funded to increase understanding of the speech and language processes and to develop assessment techniques for early intervention.

No single development could have greater potential impact upon the incidence of unwanted pregnancy here and around the world than the creation of a new generation of safe and effective fertility regulation methods, compatible with individual

needs. Frustratingly, it is not for want of scientific ideas that this area of biomedical research lags behind many other investigative areas; according to a recent Ford Foundation-sponsored report, scientists could right now put to work some $360 million - three times current worldwide expenditures - on some 230 promising research leads. Among them are lines of inquiry directed to the development of a vaccine to prevent pregnancy; of a male "pill" to suppress sperm formation; of agents which "hide" the egg from approaching sperm; of agents that keep a fertilized egg from taking root in the womb; and a once-a-month contraceptive.

Contraceptive research is at this time not just a matter of demographic management or even of forestalling unwanted pregnancy; it is a public health question of the first order. We cannot afford to be satisfied while the most modern and efficacious of our current contraceptives are acceptably safe only for certain women, in certain health circumstances, at certain ages. While fertility regulation is a national concern, this concern is even far greater in the developing countries of the world. The world-wide benefit to be derived from intensified contraceptive research makes significantly increased fund allocations in this area a high priority national issue.

Responsibility for DHEW's reproductive and contraceptive development program is lodged currently with the Center for Population Research of the National Institute of Child Health and Development. The population activity includes four major undertakings: contraceptive development, and family planning; the evaluation of existing fertility regulating methods; social and behavioral science research; and research fundamental to the population sciences. Within the context of these activities, NICHD directs research toward solving the problems of fertility regulation in men and women, contraceptive safety, fertility-infertility, adolescent pregnancy, and the effect of nutrition on reproductive performance. Spending levels for the program during 1976-77 were authorized at $60 million, then appropriated at $59 million. The program needs estimated is about $75 million. Therefore, the Coalition for Health Funding recommends that this amount be appropriated for population research under Title X of the Public Health Service Act.

The Coalition feels $178.4 million is the minimum commitment necessary to give the vital research of the NICHD adequate momentum.

National Institute on Aging

Appropriation
FY 1976 $19,388,000
(Res Tng $1,762,000)
FY 1977 $30,000,000
(Res Tng $2,200,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $34,500,000
(Res Tng $1,990,000)

Coalition Recommendation
FY 1978 $51,000,000
(Res Tng $2,800,000)

The National Institute on Aging conducts and supports research leading to greater understanding of the normal aging process and the diseases which afflict the elderly of this nation. Among its several concerns are the improvement and development of prosthetic devices; investigation of such phenomena as drug effects on the elderly, the decline of immune function with age, and the relationship between social factors and age; and dissemination of research results.

The importance of the aging research program is illustrated by the following facts. Twenty-two million Americans, 10 percent of our population, are now 65 years old. In fifty more years, 40 million persons may be that old. Two-thirds of the Federal money spent on health in this country goes for persons over 65. Over one million persons over 65 years of age live in institutions, and a significant proportion of them are incapacitated by a variety of diseases and degenerative conditions.

The NIA program currently addresses the biological phenomena of aging and age related diseases. While this research activity is extremely important and should continue to grow, the NIA seeks to expand its research program in other areas of importance to the elderly today by increasing support for grant programs in the behavioral and societal aspects of aging, such as developing criteria for a more flexible retirement system, and understanding the reasons for differences in life expectancy among various groups. Development of manpower to conduct research into new areas is an important part of this effort.

Recently it has been realized that the metabolic action of drugs in the body and the unfortunate reactions they may cause, differ with age. The Institute must support extensive studies on the pharmacokinetics and pharmacodynamics of drugs and drug combinations to gain knowledge of their effect in the elderly. The use of prosthetic agents to aid the elderly needs substantial development. There is an advanced technology that has been developed in recent years for military, astronautical and industrial purposes that should be explored for applications which will compensate for the sensory losses suffered by the elderly. Both the pharmacologic and the prosthetic programs could delay institutionalization and therefore have large economic benefits to society.

The intramural research program of the Institute needs to expand into vitally important research areas not currently represented. Programs in neurobiology, neuropsychology, biochemical pharmacology, and adequate provision for the addition of women to the Baltimore Longitudinal Study require an additional 47 positions.

In the establishment of the NIA, no provision was made for additional positions to conduct and monitor expanded research programs. A recent zero base analysis indicates 11 positions are needed to manage the greatly expanded grant and contract programs. To give the Institute adequate personnel for information dissemination, and to develop a program in epidemiology and demography, 7 positions are required.

The Coalition feels that $51,000,000 and a total of 265 positions is the commitment necessary for this new and important program to carry out its legislative mandate.

National Eye Institute

Appropriation
FY 1976 $50,285,000
(Res Tng $4,647,000)
FY 1977 $64,000,000
(Res Tng $4,640,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $64,981,000
(Res Tng $4,143,000)

Coalition Recommendation
FY 1978 $100,000,000
(Res Tng $6,000,000)

The National Eye Institute has the primary responsibility for supporting the pursuit of new knowledge about the eye and visual system and advancing the sciences relating to vision in order to further progress against blindness and visual disability. At least 10 million persons -- 1 of every 20 in the United States -- suffer from significant, uncorrectable, impairment of vision. Fifteen percent of these, 1.5 million people, are unable to see well enough to read ordinary newsprint with either eye, even with the aid of eyeglasses; five percent, approximately half a million, are classified as "legally" blind.

A 1976 Gallup Poll has reconfirmed the findings of an earlier survey that showed that Americans fear blindness more than any other affliction, save cancer. The National Eye Institute provides approximately 65-75% of the total national support for vision research.

Increases requested in this proposal would allow the National Eye Institute to focus support on: (1) blindness associated with diabetes, with the emphasis placed on clinical research in natural history, genetics and treatment of diabetic retinopathy, especially the formation of abnormal new blood vessels in the retina; (2) research on other circulatory abnormalities and vascular disorders which contribute to newly recorded blindness, such as hypertension, arteriosclerosis, sickle cell diseases, and vascular occlusion disorders; (3) development and testing of new drugs for the treatment of infections of the cornea by herpes simplex virus and the definition of host factors responsible for the primary acquisition of herpes virus and recurrent infections; (4) research on protein changes in the lens and the role of protein aggregation in the development of cataract, with a view toward preventing or retarding the development of cataract by drugs or other nonsurgical means; (5) investigations of changes in blood circulation of the eye which may lead to glaucoma - an increased pressure of the fluid within the eye accompanied by damage to the optic nerve and partial or complete loss of sight; (6) research to pursue information on early growth patterns and improved capabilities for treating or preventing such disorders as strabismus and amblyopia; (7) increased usage in all programs of the core center grant for strengthening vision research environments in institutions where there are already present a substantial number of high quality vision research projects funded by the NEI or other agencies; (8) increased usage in all programs of the specialized clinical research center grant to facilitate the application of scientific methods to the achievement of clearly defined objectives in vision research involving human patients.

National Institute of Environmental Health Sciences

Appropriation
FY 1976 $37,780,000
(ResTng $ 1,745,000)
FY 1977 $49,141,000
(ResTng $ 2,243,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $58,100,000
(ResTng $ 1,485,000)

Coalition Recommendation
FY 1978 $69,375,000
(ResTng $ 2,800,000)

The National Institute of Environmental Health Sciences investigates the harmful effects of environmental agents on humans, and reports any findings to those agencies responsible for environmental monitoring, standard setting and control. The Institute studies chemical, physical, and biological agents in the atmosphere and their potential to cause disability, disease, or death.

The Administration's request for this Institute does permit a reasonable increase in the grants program; however, the training program has been severely limited. Both institutional and individual awards have been cut within the training program. In the areas of etiology of environmental diseases and disorders and environmental pharmacology and toxicology the funding cuts are focused. Both these programs train scientists to identify the mechanisms by which agents cause harmful effects on the body. The commitment to these programs is necessary and should be continued.

Division of Research Resources

Appropriation
FY 1976 $130,300,000
(ResTng $ 334,000)
FY 1977 $137,500,000
(ResTng $ 515,000)

Authorization
Open, except Research Training

President's Request
FY 1978 $102,074,000
(ResTng $ 515,000)

Coalition Recommendation
FY 1978 $159,131,000
(ResTng $ 600,000)

The primary mission of the Division of Research Resources is to develop and maintain research resources for the use of grantees of the National Institutes of Health (NIH). The Division programs are not targeted to a single categorical disease; the full range of human health problems comes within its purview as it serves the resource needs of all the categorical Institutes. Its goal is to provide not only the best possible resources, but also to provide them at reasonable cost and make them available to as many researchers as possible. To accomplish its mission, the Division administers six programs. A total of $159,131,000 is required for fiscal year 1978, an increase of $57,057,000 ($48,275,000 for the Biomedical Research Support Program and $8,782,000 for the remaining programs) over the President's request to enable the Division to meet its goals and the needs of NIH-supported biomedical investigators.

The Clinical Research Program establishes and maintains resource facilities for clinical investigation in order to increase knowledge of the cause, progression, prevention, and control of human diseases. This Program currently supports an estimated 760 beds assigned to research in approximately 83 Clinical Research Centers nationwide. No increase is proposed for this Program.

The Biotechnology Research Program provides support for the development and assures the availability to biomedical investigators of technologies and tools previously inaccessible to them, thus increasing their research capacities. Developments in the fields of physics, chemistry, mathematics, engineering, and computer science have been applied to biomedical problems, making possible studies that, at one time, were very impractical or even impossible. Through its grants and contracts, the Biotechnology Research Program plays a major role in the development of high voltage electron microscopy, nuclear magnetic resonance spectrometry and many other related biotechnologies. An increase of $2,771,900 over the President's request is recommended for this Program.

The Laboratory Animal Sciences and Primate Research Program helps provide biomedical investigators with suitable research animal models, properly maintained, in an appropriate environment. One important activity of the Program is the domestic breeding of nonhuman primates. The shortage of these animals resulting from widespread habitat destruction and concern for conservation of these animals

have caused many countries to curtail the number of animals that are exported. An increase of $2,480,500 over the President's request is recommended.

The Biomedical Research Support Program, formerly known as the General Research Support Program, provides flexible research support on a formula basis to non-federal public, private and non-profit institutions actively engaged in biomedical and behavioral research. Projects supported are selected by the institutions, based on their self determined emphasis, specific direction and content. In 1976, the Congress authorized the initiation of a sub-program, the Biomedical Research Development Program, to assist new, small and developing institutions to advance their capabilities and involvement in biomedical and behavioral research. This Program may be funded by up to 10 percent of the funds appropriated for the Biomedical Research Support Program.

It is recommended that $48,275,000 be appropriated for this Program, in spite of the Administration's attempt to terminate this Program by requesting no funds for it in the 1978 budget. Although the amount requested is comparatively small with respect to the total NIH budget of over two billion dollars, it is a vital component in the fabric of the national biomedical research effort. These awards provide an essential element of needed flexibility for the overall biomedical research activities of the particular institutions on which the success of the NIH programs is so very dependent.

The Minority Biomedical Support Program is the major focus and effort of the National Institutes of Health to involve ethnic minorities in biomedical research. The Program's objectives to increase the numbers of ethnic minority faculty and student investigators engaged in biomedical research, in pursuit of its goals, has strengthened the biomedical research capabilities of minority institutions and has capitalized on the talents of minority biomedical investigators.

During the past year, the General Accounting Office conducted a study on the economic impact of not paying indirect costs to recipients of MBS grants. The Coalition recommends that an additional $2,700,000 be appropriated for the MBS Program to pay indirect costs generated by its research projects.

The Chemical/Biological Information Handling Research is responsible for new computer-based tools for handling research information about chemical substances and drugs and their biological effects. These tools are made available via a telecommunications network to the scientific community nationally. These scientists are seeking to understand and to predict how drug and chemical substances interact with human and animal systems. An additional $895,000 over the President's Budget is recommended for the CBIH Program to meet continually increasing costs and to increase the number of user groups across the nation who have access to this invaluable technology.

## John E. Fogarty International Center for Advanced Study in the Health Sciences

Appropriation
FY 1976 $5,694,000
FY 1977 $7,992,000

Authorization
Open

President's Request
FY 1978 $8,369,000

Coalition Recommendation
FY 1978 $8,369,000

The Center, a unique resource within the Federal government, serves as a focal point and principal advisor to the Director, NIH on all international activities involving NIH, as an Advanced Study Center, and administers a number of international programs.

A primary focus of the Center is its international exchange programs, one of which has been in existence for over 15 years providing opportunities to selected young foreign scientists to engage in research study and collaboration with U.S. scientists. This Program has influenced research in the United States and abroad; a second Program provides opportunities to U.S. faculty members of U.S. schools of medicine, osteopathy, dentistry and public health to go abroad and study. This Program, although comparatively new is of great interest to the faculty of those schools and will serve the interests of the people of the United States, as well as those of other countries.

As a Study Center, the first of its kind in the Federal government, it is engaged in international studies of biomedical research and the use of biomedical research in health services where the subjects are of interest to several Institutes or a multidisciplinary approach promises to be fruitful.

Concurrent with its studies, conferences and workshops concerning biomedical research, the Center is also conducting international comparative studies of systems and programs which should be of value to all health planners within the United States.

The distinguished history and accomplishments of the Gorgas Memorial Laboratory have been fully documented by Annual Reports to the Congress and by more than 8000 scientific publications. Unfortunately, prior to the receipt of core support funding for Fiscal 1977, there was a period of financial uncertainty which precluded a highly active research program. This new funding, however, assures the improvement in the research activities of the GML. The GML should be a high quality center for tropical disease research and its resources give it considerable potential as a regional center for disease studies.

The Coalition proposes a modest increase for the Center in excess of the increase contained in the President's Budget for 1978. This increase to a total of $8.4 million is considered to be the amount necessary to maintain these programs at a viable level.

National Library of Medicine

Appropriation
FY 1976 $29,244,000
FY 1977 $35,234,000

Authorization
FY 1977 Open
FY 1978 Undetermined

President's Request
FY 1978 $36,746,000

Coalition Recommendation
FY 1978 $40,000,000 *

The National Library of Medicine (NLM) is the central information resource for our national biomedical information system. NLM collects, organizes and distributes biomedical information to investigators, educators, and practitioners in this country and abroad. The Library also develops and executes programs to improve the information flow in its own system and in library services throughout the country.

Embodied in the Coalition's recommended increase for NLM funding is approximately $1.9 million for basic library services. During the past two years the demand for library services has been rising about 20 percent per year. This has resulted primarily from the expansion of the Library's online bibliographic services and from the large expansion of services made available through the Regional Medical Library Network and the resulting increase in backup services provided by NLM. The increase would be used to improve the Library's resources to respond to increased demand. More importantly, to meet this increased demand, the Library would require 20 additional positions for this effort.

The Lister Hill National Center for Biomedical Communications was established to develop methods for application of recent advances in the fields of computer and communications technology to the improvement of the transfer of biomedical information. A recommended $2 million increase for this program would be used for wider dissemination of biomedical research results and other basic biomedical information, to explore the potential value of computer technology in assisting in biomedical information transfer, and to develop and evaluate instructional materials for health professional education. To continue this investigation into communications technology the NLM would require a minimum of 12 additional positions.

The Medical Library Assistance program represents collaborative effort between the health sciences library community and the National Library of Medicine to develop facilities and techniques for dissemination and use of health science information. This program needs a $1,000,000 increase to (1) award research grants to investigate new procedures in biomedical and health information; (2) expand training grants which emphasize support for training health scientists in the application of computer technology; and (3) support efforts to develop the health science information network to the point where community hospitals and health care institutions have immediate access to high-demand biomedical information.

In addition, NLM continues to maintain programs in toxicology information, learning resources development, and development of audiovisual educational materials.

NIH Buildings and Facilities

Appropriation
FY 1976 $54,000,000
FY 1977 $67,400,000

Authorization
Open

President's Request
FY 1978 $65,650,000

Coalition Recommendation
FY 1978 $65,650,000

For many years the National Institutes of Health has maintained up-to-date Master Plans for facility development at Bethesda, Maryland, Poolesville, Maryland, and the Research Triangle Park, North Carolina. In addition, this activity is responsible for the Rocky Mountain Laboratory in Hamilton, Montana, the Gerontology Research Facility in Baltimore, Maryland, and other NIH field stations.

In fiscal year 1977 Congress appropriated $21.7 million for construction of the first phase of the Ambulatory Care Research Facility which is estimated to cost a total of $118.9 million. The 1978 President's request includes $57.4 million for the second phase of construction leaving a balance of $39.8 million for a third and fourth phase of construction to be implemented during fiscal year 1979 and fiscal year 1980. The Ambulatory Care Research Facility project is an annex to the existing Clinical Center at Bethesda. This construction would provide enlargement and modernization of the various departments required to support the existing Clinical Center as well as the new Ambulatory Care Facility. In addition, the Ambulatory Care Facility will permit expansion of the current outpatient program resulting in an effort to advance the transition of basic research into clinical practice. The Coalition supports the Administration FY 1978 request.

The original laboratory buildings at Bethesda, constructed during the late 1930's and early 1940's are in need of major renovation to bring the buildings up to par with modern day standards and render them adequate to support modern medical research needs. These laboratory buildings Nos. 2, 3, 4, 5, and 8 must be vacated to permit the needed renovation. In addition, two Buildings Nos. 7 and 9 are of such poor configuration and so physically deteriorated that studies have demonstrated it would be more economical to raze the buildings and build new than to renovate them.

To embark upon a program of renovation over a period of eight to ten years it is imperative that a new building be constructed soon to house the programs of a vacated building and Buildings Nos. 7 and 9 which are to be razed. This would permit renovation of the vacated building and the remaining older buildings by a series of move/renovate efforts. A request for funding to plan the new building is not included in this year's budget but should be considered for next year.

Office of the Director

Appropriation
FY 1976 $15,325,000
FY 1977 $16,234,000

Authorization
Open

President's Request
FY 1978 $17,871,000

Coalition Recommendation
FY 1978 $17,809,000

The Office of the Director over the past several years has been operating under the most austere financial conditions and without any increase in staff. The only increases allowed in FY 1977 were of a mandatory nature, permitting the Office of the Director to operate at the FY 1976 level. The FY 1978 President's Budget again provides only mandatory increases such as within-grade pay increases, statutory pay increases, increased payments to the Federal Employees Compensation Fund, etc. The FY 1978 President's Budget also contains a decrease of two positions and $38,000. In FY 1977 and FY 1978 the Office of the Director has assumed additional workload and responsibilities in such Congressionally mandated programs as: (a) Dissemination of Research Results; (b) The Freedom of Information and Privacy Acts; (c) Protection from Research Risks; (d) Equal Employment Opportunity Programs; and (e) Civil Rights Compliance. In addition, the pressures on the National Institutes of Health to continue its strong leadership in the advancement of science and at the same time to ensure the application of science to health problems develops conflicts in mission and resource utilization. The NIH must bridge the continuum from support of basic research through clinical trials and demonstrations of new techniques. It is

recognized further that NIH must develop a capacity to not only continuously be alert for opportunities for development but to monitor clinical trials for efficacy, develop a capability for technology assessment, and a process for developing medical practice concensus. All of these activities are beyond what was at one time considered the NIH mission and must be managed by the Office of the Director. This leadership and resources are critical to carry out these important health research functions and are included in the recommended appropriation for the Office of the Director for FY 1978.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION

Mental Health Research and Training

| Appropriation | |
|---|---|
| FY 1976 Research | $ 92,908,000 |
| FY 1976 Rape Control | $ 3,000,000 |
| FY 1976 Training | $ 85,100,000 |
| FY 1977 Research | $101,908,000 |
| FY 1977 Rape Control | $ 5,000,000 |
| FY 1977 Training | $ 86,600,000 |
| **Authorization** | |
| FY 1978 Open except Research Training | |
| FY 1977 Rape Control | $ 10,000,000 |
| FY 1978 Rape Control | Undetermined |
| **President's Request** | |
| FY 1978 Research | $101,908,000 |
| FY 1978 Rape Control | $ 5,000,000 |
| FY 1978 Training | $ 86,600,000 |
| **Coalition Recommendation** | |
| FY 1978 Research | $120,000,000 |
| FY 1978 Rape Control | $ 8,000,000* |
| FY 1978 Training | $110,000,000 |

Funding for these programs which are vital to the sustenance of the nation's mental health effort has been on a downward trend for the past five years, with the exception of some upward adjustment in fiscal year 1977. The mental health manpower training program has been on a phase-out course since fiscal year 1972, when it was funded at the level of $120,600,000. The President's Request for the last budget year was $30,000,000 and only intervention of the Congress has kept this program alive. Nevertheless, the appropriation of $86,000,000 was a staggering $24,000,000 lower than the funding level of five years ago. The effect of funding cuts in real dollars is even more deleterious. The result has been that the program is only a shadow of its former self, with fewer mental health professionals being trained, and proportionately fewer services being rendered to the mentally ill.

The Coalition strongly supports reversal of this unrealistic policy pursued by the former Administration. It is in the interest of national mental health care to begin again at the funding level of FY 1972 (circa $120,000,000) and to build from that point in order to insure the availability of adequate numbers of well trained professionals in mental health care, including psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses. The program should also include training funds for mental health paraprofessionals, but not at the expense of desperately needed researchers and clinicians trained in mental health.

The previous Administration's policy in the mental health training program has resulted in an absolute decline in 1975-76 in the number of psychiatric residents. The 1975 data projects a shortage of over 9,000 psychiatrists within five years. The gap will be much larger unless immediate corrective action is taken.

Funding for psychiatric education in FY 1976 was about $24 million, or one-third of the overall NIMH appropriation for clinical training. An appropriation targeted for psychiatric education for fiscal year 1978 is recommended at the level of $41 million. This is the level that was operative prior to the phase-out policy. The total Coalition recommendation for clinical and research training is $110 million, which is less than the general level at the beginning of the phase-out. Recent legislation supports training of primary care physicians. Delivery of primary care services by these professionals must be supported by trained mental health specialists. Training of these specialists should complement the training of primary care physicians. The recommended funding level for child mental health training is $20 million and $10 million should be specifically identified for the training of child psychiatrists.

There is also a need for training support of researchers in the mental health field. The mental health system in this country cannot continue to be effective without continued production of a stable core of mental health researchers. Because of inflation, of stable or lessening university involvements in research support and of states' inability to support higher education, it is not possible for states and universities to replace losses in federal support for research training in mental health areas. It is critical that a long range plan for financing of mental health research training continues to exist. While support for clinical training and for the provision of mental health services remains important, progress in the mental health areas is dependent on well-trained basic and applied researchers. The well-documented progress against mental illness over the last decade has been the work of a stable pool of superbly trained researchers, who were the product of a stable financial support system for research training.

Mental health research has made notable achievements in the areas of schizophrenia, mental illness in the aging, depression, the brain and behavior, neuropharmacology, child development, and other areas, and we are on the threshold of some significant breakthroughs. Nonetheless, mental health research has been the victim of vastly reduced funding. Approved but unfunded proposals in child mental health include research on the effect of television violence on child development and behavior; the use and abuse of psychotrophic drugs under various conditions and settings; dyslexia and its implications in psychosocial functioning; adolescent physiology and behavior, and teenage pregnancy and the lack of motivation for contraception. Recent research developments have brought scientists closer to an understanding of schizophrenia, which causes longer term disability and treatment than do the other major psychoses. If major breakthrough in the treatment of this illness can be made, much of the chronic mental illness, and the custodial care that results when active treatment is ineffective will be eliminated. Nearly two million Americans now living will have been hospitalized for schizophrenia by the time they reach middle age. A conservative estimate by ADAMHA of the annual cost of this illness is between $11.6 and $19 billion.

Many other important research areas, such as basic biological and developmental studies, treatment assessment research, rape, minority research scientist development awards in crime and delinquency, research on mental health services, have been seriously hampered by reductions in funds and research staff. It is vital that the capabilities be expanded to meet the need for research programs of special interest to the federal initiative in mental health.

## Community Mental Health Centers

Appropriation
FY 1976 $215,707,000
FY 1977 $232,846,000

Authorization
Continuation grants
FY 1978 Open
Other programs
FY 1977 $113,750,000
FY 1978 Undetermined

President's Request
FY 1978 $232,846,000

Coalition Recommendation
FY 1978 $305,500,000*

By initiating the community mental health centers program in 1963, the federal government made a firm commitment that a nationwide system of community care would be provided through roughly 2,000 CMHCs. The basic principle of the CMHC program is to provide community-based treatment of mental and emotional illness and to de-emphasize confinement in large state institutions. As a result of the CMHC program and the availability of new psychotherapeutic drugs, the number of patients in state institutions has been declining. Admissions to state mental institutions have been cut for the first time, and there is statistical evidence showing that fully operational centers reduce state institution admissions by as much as one-third.

Community mental health centers must not only provide inpatient, outpatient, partial hospitalization, emergency, consultation and education services, as mandated in the original CMHC Act, but now, as a result of PL 94-63, CMHCs must also provide, among other additional services, comprehensive services for children and the elderly, effective follow-up care for persons recently discharged from state institutions (including halfway house services), and screening of individuals being considered for admission to an institution.

Authorizing legislation to extend the Community Mental Health Centers Act had not been enacted when this booklet went to press, and the Coalition's recommendations for FY 1978 for CMHC programs are therefore based upon estimates of need.

For initial operations, the Coalition recommends $50 million, an increase of $23.5 million over FY 1977. Currently there are 35 applications pending, approved in FY 1976 but not funded due to lack of a sufficient appropriation. To fund just these 35 grants would require over $28 million. Yet less than this amount was appropriated in FY 1977. Thus some of these grants must wait two years for funding. To alleviate this problem in the future, the Coalition recommends this substantial increase in FY 1978 for new starts.

For planning new CMHC programs, the Coalition recommends $2.5 million, an increase of $1.5 million over the FY 1977 appropriation because the FY 1976 appropriation left 33 planning grant applications approved-but-unfunded. An additional $1.7 million would be needed to fund these programs. This is a serious shortfall in available funds, and an increase in this category is necessary.

For the preventive and early intervention programs run by CMHCs' consultation and education programs, the Coalition recommends a substantial increase over FY 1977 funding, from $8 million to $16 million. However, this level includes funds for both new grants and continuations for those centers funded from FY 1976 and FY 1977 appropriations. Thus, about $8 million would be available for new C&E grants. Preventive measures are the key to reduced societal costs of mental illness, and the Coalition therefore places high priority on the C&E grants to CMHC.

FY 1978 is the last year for which conversion grants will be available, since these grants are to be used by centers funded under the old law and which must add new services to continue to qualify under the new legislation. By the end of FY 1978 all such centers must meet the new standards. On the assumption that Congress will again authorize $20 million for conversion, this is the Coalition's recommendation. In the event that a higher figure is authorized, the Coalition would support appropriation of the full amount authorized since expansion of services in the existing centers requires substantial outlays, only part of which is being met through conversion grants.

The Coalition again recommends $12 million for distress grants. The distress grant program is extremely important to those centers facing special problems in becoming self-sufficient, such as centers in states which do not cover CMHC services under Medicaid, centers which cannot qualify for Medicare or other third party payments because they are not hospital-based, and centers serving scattered rural populations where costs are high and few individuals have health insurance coverage. Through the distress grant program these important CMHC programs can be kept in place until a national health insurance scheme is operational and providing funding for mental health services.

The Coalition recommends an appropriation of $10 million for facilities grants in FY 1977, $500,000 of which could be made available to states for devising state CMHC plans. This planning program is extremely important at this time, to help states improve their mental health system prior to enactment of NHI. The facilities grants funds are also particularly important now, primarily to enable CMHCs to upgrade all their new and existing facilities to meet life-safety code requirements and therefore qualify the CMHC for various third party (and NHI) payments and to help them to become self-sufficient as federal grants are terminated.

Drug Abuse

Appropriation
FY 1976 $232,172,000
FY 1977 $259,472,000

Authorization
FY 1978 Research and Training - Open
FY 1978 Community Programs $205,000,000

President's Request
FY 1978 $262,072,000

Coalition Recommendation
FY 1978 $273,500,000

Drug abuse prevention is the major purpose of the National Institute on Drug Abuse (NIDA). The Institute accomplishes this by funding research grants in both the pharmacology of drug addiction and applied research on treatment; supporting training programs in treatment, prevention, and research of drug abuse; assisting development of community treatment programs; and collecting and disseminating all types of information on drug abuse.

The President's budget for NIDA recommends holding the funding level of FY 1977. The Coalition recommended increases are higher in the areas of research, training, and community programs. The serious public health problem of drug misuse, abuse and addiction continues to justify increased funding for this important program.

National Institute on Alcohol Abuse and Alcoholism

Appropriation
FY 1976 $139,227,000
FY 1977 $152,262,000
(Partially continuing resolution)

Authorization
FY 1978 $198,000,000 except Clinical Training and Management
FY 1978 Open

President's Request
FY 1978 $154,066,000

Coalition Recommendation
FY 1978 $225,000,000

The Coalition again appeals to the Congress to give greater attention to the problem of alcohol abuse, so that the National Institute on Alcohol Abuse and Alcoholism can respond to this national catastrophy in something more than a cursory way.

The Federal Alcoholism program seems to suffer the same neglect as the alcoholic himself. For example, depending on the state, cirrhosis of the liver is either the third, fourth, or fifth leading cause of death throughout the country. And yet, treatment of this major illness is being inadequately researched because there are limited Federal funds available to support it.

In general, there is an unexplainable disparity between the amount of Federal resources for alcohol research compared to those directed to research in other health categories of similar magnitude. The President's Biomedical Research Panel expressed amazement at the primitive state of knowledge about alcohol related illnesses, and called for immediate expansion of the Federal alcohol research effort. Largely as a result of the Panel's findings, new provisions and dollar authorizations for alcohol research were written into the alcohol renewal legislation (Public Law 94-371).

The Coalition requests the appropriation committees to provide funding in FY 1978 to support these new provisions at the full authorization levels. Among them is the creation of six National Alcohol Research Centers at $1 million per Center, which will establish concentrated studies in biomedical and behavioral areas, promote visibility, and arouse interest in the health scientific community as rapidly as possible. This is an important catalytic step, but it is not enough. The most important development in 1978 is to create a larger base of alcohol related studies in universities and medical schools across the country. The health research community has shown little interest in alcohol research because of the scarcity of funding. It will take a reasonable investment of Federal funds to attract top quality researchers into alcohol-related studies, since there is concern about the stability and continuity of funds in this area.

There is one other development which was specifically recommended by the President's Biomedical Research Panel, and which the Coalition strongly endorses. This is the establishment of an Alcoholism Section at the Clinical Center of the National Institutes of Health. Scientists at the Clinical Center would be able to monitor patients suffering from common alcohol-related disorders such as cirrhosis, alcoholic hepatitis, and alcoholic hyperlipidemia, in order to develop improved methods of clinical diagnosis and treatment.

Overall, the Coalition recommends a budget of $30 million for alcoholism research in 1978, including $6 million for National Alcohol Research Centers, $20 million for alcoholism research grants, and $4 million for the alcoholism intramural research program with 20 new positions for a new Alcoholism Section at the NIH Clinical Center.

The Coalition recommends a budget of $12 million for alcoholism training grants and fellowships in 1978. Increased training support in medical schools is a vital step toward the goal of bringing the treatment of alcoholism into the mainstream of the nation's health care system. At present, very little about alcoholism is taught in our medical schools. As a result, doctors are ill-equipped to treat patients with alcohol-related disorders. Another important aspect of the alcoholism training program is to attract promising young researchers into the alcoholism field. Accomplishing this will insure a continuing supply of high quality scientists researching alcoholism causes, effects and treatments.

The heart of NIAAA's mission in the past five years has been to stimulate State and communities activities for the prevention and treatment of alcoholism. Important progress has been made during this period in terms of increasing community awareness, and alcoholism is becoming an important health priority at all levels of government. At present, twenty-six of the States have passed Uniform Act legislation, substituting a treatment approach toward alcoholics in lieu of criminal prosecution. This is a favorable trend, and it is bolstered by the 750 local alcoholism treatment

approach toward alcoholics in lieu of criminal prosecution. This is a favorable trend, and it is bolstered by the 750 local alcoholism treatment and prevention programs initiated by the NIAAA and the State allotments under the formula grant program.

Prior to the NIAAA's initiatives, very little was being done at the State and local level. Without funds earmarked specifically for alcoholism programs, this would still be the case. For this reason, the Coalition strongly opposes the inclusion of NIAAA project and formula grant monies into a State Health Block Grant program, because the alcoholism problem will once again lose its focus and the NIAAA's investment of the past five years will have been in vain.

The Coalition favors going forward rather than backward in our efforts to stimulate State and community alcoholism programs. The alcoholism renewal legislation stressed the need for expansion of prevention and treatment grants for special high risk populations such as women, youth and ethnic minorities. The Coalition supports this expansion, and recommends a budget of $91 million for direct project grants and $77 million for formula grants in fiscal year 1978.

Finally, the NIAAA needs to build up staff capabilities to effectively administer the broad range of programs under its legislative authorities, and the Coalition recommends 20 additional positions in 1978. Five of these positions are needed to effectively administer the "Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism" mandated in the legislation. The other fifteen would be allocated to program and administrative areas of the NIAAA which are in critical need of increased staff support. Current staff position levels are not adequate to meet the demand for orderly processing of new applications for grant and contract support, or for the effective monitoring of existing grants and contracts.

The Coalition recommends a budget of $15 million for NIAAA Management and Information in 1978, which includes the 20 new staff positions.

## HEALTH RESOURCES ADMINISTRATION

### Health Statistics

Appropriation
FY 1976 $25,636,000
FY 1977 $27,636,000

Authorization
FY 1977 $30,000,000
FY 1978 Undetermined

President's Request
FY 1978 $34,778,000

Coalition Recommendation
FY 1978 $40,000,000 *

The collection, publication and analysis of vital and health statistics is one of the oldest health functions of the Federal government, having begun at least as early as 1878. The principal organization within the government responsible for health statistics is the National Center for Health Statistics, which is authorized under sections 304, 306 and 307 of the Public Health Service Act. The National Center is actively involved in the study, development, and maintenance of general purpose health statistical systems and a wide range of specific programs and activities to document and generate statistics on illness, accidental injuries, disability, natality, mortality, marriage, divorce, health facilities, health manpower, and the medical, dental, nursing and other health services received by the people in the United States. These data form the basis for establishing priorities with respect to health and medical care problems and afford a means for evaluating the success or failure of programs designed to respond to these problems.

The most recently developed program of the National Center is the Cooperative Health Statistics System. This cooperative system is designed to provide the framework for a coalition among the various levels--national, State, and local--of government for the collection of health statistics. Data users at each level of government are asked what health statistics they need, with what frequency and reliability, and then these needs are met by collecting the data at whatever level of government is most capable of such collection.

As it is now envisioned, when the cooperative system is fully operational, it will include components on vital statistics, health manpower, health facilities, hospital care, ambulatory care, and long-term care. The National Center for Health Statistics has the responsibility for providing the national leadership needed to develop and implement such a system, for assuring the quality and comparability of data collected by the various States and localities, and for entering into contracts with the States in order to provide the Federal share of the costs for demonstrating and implementing the system.

Currently, 47 jurisdictions (45 States, the District of Columbia, and Puerto Rico) are participating in the developing cooperative system. To date, through the Cooperative Health Statistics System, 34 jurisdictions are providing the National Center with vital statistics, 28 are providing health manpower data, 27 are providing health facilities data, and 12 are involved in developing and demonstrating methods and systems for producing hospital care data.

This Cooperative Health Statistics System is the cornerstone of the health data strategy of the Department of Health, Education and Welfare and is the major effort of the Department to coordinate its health data programs. The cooperative system is designed to produce comparable data needed by various health programs, whether operated centrally or at the State or local levels, in a coordinated manner that will insure lack of duplication and hence result in lower overall costs of data collection and processing and a reduced burden on data providers.

This Cooperative Health Statistics System is currently mandated in the authorizing legislation (P.L. 93-353) for the National Center for Health Statistics and is referred to in P.L. 93-353 (health planning legislation) and P.L. 94-484 (health manpower legislation) as the major source of data for the health planning and health manpower programs. The National Center has been working with these, PSRO, and other programs (national, state and local) to insure that this cooperative system will truly be responsive to users' needs.

The Fiscal Year 1977 congressional appropriation for the National Center for Health Statistics is $27.6 million. In order to provide adequate growth for the Center's programs, particularly the Cooperative Health Statistics System, it is recommended that the authorization level for FY 1978 be at least $40 million. This level of support is necessary if the cooperative system is to be implemented at a level adequate to insure its continued development and support from State and local agencies.

The Statement of Managers in the Conference Report on P.L. 93-353 (the authorizing legislation for the National Center for Health Statistics) states "The conference committee noted that the authorization of $30 million for health statistical activities for 1976 will almost certainly be inadequate, but could not authorize a greater amount within the scope of the conference and therefore, noted their intent to reauthorize an appropriate amount on a later occasion if necessary." Legislation (H.R. 12679) passed last year by the House to amend and extend for three years the authorizing legislation of the National Center for Health Statistics authorized appropriation levels of $40.0 million for FY 1977, $45.0 million for FY 1978, and $50.0 million for FY 1979. This legislation however, was not acted upon by the Senate.

Health Planning and Resource Development

Appropriation
FY 1976 $112,500,000
FY 1977 $125,000,000

Authorization
FY 1977 $296,000,000
FY 1978 Undetermined

President's Request
FY 1978 $125,000,000

Coalition Recommendation
FY 1978 $180,000,000 *

The problems facing the health system of the United States are many, but two of the most important are the uneven distribution of health resources and the continuous rise in health costs. In some areas, there are virtually no health services to serve the public, while in other areas there exists a surplus of facilities and manpower. Health costs to the nation rose 14 percent in 1976, have doubled in six years, and have increased nine-fold since 1950. In an effort to ensure proportionate allocation of resources and slow the rate of increase of health costs, the Federal Government passed the Health Planning and Resources Development Act of 1974 (PL 93-641). The law is an unprecedented attempt to improve the availability of health services and cut costs through a co-operative planning effort at the Federal, State, and local levels.

In order for PL 93-641, operative for only two years, to have the best opportunity for success, it is necessary that funding be increased for the five components created by the law. Adequate funding is necessary to meet Congressional expectations. The five components of the law are described below.

Health Service Areas. In the two years since the law was passed, local HSAs have been in the organization/development stage and have not been fully staffed. In FY 1978, however, all 213 potential HSAs will be operational, capable of performing all functions required by law, and will move to full designation. In order for the HSAs to fully implement the law, the average minimum staffing level will be 15 per agency (based on the legislative requirements of one professional per 100,000 population). The estimated staff support is two per five professional staff. Taking an average of $25,000 per position (including administrative expense), the total funding necessary would be $125,000,000 (23.4 staff x $25,000 x 213 HSAs). (Per capita funding would yield the same total. Considering 23 minimum level agencies (population: 4,997,000) with funding at $175,000 minimum per agency, and 190 above minimum agencies (population: 210,183,000) at $ .50 per capita with $.075 per capita matching funds, the total would be $125,000,000.) Since FY 1978 is the first year that all 213 HSAs will be fully designated, funding should reflect that fact. The Coalition recommends $125,000,000 to fund the HSAs.

All other components of PL 93-641 are directly linked to the increased number of designated HSAs and their increased responsibility.

State Health Planning and Development Agencies. At the present time, all but five State Agencies are functioning and, during 1977, they will be gradually assuming the full range of functions expected. By FY 1978, all 56 potential State Agencies will be fully designated and be fully operational in conjunction with the 213 HSAs. In addition to the increased duties created by the increased number of HSAs, the State Agencies will also be responsible for administering a state certificate of need program (all states will have a certificate of need program by FY 1978). In order for the HSAs to be effective and to have a coordinated statewide system, it is imperative that the State Agencies be funded close to, or at, the authorization level. The Coalition recommends $35,000,000 to fund the State Agencies.

Resource Development Funds. In order to be fully designated, the HSAs need an acceptable Health System Plan and an Annual Implementation Plan; all HSAs will have HSPs and AIPs by FY 1978. The development funds, when no other sources of support are available, will serve to plan and develop projects which align with the high

priorities of the AIP and will assist in the implementation of the HSP. It is necessary to have such funds available to areas having limited resources to effect a systematic plan implementation. Funds must be made available to allow individual HSAs to meet their own development needs. In the beginning of the full designation period, these funds are particularly needed to assist communities in developing unique resource needs and encouraging community participation. The Coalition recommends $20,000,000 to fund Resource Development.

Two other important components of the law, for which the Coalition is not recommending funding levels, are rate review and technical assistance programs.

Rate Review. In FY 1978, all 56 SHPDAs will be operational on a fully designated basis. One of their most important functions will be that of rate regulation in containing rising health costs. PL 93-641 authorizes six rate review demonstration programs to assist the SHPDAs in implementing efficient rate review procedures and to add to the knowledge of methods of rate review. These demonstration programs will be "operational", as opposed to "developmental." "Operational" means that SHPDAs would already have authority under State law to carry out rate regulation functions. It is important that the development programs be established now to ensure that rate review methods be available to the SHPDAs. Information acquired from these programs will be of the utmost importance to any national health program in the future.

Planning Methods and Technical Assistance (Centers for Health Planning). In their capacity as centers for training staffs and board members of agencies, consulting services and the development of materials for use by the agencies, the Centers for Health Planning must have a budget that reflects the increased demands that will be placed upon them. In order to assist all 213 HSAs and 56 SHPDAs, authorization-level funding will be necessary to co-ordinate nationwide planning, development training, and consulting. The agencies will need assistance in developing an HSP, a State Systems Plan, and a State Medical Facilities Plan. As the responsibilities of the agencies increase, efficiency demands adequate funding of the Centers.

Overall, PL 93-641 has the potential to develop economy and organization throughout our health services system. However, its effectiveness and success depend upon adequate funding of the entire program.

## Health Services Research and Evaluation

Appropriation
FY 1976 $26,000,000
FY 1977 $24,000,000

Authorization
FY 1977 $80,000,000
FY 1978 Undetermined

President's Request
FY 1978 $30,442,000

Coalition Recommendation
FY 1978 $35,000,000 *

The National Center for Health Services Research was established in accordance with the provisions of Public Law 93-353, the Health Services Research, Health Statistics, and Medical Libraries Act of 1974. It is the mission of the National Center to undertake and support research, evaluation, and demonstration projects respecting: (1) the accessibility, acceptability, planning, organization, distribution, technology, utilization, quality, and financing of health services and systems; (2) the supply and distribution, education and training, quality, utilization, organization, and costs of health manpower; (3) the design, construction, utilization, organization, and cost of facilities and equipment.

The priorities of the National Center are expressed as a set of issues that have been identified as the foci for intensive research. The process through which issues are selected and defined has been formulated to involve policymakers, consumers, providers, and administrators and to be responsive to their concerns. The process is ongoing and reiterative, and incorporates considerations of the extent to which the various issues affect the health of large segments of the population, affect the allocation of substantial resources, or command growing legislative interest.

Collectively, the set of issues constitutes an initial point of departure for the research activities of the National Center. The broad issue areas currently identified are: health care and the disadvantaged, inflation and productivity, health manpower, health insurance, planning and regulation, quality of care, emergency medical services, and long-term care. Additionally, the National Center intends to emphasize areas of special concern, the study of which will involve consideration of the issues identified above. Areas targeted for special emphasis include rural health care and the evaluation and application of technology.

Health Services Research is carried on both intramurally and extramurally. Extramural research, evaluation and demonstration projects are supported by grants and contracts awarded to non-Federal organizations and individuals. As one part of the extramural effort, the National Center has published program solicitations inviting the submission of grant applications proposing research on the issues of Health Care and the Disadvantaged, Emergency Medical Services, and Long-Term Care. In the near future the National Center will publish another program solicitation concerned with Health Manpower. Additionally, the National Center plans to make available grants to support the preparation of doctoral dissertations in health services research.

The Center is strongly committed to the development and growth of an intramural program which involves itself in projects that are multi-disciplinary, relevant to the policymaking process, and focused on problems where informational or methodological inadequacies have been identified. The Center has established the Service Fellow Program to attract researchers with experience in health-related fields and to provide a flexible mechanism for the employment of highly skilled professionals and the development of junior researchers. Distinguished foreign researchers are considered for appointments as Visiting Scientists. Additionally, the Intergovernmental Personnel Act authorizes the National Center to temporarily obtain the services of State and local government or academic institution employees who possess special expertise in health services research.

A limited number of Health Services Research Centers are supported by the National Center. These Centers are located in academic and research institutions, have a multidisciplinary research staff, and have working relationships with health services delivery systems. The Health Services Research Centers have wide latitude to implement research programs of their own design and content, but research programs must be consistent with national goals.

In addition, "special emphasis centers" have also been established to deal with the areas of technology and management pertaining to health services delivery.

## Health Professions Institutional Assistance

Appropriation
FY 1976 $109,100,000
FY 1977 $109,100,000

Authorization
FY 1978 $225,583,000

President's Request
FY 1978 $117,500,000

Coalition Recommendation
FY 1978 $225,083,000

Support for the health professions schools is made available primarily through capitation funding, but also by startup and financial distress funds. This year, funding for the health professions institutions is especially critical because of the uncertainty of continued financial support which has existed over the past few years.

The schools of medicine, osteopathy, and dentistry (MOD) in FY 1975 received an average of $1606 per student capitation under the continuing resolution. When the House passed its version of the health manpower legislation on July 11, 1975, it agreed on an authorization level of $2100 per student for MOD capitation funding in FY 1976 and FY 1977. Noteworthy too, is the fact that the House Budget Committee provided for the health manpower bill to be fully funded at $509.7 million in FY 1977. Since passage of the health manpower law was delayed, funding under the subsequent continuing resolutions provided funding at levels totally unrealistic to the fiscal stability of these institutions. Although the schools' financial needs continued to increase, the funding in FY 1976 approximated $1046 per MOD student which was 65% of FY 1975 funding. The Senate version of the extension of the health manpower law and the ultimate formula embodied in the new statute provides a MOD FY 1977 authorization level of $133.7 million, which is approximately $1600 per student. This level is approximately equal to the amount appropriated in FY 1975, and obviously does not account for an annual inflation factor of approximately 7.2 percent.

If one assumes a 13.4% cost of living rise between FY 1975 and FY 1977, funding for MOD school capitation for FY 1977 should be $1828 per student to maintain the same level of support. However, for FY 1977, the maximum authorization for MOD capitation is $133.7 million, or about $1600 per student, a level which is about 14% less than even 100% funding for FY 1977 would provide.

To continue the level of support that existed in FY 1975, and to account for an inflationary increase over three years the Coalition is recommending full funding of the FY 1978 authorization level of $176,660,000, which would allow $2000 per student. The new law requires MOD schools to conform to more involved conditions in order to receive capitation funds than were mandated under the 1971 law. It seemed implicit in the development of this new law that Congress would not expect the MOD schools to meet the required capitation conditions, which are based on achieving identified national health goals, without sufficient financial resources to realistically plan new programs as well as carry on their existing educational commitments. Existing enrollments and facilities are largely the result of conditions contained in the previous health manpower law.

Appropriation of at least 75% of the authorized funds for MOD capitation will ensure that NHSC scholarships and scholarships for first year students of exceptional financial need will be fully funded. This "trigger" concept (Section 700 of P.L. 94-484) was designed to assure the schools that would make efforts to conform to capitation provisions that a minimum level of funding would exist. The trigger concept was based on the assumption that the appropriations committees would provide budget authority for at least 75% of the authorization.

The schools of public health are authorized for the first time under the capitation program to receive $1400 per full-time equivalent student. Formerly, the schools participated in an institutional formula grants program. There are 19 schools of public health in the country, yet from them come the professionals whose expertise is in the comprehensive area of the national public health. These schools are unique in that they offer multi-disciplinary training in comprehensive health planning, environmental health, family planning, health administration, epidemiology, biostatistics, nutrition, health education, occupational health, and other areas of national health need. According to the new law, school enrollments must increase to meet requirements for capitation funding. It is upon the anticipated need for these students to carry out the programs of the Public Health Service Act, as amended, that the authorization was based. In the words of the Committee Reports of both the House and Senate, "studies...indicate that the number of qualified public health...personnel must be significantly increased. It simply does not make sense...for the Federal government to foster programs that will require substantial numbers of health planners, public health personnel, environmental engineers, health maintenance organization administrators, nursing home administrators and other health management personnel without insuring that financial resources are available to provide for the competent training of such personnel." For school year 1976-77, the enrollment for the nation's Schools of Public Health is approximately 6500, an increase from 3500 in 1972.

The schools of optometry, pharmacy, and podiatry have existed under the same difficult financial circumstances as those of the MOD schools for the past few years. Capitation grants to schools have steadily decreased, more than $400 per student, and greater educational commitments and inflation have increased expenses. In the case of the five colleges of podiatric medicine, the schools are all private institutions, have all undertaken construction programs, and now must increase revenues. The colleges are faced with difficult alternatives. They can ask students to pay a greater share of the cost of education. However, students are already providing these colleges with about 50% of their revenues and will be expected to pay at least 15% - 25% more tuition per year, even if federal aid remains at present levels. Yet, there is a practical limit to the financial support which students should be expected to bear. To reduce costs, the colleges might consider a reduction in faculty and support staff, but such actions can have only a deleterious effect on the educational programs at the colleges. The colleges are making every effort to tap new sources of financial support, but until these efforts bring significantly greater revenues to the colleges, federal capitation support is critically important. The colleges of podiatric medicine are currently operating programs at minimum levels. The Congress has already recognized the needs of the colleges by increasing the capitation authorization for podiatry to $965. Yet, unless the appropriated funding reaches that level, the colleges will be hard pressed to maintain their present level of operations.

In the case of the pharmacy colleges, for FY 1978 the Congress has authorized $16,990,000 to be awarded at the rate of $695 per student in eligible schools. The amount is $105 per student less than the level in effect since FY 1972. In the current school year (1976-1977), there are 28,939 students enrolled in pharmacy. Assuming that the number will be approximately the same in the fall of 1977, a total of $20,112,605 will be required to fund the capitation grants - more than the

amounts authorized. Pharmacy schools have used capitation funds to respond to the desires of the Congress to improve clinical pharmacy programs. Enrollments are leveling off for the first time in years and the schools are working hard on improving the quality of patient oriented education programs. The entire authorized amount is necessary this year because of these circumstances.

The Coalition has been encouraged by the strong support of members of Congress for the funding of health manpower programs. Members of both the authorizing and appropriations committees have gone on record as supporting an increase in the funding for health manpower. We strongly suggest that those members continue their support during the development of the appropriations bill for FY 1978.

Health Professions Student Assistance

Appropriation
FY 1976 $ 56,000,000
FY 1977 $ 55,358,000

Authorization
FY 1978 $117,160,000

President's Request
FY 1978 $ 46,500,000

Coalition Recommendation
FY 1978 $126,018,000

Six federal programs exist which could provide direct assistance to health professions students. The National Health Service Corps (NHSC) program places trained health professionals in rural or inner-city shortage areas. Recipients of scholarships are required to work for a minimum of two years in a designated shortage area. The problems of geographic and specialty maldistribution of physicians, dentists, physicians assistants, expanded function dental auxiliaries, and nurse practitioners are addressed by the scholarship program. The funding level of $75 million would support approximately 7500 students, and would make great progress in the maldistribution problem.

A new provision in the health manpower legislation intends to encourage persons coming from a disadvantaged background to enter health professions training programs. It has been shown that a higher number of persons coming from disadvantaged backgrounds will return to usually underserved areas to practice. The program supports full-time students in their first year of post baccalaureate study at any of the (MOD,VOPP) health professions schools. This program, as well as the NHSC Scholarships would be fully funded if the appropriation for MOD capitation funding is more than 75% of the authorized level (as explained in the discussion on Institutional Assistance).

The Student Loans program is authorized at $26 million, in addition to a Federally Insured Loan program. Because of the financial bind in which the health professions schools have found themselves over the past few years, tuition costs have slowly increased. Podiatric medicine colleges, for example, have had to increase tuition to $4,000 per student per year, and it is expected to increase another $500-1000 this year. Since loan programs are so vital to the education of many health professionals, and since the federally insured loan program will take another year to implement and advertise, the Coalition supports funding of the Loan program at $26 million.

The remaining programs of health professions scholarships, loan repayments and physician shortage area scholarships are designed to accommodate the same problems of maldistribution and assistance to disadvantaged persons. These programs are supporting health professions students, therefore, the Coalition recommends continued funding.

Special Projects and Facilities Construction

Appropriation
FY 1976 $ 80,169,000
FY 1977 $ 80,169,000

Authorization
FY 1978 $204,000,000*

President's Request
FY 1978 $ 97,600,000

Coalition Recommendation
FY 1978 $175,500,000

The new health manpower legislation (P.L. 94-484) authorizes funding for special projects through grants and contracts, defining new priorities for governmental support. One of the largest single authorizations is $45,000,000 for residencies in family medicine. Amendments to the previous program now (1) permit dentistry to participate in at least 10% of the appropriated funds, (2) specifically authorize support for osteopathic internships and (3) provide authority for programs for the training of physicians who plan to teach in family medicine training programs. This program attempts to reverse the trend of medical over-specialization by training physicians and dentists to treat most medical problems encountered with patients as well as the emotional concerns and anxieties of their families. The Coalition recommendation of $40 million would support some 200 family medicine projects and train over 2500 residents. The $10 million proposed for family medicine departments would assist medical and osteopathic schools to establish and maintain clinical instruction in family medicine. The Coalition suggests $16 million for the support of physician assistants and dental extenders programs in FY 1978. The amount suggested will provide funds for about 50 physician assistant programs having 3000 trainees and will allow for training programs for approximately 275 primary care faculty.

The Coalition also recommends $18 million for modest expansion for Area Health Education Centers (AHEC). The AHEC Program links local health service organizations and educational institutions to serve both students and surrounding communities. The program provides new training opportunities and added health care capabilities to areas where services are scarce or non-existent. This funding level will continue support for existing AHECs which principally serve rural areas, and also will provide for eight new AHECs which would address similar needs in some urban areas. The Coalition recommends $15 million for the primary care, internal medicine, and pediatrics program to increase the numbers of practitioners engaged in these areas.

The authorizations for special projects, interdisciplinary training, and curricular development, as well as start-up and financial distress funds for facilities, have been consolidated into one level of $25 million under the new law. The FY 1977 continuing resolution funding level for these projects is $37,583,000, so the new law severely limits the potential appropriation as well as expands the types of projects and eligible applicants to be funded. For these reasons, the amount of funding available to each of the health disciplines (medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, public health) eligible for this funding is significantly reduced. Projects relating to regional health professions schools, which have been shown to create cost savings in regional health education planning, would also be competing for these funds. The Coalition recommends funding of this group of programs at the authorization level of $25 million.

Funding for construction of medical facilities is authorized in the new legislation at $40 million. Appropriations for health construction have been nonexistent during FY 1976 and FY 1977; therefore, schools have been unable to obtain federal assistance for renovation or construction. The new emphasis on primary care education will require adequate clinic and outpatient care facilities for proper training in this area. Existing facilities in most medical teaching centers are either outmoded or inadequate. Construction grants would be available on a matching basis, which would assure a multiplier effect for those Federal funds provided. The new Administration's expressed priorities to create jobs, especially in the public sector, could be realized by this construction. For these reasons, the Coalition supports funding of health facilities construction at the level of $40 million, to balance out the development of the facilities portion of the federal health manpower program.

* The authorization level contains authority for EFDA and TEAM grants. The other funding levels mentioned above do not.

Dental Health

Appropriation
FY 1976 $2,942,000
FY 1977 $2,942,000
(Continuing Resolution)

Authorization
FY 1978 Open

President's Request
FY 1978 $0

Coalition Recommendation
FY 1978 $5,000,000

For Dental Health Activities within the Bureau of Health Manpower the Coalition recommends $5 million for FY 1978. Of that amount, $3 million is necessary to continue the important, ongoing programs of Continuing Education Grants and Educational Development and Application. A total of $2 million is recommended to initiate three particularly timely activities associated with assuring the quality of dental services, preventing dental disease, and making effective use of available dental resources.

To enhance the capacity of private dental practitioners to develop and carry out effective peer review quality assurance procedures, $1 million is recommended for approximately ten contracts to support the development of quality assurance mechanisms and the teaching of dental quality assurance concepts and methods to dental students and dental practitioners.

To provide greater opportunities for the training of dentists and dental auxiliaries in the use of dental disease prevention measures in private practice and in community health programs, $500,000 is recommended for approximately five contracts to support the development of preventive dentistry curricula in dental and dental auxiliary schools and the teaching of preventive dentistry techniques, particularly those useful in private practice.

To develop a fuller understanding of the kind and extent of the factors which act as barriers to the full provision of dental services for children eligible for the EPSDT program of SRS, $500,000 is recommended for one or two contracts to support a comprehensive investigation and analysis of the kinds and amounts of dental services required to complement those already provided children participating in the EPSDT program, their projected costs, and ways in which to coordinate and use available financial and manpower resources with maximum effectiveness to meet these service needs.

Public Health and Health Administration Special Projects and Traineeships

Appropriation
FY 1976 $14,620,000
FY 1977 $14,620,000
(Continuing Resolution)

Authorization
FY 1978 $15,000,000

President's Request
FY 1978 $ 5,000,000

Coalition Recommendation
FY 1978 $15,000,000

The Coalition recommendation represents the sum of authorizations for special projects and traineeships in both public health and health administration.

Special Project grants are intended to aid both accredited schools of public health and accredited graduate programs in health administration to develop new programs and to expand existing programs in bio-statistics, epidemiology, health administration, health planning and health policy analysis and planning, environmental and occupational health, and dietetics and nutrition. The authorization level has been set at $5,000,000 for these purposes.

Two separate traineeship programs, one for students in accredited schools of public health and one for students in accredited graduate programs of health administration, hospital administration and health planning are authorized by the new legislation. Forty-five percent of the traineeships awarded in accredited schools of public health must go to students with a postbaccalaureate degree or three years of work experience in health; 80% of the traineeships awarded by accredited programs in health administration, hospital administration, and health planning must go to similarly qualified students. Authorization levels have been set at $7.5 million for schools of public health and $2.5 million for graduate programs in health administration.

Full funding is requested by the Coalition for these programs. It is the design of these provisions to attract highly qualified and experienced personnel to programs which will prepare professionals in public health administration assume responsibility for the planning, management, and coordination of health care

delivery programs, including such recent innovations as comprehensive health planning programs, prepaid group practices, and entities to improve the evaluation of the quality of health services. The Senate and House reports further mentioned environmental problems and the impending enactment of a form of national health insurance which will create further demands for the expertise and management of these professionals in the health delivery system.

Institutional Grants for Programs in Health Administration

Authorization
FY 1978 $3,250,000

President's Request
FY 1978 $3,000,000

Coalition Recommendation
FY 1978 $2,800,000

In recent years the Congress has added complex service programs, planning agencies, and regulations which require sophisticated management. Against this bacground, the Health Professions Educational Assistance Act of 1976 has provided for the first time a piece of legislation to provide for stable support for graduate programs in health administration, hospital administration and health planning. The Congress has recognized that the health care system is becoming more and more complex from a management point of view, and has authorized grants to these programs to help prepare top level management and a variety of other skilled individuals for the management of the delivery of health services.

The intent of these grants is to put health administration education on a firm base for the first time and assure long-range commitment of the management sciences to health services delivery problems. In order to receive this type of grant a program must be accredited, must have 25 graduates a year, and must be supported by at least $100,000 in funds from non-federal sources. The authorization in the Health Manpower legislation is designed to assure a minimum financial base of $200,000, half of which is provided by the federal government. This concept assures that the programs will not rely totally on federal support, but look to other sources of support as well.

This support will expand teaching activities to create linkages and provide technical assistance to planning, regulatory and delivery organizations, and to enable the programs to be responsive to the continuing education needs of health administrators in the community. Further study indicates that 28 programs will be able to meet the eligibility criteria and the Coalition recommends that $2,800,000 be appropriated for this purpose.

Allied Health Manpower

Appropriation
FY 1976 $28,321,000
FY 1977 $28,321,000
(Continuing Resolution)

Authorization
FY 1978 $27,500,000

President's Request
FY 1978 $ 8,000,000

Coalition Recommendation
FY 1978 $27,500,000

Allied Health training monies find their way to a multiplicity of two-year and four-year colleges, graduate schools and clinical teaching facilities. Through the variety of programs federal funding makes possible, allied health personnel are equipped to relieve physicians and dentists of a significant portion of the load in health delivery. Without a growing supply of allied health professionals, the burden on the more specialized professionals will grow increasingly overwhelming.

The President's FY 1977 budget spelled out total disaster for many programs at institutions across the country. Many young people who are pursuing careers in the allied health area come from homes where extra money for such education is at a premium. Cutting off all federal aid at a time when need is so great will close the door to a better future to thousands of potential and current students. Further, the burden of a national health insurance plan will place a great burden on America's health care delivery system without curtailing the Allied Health professions training monies--it would be self-defeating for the nation to embrace national health insurance while at the same time refusing to insure the availability of supporting personnel needed for a national health insurance program.

The Coalition asks that the Congress again restore Allied Health professions support in the FY 1978 appropriation. Because of the decrease in actual funding dollars for Allied Health, the impact of inflation on existing programs, and the obvious need nationwide for more allied health professionals, the Coalition supports full funding at the level of $27,500,000.

Training in Expanded Auxiliary Management (TEAM) and Expanded Function Dental Auxiliary (EFDA) Grants

Appropriation
FY 1976 $ 7,200,000
FY 1977 $ 7,200,000
(Continuing Resolution)

Authorization
FY 1978 $25,000,000*

President's Request
FY 1978 $ 4,100,000

Coalition Recommendation
FY 1978 $ 7,500,000

The TEAM program was initiated by the dental profession in its accredited dental schools and is designed to teach dental students to organize and manage dental auxiliaries in both traditional and expanded roles. Through the TEAM programs, dental graduates are encouraged to establish practices which make broader use of the services of dental hygienists, dental assistants and EFDAs, in order to improve the dentist's productivity and the quality of dental care at the most economical level possible. Experience with TEAM programs and their forerunner, the Dental Auxiliary Utilization (DAU) programs, has demonstrated that recent dental graduates who were given an opportunity to work with dental auxiliaries in their predoctoral education tend to employ dental auxiliaries when they establish their dental practices.

The Coalition recommends that funding for the TEAM program be continued in FY 1978 at $5,500,000. These funds are needed to support ongoing TEAM programs in 27 of 58 dental schools and also to set up new programs in schools which have planned to establish them.

EFDA training programs described in P.L. 94-484 have been identified by Congress as a mechanism through which the dental profession can provide comprehensive dental care to more people and maintain quality services. EFDA programs train dental auxiliaries to perform certain treatment services. EFDAs can be particularly effective in providing access to dental care in manpower shortage areas where it is difficult to attract adequate numbers of qualified health personnel.

In several recent studies, the dental profession has demonstrated that qualified dental hygienists and dental assistants, with additional formal education, can provide dental care and services beyond those for which they have been traditionally prepared. Research has demonstrated that the dentist's efficiency and productivity dramatically increase when dental auxiliaries are used in dental practice. There are currently 18 EFDA training programs in accredited dental and dental auxiliary schools. In 1975-1976, 581 students were graduated and qualified to enter multiple team practices. Since 1972, when EFDA training programs were established in accredited schools, a total of 4,351 dental auxiliaries have received expanded function training. As a result of EFDA training programs, dental auxiliaries not only will be functioning in a greater capacity to meet current dental care needs, but also they will be prepared to respond to a further expansion of the auxiliary role. The Coalition supports continuing funding of EFDA training programs in dental and dental auxiliary schools at $2,000,000 in FY 1978.

The HEW Bureau of Health Manpower's Division of Dentistry will continue to administer TEAM and EFDA programs in FY 1978, along with its basic dental health activities in continuing education and educational development, and new programs described in a previous section of this booklet. The Division needs to increase the number of staff to accommodate substantial program expansion. It is believed that not less than 11 new staff positions will be needed, requiring an additional

*The authorization includes EFDA, TEAM, and grants for Physician Assistants. The other funding levels mentioned above do not.

$500,000 over the Division's FY 1977 program management budget, to improve the efficiency of this agency in the coming year.

The Coalition recommends that program management funds for new activities of the Division of Dentistry be increased by $500,000 over FY 1977 levels in FY 1978. Since the amount of HRA program management funds allocated to the Division of Dentistry is not identifiable, this increase is included within the recommendation for HRA Program management in the summary tables at the back of this booklet.

Health Manpower - Nursing

Appropriation
FY 1976 $107,500,000
FY 1977 $125,000,000

Authorization
FY 1978 Open

President's Request
FY 1978 $ 24,000,000

Coalition Recommendation
FY 1978 $176,500,000

Support for nursing education was minimal during the last two Administrations in spite of continually increasing evidence of need for more and better prepared nurses. Fortunately, the Congress has not wavered in its support for schools and students. Members of Congress have shown considerable perception as to the changing role of nursing and the unique potential that it has for filling gaps in health care and helping to expand health services. This is particularly significant as the enactment of some form of national health insurance becomes a reality.

It is to be hoped that a more predictable funding procedure will be possible for fiscal 1978, enabling schools and students to plan in a more orderly fashion and the public to realize the maximum results from its investment of tax dollars.

The current appropriation for capitation support to schools of nursing is $40 million. It is estimated that in the vicinity of 1,000 schools could receive grants. In general, the smaller amount of money appropriated in fiscal 1977 than in fiscal 1976 ($40 million rather than $44 million) will result in smaller grants to individual schools. The Coalition is recommending $50 million for capitation support for fiscal 1978. These funds are critical to the schools' ability to provide faculty and facilities essential to maintain enrollment, provide for curricula improvement and insure continuation of other administrative aspects of education programs.

Special projects have been called the heart of the federal program of support for nursing education making possible the development of innovative programs, the recruitment and retention of educationally and economically disadvantaged students and fostering cooperative arrangements among schools in the interests of both innovative programs and economical use of facilities. Projects of statewide, regional and national significance can be funded, provided they are new and have not been part of ongoing budget (additional cost factor). The full authorization is needed just to fund approved applicants. The $15 million requested in the proposed budget is the same amount as in the fiscal 1977 appropriation. It is estimated that the current appropriation will fund some 140 awards, of which about 70 will be new.

Advanced training grants also provided under P.L. 94-63 are the only source of funding for graduate programs in nursing. Congressional intent was to provide large enough grants to promote major curriculum improvements plus significant increases in enrollment. The $9 million appropriated for this purpose in fiscal 1977 will permit about 80 awards of which 18 are continuations.

The Coalition recommends an increase to $17 million in this appropriation to meet the need projected for 1980 for at least 440,000 nurses with advanced preparation. At present, only about 20 percent of nurses have baccalaureate or higher degrees. An estimated 28,000 R.N.'s employed in 1974 had received their master's or doctoral degrees. Demands for continued improvements in the health care delivery system and also new opportunities for nurses in education, administration and "expanded role" careers require that increasing numbers of registered nurses continue their education beyond their initial training.

The new nurse practitioner grants established in 1975 under P.L. 94-63 foster the development of nurses prepared to practice in this primary care role in response to a growing demand. In passing the legislation, Congress particularly emphasized the need for geriatric nurse practitioners for care of the elderly, a

group whose lack of adequate health care has been graphically reported in the press in recent months. Funding for nurse faculty preparation for this new type of program, project staff and related costs are eligible for funding. The fiscal 1977 appropriation was $9 million. HEW estimates that this amount will fund approximately 60 grants of which 18 are continuing. The program was launched in fiscal 1976 with an appropriation of $3 million. We are recommending an appropriation of $16 million in fiscal 1978 to continue the impetus of the program and to help meet the rapidly expanding demand for nurses with this kind of advanced preparation. Beginning in fiscal 1978, student stipends also will be funded from this item.

The Coalition recommends some increase in funding for student support to $18 million for traineeships which are chiefly for nurses receiving graduate education programs; $24 million for loans, and $8.5 million for scholarships.

The Coalition also recommends a total of $3 million for educational grants and contracts. For fiscal 1976 and 1977, funding for these was at the agency level. Previously they were in the Division of Nursing, and we believe that they should properly be a line item for nursing.

In its most recent report, the National League for Nursing, which does an annual survey of nursing schools, forecast a zero growth rate for basic nursing programs and a decline in graduate degrees. Survey results, the NLN says, show a leveling off in admissions to nursing programs reflecting the end of a growth market of the past ten years. Another trend is toward part-time rather than full-time attendance in graduate programs. This will mean a leveling off in the supply of nurses. The NLN warns that these trends should not be ignored, pointing out that "the shortage of nurses prepared at the graduate level is one of the most serious problems of supply today."

Another study - recently conducted by the Stanford University Center for Health Research and funded by the National Academy of Sciences - National Research Council - gains additional significance in light of the NLN survey results. The Stanford study of hospital care shows that the proportion of registered nurses on the hospital staff is one of three major factors in determining whether the surgical patient lives or dies.

The importance of good nursing care to the quality of health care in general in all settings throughout the country is only beginning to be recognized. With innovations in nursing education, more nurses receiving advanced preparation, and with the expanding role of registered nurses, nursing care is having an increasing impact on the nation's health care delivery systems, and there is a growing public recognition of the nursing contribution. Nursing's potential, however, still remains far greater than is generally understood today.

Significant advances in nursing and health care are being made through nursing research. Nursing research particularly deals with the important human and behavioral aspects of the treatment of disease and the prevention of illness and maintenance of health.

Just a few of the areas to which nursing research addresses itself are alleviation of pain, prevention of post-surgical infection, drug interaction among the elderly, screening for cystic fibrosis, development of an assessment instrument to predict rehabilitative progress in the home setting, and predicting child abuse and developing methods to prevent it.

Adequate federal support is essential for the continuation of ongoing research projects and the initiation of new ones. The Coalition is recommending $7 million for this purpose.

Federal support has been responsible for the development of the still very small group of nurse researchers. To date the nurse research fellowship program has supported somewhat over 600 nurses in doctoral study. The amount of $1 million was appropriated for this purpose in fiscal 1977. The Coalition believes that this should be increased to $3 million for fiscal 1978. There is a continuing need for construction funds both for renovations and new buildings in several sections of the country. The Coalition recommends $10 million for this purpose.

Health Facilities Construction

Appropriations
FY 1976 $ 63,335,000
FY 1977 $ 9,000,000

Authorization
FY 1977 $135,000,000
FY 1978 Undetermined

President's Request
FY 1978 $0

Coalition Recommendation
FY 1978 $135,000,000 *

Included in the Health Planning and Resources Development Act is a provision which regulates the renovation, upgrading, and construction of facilities for health care. Before any project can be approved for funding under this program, it must also be reviewed by the state health planning agency in which the project is located, and deemed to be consistent with the state health plan. A statewide Health Coordinating Council prospectively develops the state health plan. The state medical facilities plan must be approved by the Secretary of HEW. Further, in order for the state agency to prepare a state health plan, it is necessary that each health systems agency have a health systems plan and submit such to the state agency. Until the state health plans and the state medical facilities plans are complete and approved, no medical facility construction should be initiated. Also, no extensive renovation and/or modernization to existing facilities should take place until it is determined which areas have too few facilities and which areas have a surplus.

The intent of the law requires that an integrated planning process be completed before extensive funds are expended. This year is the first year all of the 49 State Health Planning and Development Agencies and 205 Health Systems Agencies are required to be fully operational. Because of increased health planning capabilities, the need for health service facilities, and stricter accreditation requirements for health facilities, the Coalition supports funding of this program, primarily for renovation and modernization of existing facilities.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Appropriation
FY 1976 $69,351,000
FY 1977 $77,768,000

Authorization
FY 1978 Open

President's Request
FY 1978 $93,113,000

Coalition Recommendation
FY 1978 $89,988,000

The President's budget of $93,113,000 provides the Office of the Assistant Secretary for Health (OASH) with 599 positions and $23,178,000 for fiscal year 1978. These levels of resources are insufficient for OASH to implement the recent drug cost containment regulations, reduce a substantial and costly backlog in the Health Maintenance Organization (HMO) Program, carry out recently enacted health education and promotion legislation, and meet anticipated legislative requirements related to regulating clinical laboratories. Furthermore, the allowance requires that OASH absorb the full impact of the 1976 pay raise and other mandatory costs. In fiscal year 1978, an additional $2,713,000 is required for pay costs and mandatories as well as additional responsibilities of OASH.

The Maximum Allowable Cost (MAC) for Drugs Program is a cost containment program that establishes limitations on payment for drugs provided under HEW funded programs (principally Medicaid). Anticipated savings at the Federal and State levels from the MAC program are estimated at between $60 and $75 million annually when the program is in full effect. The MAC program has moved into the implementation phase and as a result of increasing workload is inadequately staffed to meet its objectives. The increasing workload will require consideration of 25 to 30 drugs for coverage as well as updating of the comparative price data book distributed to prescribers and pharmacists.

Increased staff resources will permit reduction of the substantial backlog of Health Maintenance Organizations (HMOs) awaiting qualification. The backlog is costly because long delays in qualification impede newly organized HMOs from reaching operational status. Additional positions will also provide staff to handle emerging compliance and monitoring responsibilities as more organizations achieve qualified status. The National Health Promotion and Disease Prevention Act of 1976, P.L. 94-317, directed the establishment of an office of health

information promotion in the Office of the Assistant Secretary for Health. The office will coordinate all departmental activities related to health information and promotion, preventive health services, and education in health care use and coordinate its activities with private sector organizations. It will establish a national health information clearinghouse and assist in the analysis of issues and problems.

Legislation (HR 14319) under consideration by the Congress when it adjourned proposed that the Secretary establish, under the direct supervision of the Assistant Secretary for Health, a unit that would be responsible for coordinating regulatory functions associated with Clinical Laboratories. It is expected that a bill similar to HR 14319 will be enacted by the new Congress in 1977, and its implementation would require the addition of five positions in OASH. In addition to the above resource requirements, an allowance must be made for increased pay costs resulting from the October 1976 pay raise and mandatory costs such as space rental charges and within grade increases for personnel. Also required is restoration of 35 positions reduced below the current OASH position base.

The Coalition supports an overall recommendation of $89,988,000 which allows for the support of new programs as discussed above, but cuts back on the funding for international scientific programs.

## OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT

### Rehabilitation Services and Facilities

Appropriation
FY 1976 $804,974,000
FY 1977 $838,909,000

Authorization
Basic State Services
FY 1978 $760,000,000
Innovation & Expansion
FY 1978 $ 25,000,000
Research $ 30,000,000 plus sums as necessary
Training $ 30,000,000 plus sums as necessary

President's Request
FY 1978 $852,700,000

Coalition Recommendation
FY 1978 $887,600,000

The state-Federal program of vocational rehabilitation under the Rehabilitation Act of 1973, as amended, provides grants to the states for vocational rehabilitation services; supports programs of rehabilitation research, training, and special projects; aims at developing new knowledge directly related to client care; trains professionals to deal with various types of clients; and demonstrates new methods of fostering innovative programs in rehabilitation. The mainstay of the Nation's effort in rehabilitation policy, program development, research, and training is represented by the Vocational Rehabilitation Program, for which the Coalition recommends $887.6 million for fiscal year 1978.

In 1972, 26 million citizens had some limitation in their activity as a result of a disabling condition. In addition, some 18 million persons suffer from arthritis, another 10 million have heart-related problems, while 10,000 children are born each year with cerebral palsy. To these figures can be added each year another 380,000 people who, according to a 1974 Report from the National Safety Council, suffer permanent impairments resulting from accidents.

The proper rehabilitation services, provided in appropriate settings by trained professionals, can reduce the effects of a disabling condition, restore life functions, and reinstitute the ability to work for the majority of these people, even for the most severely and catastrophically disabled.

Vocational rehabilitation is a program of comprehensive care, including physical and mental restoration services, vocational training and placement, and necessary social services. When a person sustains a serious injury, such as a spinal cord injury or an amputation, or an acute disease, such as a stroke, life functions decrease rapidly. Activities such as walking, talking, functioning independently, working--all these endeavors, which had been simple, daily routines, become difficult, if not impossible.

The availability of comprehensive rehabilitation services determines if these normal life functions can return to the highest level of functioning in the shortest amount of time and reverse the deterioration. Studies demonstrate that, upon hospital admission for rehabilitation, life functions for a disabled person are about 35% of the normal rate. Yet, at discharge from comprehensive rehabilitation services, 70% of normal functions have returned. Seventy per cent of the spinal cord patients can now be restored to a physical and mental capacity

which allows them to return to work. In addition, lifetime cost savings per patient, owing to decreased nursing and medical care and increased earnings, are estimated at $60,000 for those who receive comprehensive rehabilitation services after a spinal cord injury.

As another example, one of the most common hereditary conditions is cystic fibrosis; there are an estimated 10 million carriers of the cystic fibrosis gene in this country. Fifty per cent of the cystic fibrosis patients can be expected to live longer than 18 years of age, thereby requiring vocational rehabilitation services.

It is estimated that in FY 1976 the $720 million authorized and appropriated for Basic State Grants was used by state rehabilitation agencies to serve nearly 1.8 million disabled individuals, of which 331,000 cases were closed as being rehabilitated. Despite that expenditure, there still was not enough to serve all those persons who need rehabilitation and are eligible for rehabilitation services. In fact, fewer persons are being served as the purchasing power of the dollar has decreased through inflation, despite the annual modest increases in program funding.

A major thrust of the program is the rehabilitation of severely disabled persons. The Coalition's request for rehabilitation services and facilities would allow the vocational rehabilitation program to focus greater resources towards these individuals without a significant reduction of services elsewhere. Research to serve this target group must be stepped up in order to develop new medical techniques, new engineering and technological improvements, and better vocational training and placement. There is a drastic need for more professionals in medicine, nursing, physical therapy, speech pathology, occupational therapy, and counseling to meet the added demand for services. Traditionally, speech impairments have not been thought of as severely handicapping. Yet, increasing numbers of young-to-middle-aged stroke and head injury victims argue for inclusion of speech handicaps in the severely handicapped category. Demonstration grants are needed for job development and job placement programs for the underserved severely speech handicapped.

To ensure that all disabled Americans can attain the independence and ability to work that comprehensive vocational rehabilitation services provide, the Coalition recommends $760 million for Basic State Grants. A total of $60.1 million is recommended for special projects, including $25 million for innovation and expansion, $2.1 million for the Helen Keller Center for Deaf Blind Youths and Adults, $3.8 million for evaluation projects, $4 million for projects with industry, $4.1 million for spinal cord centers, $3.6 million for other severely disabled projects, $750,000 for services to migrants, $1 million for client assistance projects, $250,000 for technical assistance projects, $8 million for construction, and $7.4 million for training and facilities improvement grants. Research and training are recommended to be funded at $35 million and $31 million, respectively.

In addition, the Coalition strongly recommends that the full authorized amount of $1.5 million be appropriated for the Architectural and Transportation Barriers Compliance Board in order to go forward with the goal of removing architectural, transportation, and attitudinal barriers confronting handicapped persons.

Developmental Disabilites

Appropriation
FY 1976 $55,625,000
FY 1977 $58,125,000

Authorization
FY 1978 $109,000,000

President's Request
FY 1978 $58,125,000

Coalition Recommendation
FY 1978 $73,000,000

The Developmentally Disabled Assistance and Bill of Rights Act of 1975 (PL 94-103) extends and improves upon programs initiated under the Developmental Disabilities Services and Facilities Construction Act of 1970. Developmentally disabled persons are defined as those suffering mental retardation, cerebral palsy, epilepsy, autism or dyslexia. They frequently receive inadequate services and treatment, and often end up institutionalized and virtually forgotten. When this happens, these persons become unnecessary financial burdens upon their families and their communities, falling far short of their human potentialities.

PL 94-103 increases the numbers of persons eligible under the Act, sets minimum state allotments, establishes a separate project grant authority for projects of national significance, and requires the elimination of often inappropriate institutionalization. The Act provides for

establishment of satellite centers in areas not serviced by University Affiliated Facilities, gives state councils review and comment privilege over Federal plans, requires HEW and states to develop evaluation systems, and creates a "bill of rights" for the developmentally disabled, including individualized rehabiliation plans and quality assurance mechanisms, establishing at the state level a protection and advocacy system and minimum service standards for residential facilities.

The Act authorizes formula grants to states for planning, provision of services and construction and operation of facilities for persons determined to be developmentally disabled. Formulae are based upon each state's population, extent of need for services and facilities, and financial need. This is a high priority portion of the legislation. The Coalition strongly recommends an appropriation of $43 million.

For special service projects, the Coalition recommends $22 million. These grants support demonstration projects for expanding and improving services, promote public awareness of the problem, coordinate community resources, provide technical assistance and further the development of innovative treatment modalities.

Since 1963, the Federal government has provided financial support for the operation of clinical facilities associated with institutions of higher education, directed at the mentally retarded. These "university affiliated facilities" (UAF) provide clinical training of physicians and other health professionals to serve the developmentally disabled; they demonstrate new techniques to care for the mentally retarded and provide in- and outpatient services. UAF have as priority goals deinstitutionalization, early screening, diagnosis and evaluation of infants and children, adult services and normalization of institutional life. The Coalition recommends an appropriation of $8 million in FY 1978 to support UAF activities.

An important objective of the developmental disability legislation is to establish a protective and personal advocacy agency or agencies in each state that will operate independently of all other state agencies administering or delivering services to developmentally disabled persons. This provision was included in the Act to reconcile each state's dual role as provider of service and protector of individual rights. Each agency will review human rights and benefit denial complaints from the developmentally disabled. Heretofore, these persons have had no mechanism to adjudicate complaints relating to their rights as citizens and human beings. Now, these advocacy agencies lend substance to the idea of a "bill of rights" for these often neglected people. This important function would be supported by the recommended appropriation of $43 million for "grants to states".

Although the total appropriation for all these functions now recommended by the Coalition, $73 million for FY 1978, is far short of the $109 million authorized for that period, the Coalition finds that the recommended appropriation will permit reasonable growth and substantial progress toward realizing the purposes of this excellent legislation.

## ANALYSIS TABLES

### Introduction

The following tables provide the details of the figures which are discussed in the preceding narratives. The appropriation figures for fiscal years 1976 and 1977 were compiled from tables and discussions with staff members of the Department of Health, Education and Welfare and the Senate and House Appropriations Committees. The appropriations figures for FY 1976 are actual appropriations plus the continuing resolution levels, where applicable. The FY 1977 figures are actual appropriations plus the levels included in the House Appropriations Committee Report on the FY 1977 Supplemental Appropriations bill, where applicable.

For those programs whose authorization levels expire in FY 1977, the Coalition has made its recommendations based on our best estimate of need. These Coalition recommendations are flagged with an asterisk (*) and may be adjusted at a later date, since the new authorizations were still unknown at the time this booklet went to press.

Footnotes and explanatory notes are listed at the end of the tables.

SUMMARY TABLE
($ in thousands)

| | FY 1976 Appropriation | FY 1977 Appropriation# | FY 1978 President's Budget | FY 1978 CHF Appropriation Recommendation |
|---|---|---|---|---|
| FUNCTION 550, HEALTH | | | | |
| Controllable Health Programs | | | | |
| HEW | | | | |
| Food & Drug Administration (p. 82) | 209,600 | 253,144 | 279,258 | 307,434 |
| Health Services Administration (pp. 82-83) | 1,340,064 | 1,517,227 | 1,586,806 | 1,937,410 |
| (Indian Health Services and Facilities) (p. 83) | (350,425) | (433,055) | (442,491) | (594,844) |
| Center for Disease Control (p. 83) | 148,897 | 179,773 | 186,926 | 221,500 |
| National Institutes of Health (p. 84) | 2,302,069 | 2,540,978 | 2,576,371 | 3,070,834 |
| Alcohol, Drug Abuse, Mental Health Administration (pp. 85-86) | 867,127 | 948,235 | 947,212 | 1,161,906 |
| Health Resources Administration (pp. 87-91) | 659,707 | 802,804 | 588,211 | 1,250,893 |
| Assistant Secretary for Health (p. 92) | 69,351 | 77,768 | 93,113 | 89,988 |
| Subtotal, HEW | (5,596,815) | (6,319,929) | (6,257,897) | (8,039,965) |
| Non-HEW (p. 93) | 815,174 | 957,243 | 1,036,296 | 1,003,206## |
| Total, Controllable Health Programs | 6,411,989 | 7,277,172 | 7,294,193 | 9,043,171 |
| FUNCTION 500, EDUCATION, TRAINING, EMPLOYMENT, SOCIAL SERVICES | | | | |
| Assistant Secretary for Human Development (selections) (p. 92) | 860,599 | 903,834 | 910,825 | 960,600 |

# Appropriations by agency plus the amounts included in the House Appropriations Committee Report on FY 1977 Supplemental Appropriations bill, where applicable.

## All figures for Non-Health Agencies are not CHF Recommendations, but represent a 5.2% (inflationary) increase in the FY 1977 appropriations level. These figures are included so that the recommendation for the 550 Health Budget function will be complete.

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| I. FOOD & DRUG ADMINISTRATION | | | | | |
| A. Salaries & Expenses | | | | | |
| 1. Food | 68,600 | 76,451 | | 82,724 | 84,096 |
| 2. Drugs & devices | 84,400 | 105,038 | | 122,183 | 141,801 |
| 3. Radiological products | 17,700 | 18,343 | | 19,503 | 20,177 |
| 4. National Center for Toxicological Research | 12,100 | 12,889 | | 13,505 | 14,178 |
| 5. Program management | 25,800 | 29,256 | | 37,828 | 37,182 |
| Subtotal, Salaries & Expenses | (208,600) | (HM=250,019) | | (275,743) | (297,434) |
| B. Buildings & Facilities | 1,000 | 3,125 | | 3,515 | 10,000 |
| . TOTAL, FDA | 209,600 | HM=253,144 | OPEN | 279,258 | 307,434 |
| II. HEALTH SERVICES ADMINISTRATION | | | | | |
| A. Community Health Services | | | | | |
| 1. Community health centers | 196,648 | 215,148 | (FY77=240,000 Exp FY77) | 229,148 | 250,000* |
| 2. 314(d) grant to states | | | | | |
| a. Comprehensive health grants | 90,000 | 90,000 | (FY77=110,000 Exp FY 77) | 90,000 | 110,000* |
| b. Hypertension treatment | 3,750 | 9,000 | (FY77= 15,000 Exp FY77) | 9,000 | 30,000* |
| 3. Maternal & child health | | | | | |
| a. Grants to states | 295,700 | 317,000 | 320,000 | 315,000 | 320,000 |
| b. Research & training | 23,708 | 28,708 | 30,000 | 28,708 | 30,000 |
| c. Sudden infant death syndrome information dissemination | 2,500 | 2,000 | (FY77= 3,000 Exp FY77) | 1,716 | 3,000* |
| Subtotal, Maternal & Child Health | (321,908) | (347,708) | | (345,424) | (353,000) |
| 4. Family planning | 100,615 | 113,615 | (FY77=122,500 Exp FY77) | 123,615 | 140,000* |
| 5. Health maintenance organizations | 18,612 | 22,612 | 45,000 | 18,100 | 45,000 |
| 6. Migrant health centers | 25,000 | 30,000 | (FY77= 44,000 Exp FY77) | 30,000 | 52,500* |
| 7. National health service corps | 15,000 | HM=25,354 | 47,000 | 37,599 | 45,000 |
| 8. Genetics program | -- | -- | 30,000 | 0 | 30,000 |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| II. HSA, continued | | | | | |
| A. 9. Hemophilia treatment | | | | | |
| a. Treatment centers | 2,500 | 2,500 | ($\frac{FY77=}{Exp\ FY77}$ 9,000) | 2,500 | 4,000* |
| b. Blood separation centers | 500 | 500 | | 500 | 1,000 |
| 10. Home health services | 3,000 | HM= 3,000 | ($\frac{FY77=}{Exp\ FY77}$ 12,000) | 3,000 | 12,000* |
| Subtotal, Community Health Services | (777,533) | (859,437) | | (888,886) | (1,072,500) |
| B. Quality Assurance | | | | | |
| 1. Medical care standards | 5,187 | 4,187 | OPEN | 5,718 | 6,000 |
| 2. PSROs | 47,582 | 62,000 | OPEN | 72,234 | 74,000 |
| Subtotal, Quality Assurance | (52,769) | (66,187) | | (77,952) | (80,000) |
| C. Patient Care & Special Health Services | 117,970 | 128,209 | OPEN | 137,152 | 135,000 |
| D. Emergency Medical Services | 37,025 | HM= 40,125 | 77,500 | 33,625 | 55,000 |
| E. Indian Health Services | 294,809 | HM=344,892 | OPEN | 368,066 | 416,475 |
| F. Indian Health Facilities | 55,616 | 88,163 | OPEN | 74,425 | 178,369 |
| G. Program Management | 30,663 | HM= 36,835 | OPEN | 41,634 | 35,000 |
| H. Less: Trust Fund transfer | (-) 26,321 | (-) 40,121 | | (-) 34,934 | (-) 34,934 |
| TOTAL, HSA | 1,340,064 | 1,517,227 | | 1,586,806 | 1,937,410 |
| III. CENTER FOR DISEASE CONTROL | | | | | |
| A. Disease Control | | | | | |
| 1. Project grants | | | | | |
| a. Venereal disease | 19,840 | HM= 25,000 | 43,500 | 18,000 | 30,000 |
| b. Immunization | 4,960 | HM= 16,000 | 23,000 | 19,000 | 23,000 |
| c. Rat control | 13,100 | 13,000 | 14,500 | 13,000 | 14,500 |
| d. Lead paint poison prevention | 3,500 | 8,500 | 14,000 | 8,500 | 14,000 |
| Subtotal, Project grants | (41,400) | (62,500) | (95,000) | (58,500) | (81,500) |
| 2. Disease investigation, surveillance & control | 42,411 | HM= 33,756 | OPEN | 53,607 | 52,000 |
| 3. Laboratory improvement | 10,601 | 15,063 | OPEN | 15,490 | 18,000 |
| 4. Health education | 3,513 | 4,513 | 10,000 | 7,064 | 6,000 |
| Subtotal, Disease Control | (98,925) | (115,832) | | (134,661) | (157,500) |
| B. Occupational Health | 39,533 | HM= 47,707 | OPEN | 49,177 | 52,000 |
| C. Program Management | 10,439 | HM= 16,234 | OPEN | 3,088 | 12,000 |
| TOTAL, CDC | 148,897 | 179,773 | | 186,926 | 221,500 |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| IV. NATIONAL INSTITUTES OF HEALTH | | | | | |
| A. Cancer | 762,647 | 815,000 | (FY77=1,073,500 Exp FY77) | 818,936 | 945,000* |
| (Research training)[1] | (18,163) | (20,000) | | (18,163) | (26,000)* |
| B. Heart, Lung, and Blood | 370,347 | 396,661 | (FY77=403,000 Exp FY77) | 403,642 | 461,000* |
| (Research training)[1] | (20,954) | (21,988) | | (19,954) | (28,000)* |
| C. Dental Research | 51,427 | 55,573 | OPEN | 57,981 | 62,000 |
| (Research training)[1] | (5,497) | (4,131) | | (1,995) | (5,400)* |
| D. Arthritis, Metabolism, Digestive Diseases | 179,801 | HM=216,500 | OPEN | 216,961 | 285,100 |
| (Research training)[1] | (4,344) | (9,646) | | (11,777) | (15,000)* |
| E. Neurological, Communicative Diseases, Stroke | 144,707 | 155,500 | OPEN | 161,461 | 201,000 |
| (Research training)[1] | (7,900) | (7,100) | | (6,572) | (9,200)* |
| F. Allergy, Infectious Disease | 127,163 | 141,000 | OPEN | 153,442 | 187,000 |
| (Research training)[1] | (7,934) | (8,081) | | (6,481) | (10,000)* |
| G. General Medical Sciences | 187,388 | 205,000 | OPEN | 219,896 | 240,000 |
| (Research training)[1] | (40,851) | (43,851) | | (39,630) | (57,200)* |
| H. Child Health and Human Development | 136,573 | 145,543 | OPEN | 155,761 | 178,400 |
| (Research training)[1] | (9,515) | (9,745) | | (9,202) | (12,600)* |
| I. Aging | 19,388 | 30,000 | OPEN | 34,500 | 51,000 |
| (Research training)[1] | (1,762) | (2,200) | | (1,990) | (2,800)* |
| J. Eye | 50,285 | 64,000 | OPEN | 64,981 | 100,000 |
| (Research training)[1] | (4,647) | (4,640) | | (4,143) | (6,000)* |
| K. Environmental Health Sciences | 37,780 | HM= 51,141 | OPEN | 58,100 | 69,375 |
| (Research training)[1] | (1,745) | (2,243) | | (1,485) | (2,800)* |
| L. Research Resources | 130,300 | 137,500 | OPEN | 102,074 | 159,131 |
| (Research training)[1] | (334) | (515) | | (515) | (600)* |
| M. Fogarty Center | 5,694 | 7,992 | OPEN | 8,369 | 8,369 |
| N. National Library of Medicine | 29,244 | 35,234 | (FY77=OPEN+$20,000 Exp FY77 fr rsrch) | 36,746 | 40,000* |
| O. Buildings & Facilities | 54,000 | 67,400 | OPEN | 65,650 | 65,650 |
| P. Director's Office | 15,325 | HM= 16,934 | OPEN | 17,871 | 17,809 |
| TOTAL, NIH | 2,302,069 | 2,540,978 | | 2,576,371 | 3,070,834 |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| V. ALCOHOL, DRUG ABUSE, MENTAL HEALTH ADMINISTRATION | | | | | |
| A. National Institute of Mental Health | | | | | |
| 1. Research | 92,908 | HM=103,908 | OPEN | 101,908 | 120,000 |
| 2. Rape control | 3,000 | 5,000 | (FY77=10,000 Exp FY77) | 5,000 | 8,000* |
| 3. Training | | | | | |
| a. Clinical | 67,963 | 69,463 | OPEN | 70,463 | 97,800 |
| b. Research[1/] | 17,137 | 17,137 | Exp FY77 | 16,137 | 22,200* |
| Subtotal, Training | (85,100) | (86,600) | | (86,600) | (110,000) |
| 4. Community mental health centers | | | | | |
| a. Planning & development | 1,500 | 1,000 | (FY77= 3,750 Exp FY77) | 0 | 2,500* |
| b. Initial operations | 24,000 | 26,500 | (FY77=55,000 Exp FY77) | 0 | 50,000* |
| c. Continuation grants | 162,207 | 170,346 | Such sums as necessary | 210,241 | 195,000* |
| d. Conversion grants | 20,000 | 20,000 | (FY77=20,000 Exp FY77) | 9,372 | 20,000* |
| e. Consultation & education | 4,000 | 8,000 | (FY77=15,000 Exp FY77) | 8,245 | 16,000* |
| f. Financial distress | 4,000 | 7,000 | (FY77=15,000 Exp FY77) | 4,988 | 12,000* |
| g. Facilities | 0 | 0 | (FY77= 5,000 Exp FY77) | 0 | 10,000* |
| Subtotal, Community mental health centers | (215,707) | (232,846) | | (232,846) | (305,500) |
| 5. Management & information | 22,229 | 22,714 | OPEN | 27,695 | 25,000 |
| Subtotal, NIMH | (418,944) | (451,068) | | (454,049) | (578,500) |
| B. National Institute on Drug Abuse | | | | | |
| 1. Research | 34,000 | 34,000 | OPEN | 34,000 | 40,000 |
| 2. Training | | | | | |
| a. Clinical | 9,591 | 9,512 | OPEN | 9,094 | 11,400 |
| b. Research[1/] | 409 | 488 | Exp FY77 | 906 | 600* |
| Subtotal, Training | (10,000) | (10,000) | | (10,000) | (12,000) |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| V. ADAMHA, continued | | | | | |
| B. 3. Community programs | | | | | |
| a. Project grants & contracts | 139,051 | 160,000 | 160,000 | 161,500 | 160,000 |
| b. Grants to states | 35,000 | 40,000 | 45,000 | 40,000 | 45,000 |
| Subtotal, Community programs | (174,051) | (200,000) | (205,000) | (201,500) | (205,000) |
| 4. Management & information | 14,121 | 15,472 | OPEN | 16,572 | 16,500 |
| Subtotal, NIDA | (232,172) | (259,472) | | (262,072) | (273,500) |
| C. National Institute on Alcohol Abuse and Alcoholism | | | | | |
| 1. Research | 11,808 | 12,808 | 24,000 | 13,179 | 24,000 |
| 2. Research Centers | -- | HM=2,000 | 6,000 | 0 | 6,000 |
| 3. Training | | | | | |
| a. Clinical | 6,567 | 5,°53 | OPEN | 4,934 | 10,400 |
| b. Research[1/] | 891 | 1,337 | Exp FY77 | 2,266 | 1,600* |
| Subtotal, Training | (7,458) | (7,200) | | (7,200) | (12,000) |
| 4. Community programs | | | | | |
| a. Project grants & contracts | 56,408 | HM=68,408 | 91,000 | 68,719 | 91,000 |
| b. Grants to states | 55,500 | HM=55,500 | 77,000 | 55,500 | 77,000 |
| Subtotal, Community programs | (111,908) | (123,908) | (168,000) | (124,219) | (168,000) |
| 5. Management and information | 8,053 | 8,346 | OPEN | 9,468 | 15,000 |
| Subtotal, NIAAA | (139,227) | (154,262) | | (154,066) | (225,000) |
| D. Program Direction | 11,059 | HM= 14,869 | OPEN | 7,119 | 15,000 |
| E. Buildings and Facilities | 10,600 | 0 | | 1,160 | 1,160 |
| F. St. Elizabeth's Hospital | 55,125 | HM= 68,564 | | 68,746 | 68,746 |
| TOTAL, ADAMHA | 867,127 | 948,235 | | 947,212 | 1,161,906 |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| VI. HEALTH RESOURCES ADMINISTRATION | | | | | |
| A. Health Statistics | 25,636 | 27,636 | FY77=30,000 (Exp FY77) | 34,778 | 40,000* |
| B. Health Planning & Resources Dev. | 112,500 | 125,000 | FY77=296,000 (Exp FY77) | 125,000 | 180,000* |
| C. Health Services Research & Eval. | 26,000 | 24,000 | FY77=80,000 (Exp FY77) | 30,442 | 35,000* |
| D. Health Manpower | | | | | |
| 1. Health Professions (except nursing) | | | | | |
| a. Health professions, institutional assistance | | | | | |
| 1) Capitation grants | | | | | |
| a) Medicine, Osteopathy, Dentistry | | | | | |
| (1) Medicine | | | 124,182 | | 124,182 |
| (2) Osteopathy | | | 8,680 | | 8,680 |
| (3) Dentistry | | | 43,798 | | 43,798 |
| Subtotal, MOD | CR=82,902 | HM=101,100 | (176,660) | 114,500 | (176,660) |
| b) Veterinary, Optometry, Pharmacy, Podiatry | | | | | |
| (1) Veterinary | | | 10,220 | | 10,220 |
| (2) Optometry | | | 3,205 | | 3,205 |
| (3) Pharmacy | | | 16,990 | | 16,990 |
| (4) Podiatry | | | 2,268 | | 2,268 |
| Subtotal, VOPP | CR=18,198 | HM= 18,000 | (32,683) | 0 | (32,683) |
| c) Public Health | 2/ | 2/ | 9,740 | 0 | 9,740 |
| Subtotal, Capitation grants | (CR=101,100) | (HM=119,100) | (219,083) | (114,500) | (219,083) |
| 2) Start-up MODVOPP | CR= 3,000 | HM= 3,326 | 2,000 3/ | 0 | 2,000 |
| 3) Start-up, new med schls | -- | -- | 1,500 | 1,000 | 1,000 |
| 4) Financial distress | CR= 5,000 | HM= 3,000 | 3,000 3/ | 2,000 | 3,000 |
| Subtotal, Institutional assistance | (CR=109,100) | (HM=125,426) | (225,583) | (117,500) | (225,083) |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| VI. HRA, continued | | | | | |
| D. 1. b. Health professions, student assistance | | | | | |
| 1) Loans | CR=24,000 | HM= 24,000 | 26,000 | 0 | 26,000 |
| 2) Scholarships | CR= 3,500 | HM= 1,000 | 4/ | 0 | 3,500 |
| 3) Loan repayments | CR= 6,000 | HM= 2,000 | 4/ | 1,500 | 5,358 |
| 4) National Health Service Scholarships | CR=22,500 | HM= 39,000 | 75,000 | 40,000 | 75,000 |
| 5) Scholarships, exceptionally financially needy | | | 16,000 | 5,000 | 16,000 |
| 6) Lister-Hill Scholarships | | HM= 400 | 160 | 0 | 160 |
| Subtotal, Student assistance | (CR=56,000) | (HM= 66,400) | (117,160) | (46,500) | (126,018) |
| c. Health professions, special educational assistance | | | | | |
| 1) Family medicine departments | 0 | 0 | 10,000 | 0 | 10,000 |
| 2) Family medicine/general dentistry residencies | CR=15,000 | HM= 39,000 | 45,000 | 45,000 | 40,000 |
| 3) Primary care, internal medicine & pediatrics | 0 | HM= 15,000 | 15,000 | 15,000 | 15,000 |
| 4) Area health ed centers | CR=12,000 | HM= 14,000 | 20,000 | 15,500 | 18,000 |
| 5) Physician extenders | | | | | |
| a) Physician assistants | CR= 6,300 | HM= 8,500 | | 9,100 | 8,500 |
| b) Dental extenders | CR= 1,700 | HM= 2,000 | | 2,000 | 2,000 |
| c) TEAM grants | CR= 5,500 | HM= 6,200 | | 2,100 | 5,500 |
| Subtotal, Physician extenders | (CR=13,500) | (HM= 16,700) | 25,000 | (13,200) | (16,000) |
| 6) Dental health | | | | | |
| a) Continuing education grants | 200 | | | 0 | 200 |
| b) Educational development and application | 2,742 | | | 0 | 4,800 |
| Subtotal, Dental health | (2,942) | HM= 1,800 | OPEN | (0) | (5,000) |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| VI. HRA, continued | | | | | |
| D. 1. c. 7) Special project grants | | | | | |
| a) Health prof. special projects, interdisc. training & curricular development | CR=37,583 | HM= 20,200 | 20,000 3/ | 0 | 20,000 |
| b) Pub. hlth & hlth admin. | | | | | |
| (1) Public hlth institutional support | CR= 5,900 | | 2/ | 2/ | 2/ |
| (2) Public health traineeship | CR= 9,120 | | 7,500 | 0 | 7,500 |
| (3) Special projects--pub hlth & hlth admin. | CR= 5,500 5/ | 5/ | 5,000 | 5,000 | 5,000 |
| (4) Hlth Administrtn traineeships | 5/ | 5/ | 2,500 | 0 | 2,500 |
| (5) Hlth Admn Prog.Supprt | -- | | 3,250 | 3,000 | 2,800 |
| Subtotal, Pub. Hlth | (CR=20,520) | HM=18,000 | (18,250) | (8,000) | (17,800) |
| c) Allied Health | | | | | |
| (1) AH projects | CR=24,758 | | 23,000 | 8,000 | 23,000 |
| (2) AH traineeships | CR= 3,563 | | 4,500 | 0 | 4,500 |
| Subtotal, Allied Hlth | (CR=28,321) | HM=24,000 | (27,500) | (8,000) | (27,500) |
| d) Occupational health training & ed centers | -- | -- | 5,000 | 0 | 5,000 |
| e) Disadvantaged assistance | CR=7,286 | HM=10,000 | 20,000 | 8,000 | 15,000 |
| f) Natl Commtee on Graduate Medical Education | -- | HM= 1,000 | -- | 1,000 | -- |
| g) Manpower Supply and Distribution Reports/Initiatives | -- | HM=11,000 | -- | 2,000 | -- |
| h) Foreign med. transfers | -- | HM= 1,000 | 2,000 | 2,000 | 2,000 |
| i) Other special projects | | HM=15,300 | | 0 | -- |
| Subtotal, Special project grants | (CR=93,710) | (HM=100,500) | (92,750) | (29,000) | (87,300) |
| Subtotal, Special educational assistance | (CR=137,152) | (HM=187,000) | (207,750) | (117,700) | (191,300) |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| VI. HRA, continued | | | | | |
| D. 1. d. Health professions, facilities construction | 0 | HM=25,000 | 40,000 | 0 | 40,000 |
| e. Health professions, interest subsidies | CR= 2,000 | -- | 2,000 | 2,000 | 2,000 |
| Subtotal, Health professions manpower (except nursing) | (CR=304,252) | (HM=403,826) | (592,493) | (283,700) | (584,401) |
| 2. Nursing | | | | | |
| a. Nursing, institutional assistance | | | | | |
| 1) Capitation | 44,000 | 40,000 | 55,000 | 0 | 50,000 |
| 2) Financial distress | 0 | 0 | 5,000 | 0 | 2,000 |
| 3) Special projects | 15,000 | 15,000 | 15,000 | 6,000 | 15,000 |
| 4) Advanced training | 2,000 | 9,000 | 25,000 | 0 | 17,000 |
| 5) Nurse practitioner | 3,000 | 9,000 | 25,000 | 9,000 | 16,000 6/ |
| b. Nursing, student assistance | | | | | |
| 1) Traineeships | 13,000 | 13,000 | 25,000 | 0 | 18,000 |
| 2) Student loans | 21,000 | 22,500 | 35,000 | 0 | 24,000 |
| 3) Loan repayment | 2,500 | 3,000 | OPEN | 0 | 3,000 |
| 4) Scholarships | 6,000 | 6,500 | OPEN | 9,000 | 8,500 |
| c. Nursing, educational grants and contracts | 7/ | 7/ | OPEN | 0 | 3,000 |
| d. Nursing, research | | | | | |
| 1) Project grants | 0 | 5,000 | OPEN | 0 | 7,000 |
| 2) Training fellowships | 0 | 1,000 | OPEN | 0 | 3,000 |
| e. Nursing, construction grants | | | 20,000 | 0 | 10,000 |
| f. Nursing, interest subsidies | 1,000 | 1,000 | 1,000 | 0 | 0 |
| Subtotal, Nursing manpower | (107,500) | (125,000) | | (24,000) | (176,500) |
| Subtotal, Health manpower | (411,752) | (528,826) | | (307,700) | (760,901) |

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| VI. HRA, continued | | | | | |
| E. Health Facilities Construction | | | | | |
| 1. Medical facilities | 51,760 | 0 | FY77=135,000 (Exp FY77) | 0 | 135,000* |
| 2. Special medical facilities | 11,575 | 9,000 | 0 | 0 | 0 |
| Subtotal, Health Facilities Construction | (63,335) | (9,000) | | (0) | (135,000) |
| F. Program Management | 48,484 | HM=53,342 | OPEN | 46,699 | 56,400 |
| G. Less: Trust Fund Transfer | (-)42,000 | 0 | | 0 | 0 |
| H. Payment of Sales Insufficiencies | 4,000 | 4,000 | OPEN | 2,592 | 2,592 |
| I. Medical Facilities Guarantee & Loan Fund | 10,000 | 31,000 | OPEN | 41,000 | 41,000 |
| TOTAL, HRA | 659,707 | 802,804 | | 588,211 | 1,250,893 |



(continued)

Notes and footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF RECOMMENDATION |
|---|---|---|---|---|---|
| VII. OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH | | | | | |
| A. Assistant Secretary for Health | 21,618 | 22,316 | OPEN | 23,178 | 26,000 |
| B. Retirement, PHS commissioned officers | 45,013 | 52,352 | OPEN | 56,948 | 60,888 |
| C. Scientific Activities Overseas | 0 | 1,500 | OPEN | 11,387 | 1,500 |
| D. PHS Trust Fund | 2,720 | 1,600 | | 1,600 | 1,600 |
| TOTAL, OASH | 69,351 | 77,768 | | 93,113 | 89,988 |
| VIII. OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT | | | | | |
| A. Rehabilitation Services & Facilities | | | | | |
| 1. Basic state grants | 720,309 | 740,309 | 760,000 | 760,472 | 760,000 |
| 2. Special projects | | | | | |
| a. Innovation & expansion | 18,000 | 18,000 | 25,000 | 18,000 | 25,000 |
| b. Deaf-Blind center | 2,100 | 2,100 | OPEN | 2,500 | 2,100 |
| c. Special projects, evaluation, construction | 9,965 | HM=16,900 | OPEN | 14,328 | 25,600 |
| d. Training & facilities grants | 6,900 | 7,400 | OPEN | 7,400 | 7,400 |
| 3. Research | 24,000 | 29,000 | 30,000+Sums as necessary | 29,000 | 35,000 |
| 4. Training | 22,200 | HM=30,500 | 30,000+Sums as necessary | 20,000 | 31,000 |
| 5. Architectural & Transportation Barriers Compliance Board | 1,500 | 1,500 | 1,500 | 1,000 | 1,500 |
| Subtotal, Rehabilitation | (804,974) | (845,709) | | (852,700) | (887,600) |
| B. Developmental Disabilities | | | | | |
| 1. State grants (includes personal advocacy systems) | 31,558 | 33,058 | 63,000 | 33,058 | 43,000 |
| 2. Special project grants | 19,817 | 19,817 | 25,000 | 19,567 | 22,000 |
| 3. University affiliated facilities | 4,250 | 5,250 | 21,000 | 5,500 | 8,000 |
| Subtotal, Developmental Disabilities | (55,625) | (58,125) | (109,000) | (58,125) | (73,000) |
| TOTAL, HUMAN DEVELOPMENT (selections) | 860,599 | 903,834 | | 910,825 | 960,600 |

Footnotes at end of table

(fiscal years) ($ in thousands)

| | 1976 APPROPRIATION | 1977 APPROPRIATION | 1978 AUTHORIZATION | 1978 BUDGET REQUEST | 1978 CHF ESTIMATE 8/ |
|---|---|---|---|---|---|
| IX. NON-HEALTH AGENCIES 8/ | | | | | |
| A. Occupational Safety and Health (Department of Labor) | | | | | |
| 1. Occupational Safety and Health Administration | | | | | |
| a. Safety & hlth standards | 6,747 | 8,194 | OPEN | 8,692 | 8,620 |
| b. Compliance | | | | | |
| 1) Federal inspection | 43,492 | 55,582 | OPEN | 59,151 | 58,472 |
| 2) State programs | 35,600 | 38,100 | OPEN | 35,605 | 40,081 |
| c. Education, consultation, & information | 13,395 | 18,736 | OPEN | 19,902 | 19,710 |
| d. Safety & hlth statistics | 5,977 | 6,159 | OPEN | 6,301 | 6,479 |
| e. Executive direction & administration | 3,438 | 3,562 | OPEN | 4,989 | 3,747 |
| Subtotal, OSHA | (109,189) | (130,333) | | (134,640) | (137,109) |
| 2. Ocupational Safety & Hlth Review Commission | 5,769 | 6,280 | | 7,150 | 6,607 |
| TOTAL, OSH | 114,958 | 136,613 | | 141,790 | 143,716 |
| B. Mining Enforcement & Safety Administration (Department of the Interior) | | | | | |
| TOTAL, MESA | 84,465 | HM=97,363 | OPEN | 105,766 | 98,614 |
| C. Consumer Product Safety Commission (Department of Housing & Urban Development) | | | | | |
| TOTAL, CPSC | 39,564 | 39,000 | 68,000 | 40,192 | 41,028 |
| D. Meat and Poultry Inspection (Department of Agriculture) | | | | | |
| TOTAL, MPI | 228,218 | 232,423 | | 242,081 | 244,509 |
| E. Federal Employees' Health Benefits (Civil Service Commission) (Government Payment for Annuitants) TOTAL, FEH | 347,969 | 451,844 | | 506,467 | 475,339 |
| TOTAL, Non-Health Agencies | 815,174 | 957,243 | | 1,036,296 | 1,003,206 8/ |

Footnotes at end of table

Notes and Footnotes:

( ) Numbers enclosed in parentheses are non-add entries.

* For those programs whose authorization levels expire in FY 1977, the Coalition has made its recommendations based on our best estimate of need. Recent events indicate, however, that new authorization levels may be considerably lower than those previously anticipated.

HM For those programs which will receive funds in the FY 1977 Supplemental Appropriations bill, the amount contained in the Report of the House Appropriations Committee is included or added to the existing appropriation.

CR Those programs in FY 1976 which never received an appropriation, but were funded by continuing resolution, are noted with "CR."

1/ Research training at the National Institutes of Health and the Alcohol, Drug Abuse, Mental Health Administration is authorized by one bill which is expiring in FY 1977. The FY 1977 authorization was $185 million. The total CHF recommendation for FY 1978 is $200 million.

2/ Institutional support for Schools of Public Health was funded under Health Manpower, Special Project Grants, prior to FY 1978.

3/ Total appropriations for these three programs cannot exceed $25 million.

4/ Sums as necessary, programs phasing out.

5/ Prior to FY 1978, funds were available only to those health administration programs located in Schools of Public Health.

6/ Beginning in FY 1978, student stipends will also be funded from this item.

7/ For FY 1976 and FY 1977, funding was at agency level, previously in Division of Nursing.

8/ All figures for Non-Health Agencies are <u>not</u> CHF Recommendations, but represent a 5.2% (inflationary) increase in the FY 1977 appropriations level. These figures are included so that the recommendation for the 550 Health Budget function will be complete.

GENERAL COMMENTS

Dr. SHERMAN. My colleagues will discuss in detail the areas of provision of health services, the education and training of health professionals, and the development of new knowledge upon which advances in the diagnosis and treatment of disease are dependent.

Before they begin, however, I would like to make a few general comments.

There is probably no other aspect of our national life which is so sustained in concern and widespread in its extent as health.

Indeed, only national defense—and that only in time of war—has as lasting and deep an impact on so many of our citizens as that of our personal physical and mental well-being.

Even such headliners as gun control, educational policy, and debates about the welfare system cannot compete in the overall sense with health.

Repeatedly, public opinion polls confirm the fact that it remains for most people thus consulted the No. 1 issue on the national scene. In the context of funding for health programs, some of the reasons for this attitude are worthy of note.

First, good health is of vital importance to not only the physical and mental well-being of each of us, but it also determines to a significant degree our personal progress in the economic sense.

Second, because these attitudes are so widespread within the public, good health and access to each of the services which may assure it are not viewed as a societal goal for all rather than for only the few who could personally afford to pay for those services.

Third, as the fastest growing industry in our country, the field of health is of particular interest in two respects. It is a highly labor-intensive industry.

The extent to which it is adequately funded, therefore, has a proportional impact on the Nation's employment level. It has also represented for minorities an important opportunity for gaining entrance to meaningful labor and professional responsibility.

Furthermore, publicly supported training programs for the health professions offer to those who are unskilled the possibility of improving their natural talents so as to raise their economic and social status.

In reference to the fiscal year 1978 budget, the coalition had hoped that the revised Carter budget would improve the funding level for health. But we were disappointed.

The changes barely increased the overall funding to the current services level. We realize that the new administration has had insufficient time to completely analyze the funding cuts contained in the original fiscal year 1978 budget or the cumulative effects of insufficient funding which has occurred over the past several years.

Therefore, we must look to the Congress once again to correct deficiencies in the administration's proposals.

In addition to assessing two Presidential budgets this year, we have also attempted to project funding for programs whose authorities expire in fiscal year 1977.

In the coalition's document, we have marked those programs without fiscal year 1978 authorization levels. At the time when these

expiring authorizations are final, we will reaffirm or amend our recommended funding level through a letter to the subcommittee.

The coalition is now advocating a total of $9 billion for discretionary health programs which includes $8.04 billion for the Public Health Service and $960 million for developmental disabilities and rehabilitation services.

The narrative material which is contained in the booklet is intended to explain and justify the funding requests.

Since there is not adequate time to discuss all of our recommendations in depth, I hope you and your colleagues will carefully review the discussions contained in the document submitted for the record.

Mr. GEMMELL. The coalition confines its comments to Federal health service programs which are part of the Health Services Administration; the Center for Disease Control; the Alcohol, Drug Abuse, and Mental Health Administration; and the rehabilitation services and developmental disabilities programs in the Office of the Assistant Secretary for Human Development.

These programs provide the basis for disease prevention and health promotion efforts in this country.

They are the building blocks used by State and local governments and community based voluntary agencies for provision of health services.

Cost containment for medical care is certainly an issue in these hearings, and the best method for holding down skyrocketing costs is to prevent disease.

If these health services programs are adequately funded, they can contribute to cost efficiencies coupled with present cost restraint proposals under consideration.

Although all of these programs deserve comment, there are a few I would like to emphasize.

The health revenue-sharing grants, which are also known as the 314(d) grants, are the basis for State and local public health programs. These grants are used to fund service programs for the general population as well as high-risk groups such as alcoholics, cancer victims, and patients suffering from heart disease.

These grants have remained at $90 million a year since 1966, and it has not increased, and that amount only represents 5 percent of the national commitment to public health.

Grants for programs to identify and treat hypertensive patients are also included in the health revenue-sharing authorization.

This program has been responsible for a 21-percent decline in the number of deaths attributed to hypertension, a 9.6-percent decline in the death rate due to stroke, and a 14-percent decline in the death rate due to hypertensive heart and kidney disease.

However, an estimated 30 percent of the population does have high blood pressure and is unaware of it. Since cost containment is an issue here, the best method of cutting costs is to prevent complications of hypertensive disease.

These formula grants in addition to State and local funds provide treatment to hypertensive patients who cannot afford the medical care they need.

Maternal and child health programs are funded through State grants as well as research and training grants. These State grants are pro-

grams whereby State and local agencies match Federal dollars and translate them into services.

Pregnancy outcome projects, crippled children's programs, and children and youth projects are funded from this program.

Care for children who are afflicted with lung and digestive diseases such as cystic fibrosis, reduction of infant mortality and teenage pregnancy rates are a few of the objectives of State grants programs.

An expanded program to meet the health care needs of mothers should be administered by this program. It appears that the authorization level for maternal and child health grants might substantially increase in fiscal year 1978.

The coalition may submit a revised recommended funding level for this program.

The newly authorized genetics program has not been included in either of the President's budgets. The Genetic Diseases Act authorizes funds to establish and operate voluntary genetic testing and counseling programs to disseminate information pertaining to sickle cell anemia, Cooley's anemia, Tay Sachs disease, cystic fibrosis, hemophilia, and muscular dystrophy. The program has not been funded as of this time, and is now in need of start-up funds.

Health maintenance organizations are another health service which has demonstrated cost savings. Recently enacted legislation has lifted restraints which will make it easier for HMO's to compete with traditional forms of indemnity health insurance. The HMO program supports development, evaluation and research on the experience of HMO's.

Community mental health and alcoholism programs are inadequately funded in the President's budget. Community mental health centers have been funded at the fiscal year 1977 level, but funds have been redistributed so there is no funding for planning development, new starts or facilities grants.

There are 35 applications still pending for 1976 for community mental health centers pending which were approved in fiscal year 1976 but have not yet been funded.

Conversion grants, which are used for centers which must modify their programs to meet requirements in the new law, are much less than adequately funded.

The alcoholism formula grants to States also need to be adequately funded. These funds support local alcoholism prevention and treatment programs. We also recommend funding for emergency treatment programs.

Rehabilitation services and developmental disabilities programs, administered through the Office of the Assistant Secretary for Human Development, provide additional health services.

The availability of comprehensive individualized rehabilitation services determines how much of a patient's normal life activities can be returned to the highest level of functioning.

For every dollar invested in rehabilitating a disabled person, it has been estimated that there is a return to Federal, State, and local treasuries in the form of increased taxes and decreased social service, medical, and public assistance payments. No telling the costs not included in the part where it helps a handicapped individual that is not now functioning.

What these cost benefit studies do not reflect is the dramatic impact of the program on the self-image of the handicapped individual who has been freed from dependency on public assistance and has been restored as a contributing and productive member of society.

It is estimated that in fiscal year 1976 the $720 million authorized and appropriated for basic State grants was used by State vocational rehabilitation agencies to serve nearly 1.8 million disabled individuals, of which 331,000 cases were closed as being rehabilitated.

Despite that expenditure, there still was not enough to serve all those persons who need rehabilitation and are eligible for services. A major thrust of the program is the rehabilitation of severely disabled persons.

Our request for rehabilitation services would allow the vocational rehabilitation program to focus greater resources toward these individuals without a reduction of services elsewhere.

More extensive research to serve this target group is needed to develop new medical techniques, new engineering and technological improvements, and better vocational training and placement. There is also a need for health professionals who are specifically trained to work in this area.

The health planning and resources development program has five components to the planning process. This national program for health planning was established in 1974, but this is the first year that all 200-plus health systems agencies and 56 State agencies will be fully operational.

Funding is essential to sustain this program which is designed to eliminate duplication and increase efficiency in provision of local health services.

Construction funds to modernize and refurbish public hospitals is also necessary to round out the planning process, and should only be spent when it is in keeping with plans established by local planning agencies.

The preventive health services maintained at the Center for Disease Control are essential to national preventive health efforts.

CDC's efforts in this area have been hampered by lack of adequate funds. The incidence of measles is 60 percent greater this year than last year and venereal diseases are still not under control.

Other preventive health programs that need adequate funding include rat control, lead paint poison prevention, disease investigation surveillance and control, laboratory improvement, health education and occupational health programs.

In other words, Mr. Chairman, simply, Mr. Chairman, adequate funding of these and other health promotion services mentioned in this testimony would supplement any of the proposed cost control proposals.

Ms. MULLANE. I will speak on the health education.

Funding for health education programs has been restrained for 2 years under a continuing resolution. With the passage of Public Law 94–484 last fall, new directions for health manpower training funds have been defined.

Since health professions schools have complied with directives for increased enrollments, and increased commitments to minority and low-income students, these institutions have demonstrated an attempt

to meet the public need for greater numbers of educated health professionals.

Now that the educational institutions have expanded, are relying on the Federal funding, and are producing adequate numbers of health professionals, the necessity for Federal support is stronger than ever. These institutions, like the remainder of the economy, have been affected by rising fuel costs and inflation.

Federal support must be a combination of capitation, student, and special project grants in order to successfully support the institutions.

Authorization levels in the past have been far in excess of the actual appropriation. The continuing resolution level has had a further limiting effect upon the schools. For the schools of medicine, osteopathy, and dentistry, the authorization level this year would provide the fiscal year 1975 level of funding adjusted for inflation.

The authorization level for the pharmacy schools will support approximately 80 percent of the enrolled students at 72 colleges of pharmacy.

The five colleges of podiatric medicine received an increase in the allocation per student under the new law, which demonstrates the special situation of the private freestanding nonprofit institutions.

Many schools of optometry are also private, and have been the victims of previously inadequate appropriations.

Fiscal year 1978 is the first year that schools of public health will participate in the capitation grants system. Since 1970 the schools have experienced an annual growth rate of 11.6 percent. The fiscal year 1978 authorization level would only allow a growth rate of about half that much. The accredited schools depend upon these funds for existence.

Student support through the student loan and national health service corps programs is again vital to the support of the schools.

The NHSC scholarships are available only to those professions which are maldistributed, including physicians, dentists, physicians' assistants, expanded function dental auxiliaries and nurse practitioners.

Since students of optometry, pharmacy and podiatry are not included, they are exclusively dependent upon loans for student support.

Training in primary care for allopathic and osteopathic physicians is one of the initiatives of the Carter budget with which the coalition concurs.

However, the support systems for residencies in primary care such as facilities development and undergraduate courses also need to be funded.

The general special projects funds have been separated in the past into two separate funds—one for medicine, osteopathy, and dentistry, and a second for veterinary medicine, optometry, pharmacy, and podiatry.

Provisions in the new law combine this authority into a single category, and therefore the amount available to any one profession is significantly reduced.

This is especially true for optometry, pharmacy, and podiatry because the general fund is the only special projects fund available to these disciplines. These funds have been used for curriculum development, interdisciplinary education, and projects to evaluate cost-saving proposals.

The newly authorized level of funding for allied health and public health traineeships is less than that of the previous continuing resolution.

Programs in allied health provide an opportunity for students from low-income families to become involved in health professions. Training programs which were formerly subsidized through this program will require increased tuition from their students if the President's recommendation were enacted.

Reduced funding levels in combination with changing requirements to obtain the funds will create hardships on the recipients of these programs.

For the first time, programs in health administration will receive specific funding, which acknowledges the need for more and better trained health administrators.

The new fund is designed to provide support for effective training programs, project grants which will improve programs, and traineeships to attract the level of talent required.

Nursing education funds are severely cut in the President's budget. The overwhelming cut of $100 million in the current level of support is strongly opposed by the coalition.

Since all funding for these titles has been eliminated, restoration of funds to support advanced training, traineeships, loans, capitation, and nursing research is urgent.

For example, advanced training funds have been used to support and expand the preparation of nursing specialists in all areas of clinical nursing and management of nursing services.

Senator BROOKE. It is my understanding the reason for the administration's budget cut in nurses training was because there are already sufficient nurses in the country.

Would you address yourself to that?

Ms. MULLANE. I would be glad to. We have addressed it in the booklet which has been presented and the testimony coming to your committee from several of the nursing organizations.

It is addressed in detail. I can take the time to enlarge upon it now and would be pleased to do so if you wish.

Senator BROOKE. If you have addressed it in detail I will read it and use it because it is my impression that we don't have sufficient nurses in this country.

Ms. MULLANE. You are quite right, sir.

Senator BROOKE. And nurses are doing more than they have ever done before. I think the doctors have been doing some things that they shouldn't be doing.

There are some areas where there are not enough doctors. It seems rather than cutting back we ought to be expanding nurse training.

Is that generally the case?

Ms. MULLANE. Absolutely correct. There is a thesis to support it. I would make one addendum to it, which has logic to commend it.

It is curious always that one finds the public in full understanding of the requirements for medicine, stemming from scientific advance and technology but somehow the general public and many people in the health profession fields themselves fail to understand that there is exactly the same impact and in exactly the same proportion in the nursing profession as the medical.

Senator BROOKE. Forgive me for interrupting.

Ms. MULLANE. We again bring to the committee's attention that there are requirements for construction that cannot be met from private funds.

Nursing's most urgent needs are detailed in the coalition's booklet submitted for the record.

Finally, there is a need to expand the understaffed and overworked Bureau of Health Manpower.

Mr. WELSCH. Senator, I will address myself to health research.

The Federal Government has undertaken to support the biomedical research system in this country. As the only entity capable of supporting so large an endeavor, the Federal Government has created and supported one of the most well respected research centers in the world at the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration.

However, because of inflation and the low rate of increased funding in recent years, the research capability has been in decline rather than continuing its original growth.

The Carter budget this year worsens the pattern of recent years, since it does not even allow for an increase to cover inflation over the fiscal year 1977 level.

Health, Education, and Welfare may seem to Federal budget authorities a bottomless pit. Unfortunately, there is no society with the resources to satisfy all human wants.

The question, therefore, is where to allocate the available resources: To those activities which will yield some return.

One activity which will yield substantial returns in the field of health is the acquisition of new knowledge through basic biomedial research.

Presently we are dedicating less than one-half of 1 percent (about $750 million if we combine basic research funded by NIH and NSF) of the $150 billion we spend on health care as a nation.

This is unbelievably shortsighted if we want to contain costs. Only new knowledge will allow us to prevent and cure those diseases which we now treat palliatively for lack of knowledge.

Therefore the coalition proposes a budget, which providing an increase approximately equal to inflation, will allow us to continue the acquisition of new knowledge at the level of previous years, thus maintaining the not-very-strong momentum in research and research training, be it at the basic level or clinical trial stage.

Clinical as well as basic research at the Alcohol, Drug Abuse and Mental Health Administration has been hampered by reduced funding.

As at NIH, a large number of approved projects remain unfunded. Recent research developments have brought scientists now unfunded by ADAMHA to a closer understanding of the causes of schizophrenia.

Schizophrenia, as you know, causes longer term disability and treatment problems than many other major disorders.

As a nation we have to address ourselves not only to the 1978 budget but a long-term policy regarding biomedical research. The necessary ingredients are:

1. To assign a certain percentage of our total health budget, projected to exceed $200 billion by 1980, to basic biomedial research.

2. To provide the Office of the Directors, NIH and ADAMHA with sufficient funds so that they can clearly establish the leadership role they are mandated to exert.

3. Provide all programs and categorical institutes budgets with budget increases which cover the inflationary increase.

4. Although some basic research is funded by each of the institutes, it is the primary responsibility of the NIH Institute for General Medical Sciences. NIGMS will require in the next few years a substantial increase in budget, like NCI received some years ago.

Moneys provided to NIGMS have a particularly good chance to end up providing us with new knowledge through basic research. As taxpayers we all have to realize that the prevention or cure of a given disease, be it cancer, mental illness or alcoholism, can only come after we have acquired enough knowledge of how the cells of our bodies work, and not before.

5. Do not promise the public rapid cures when we are not sure we can deliver. New knowledge cannot be mandated: it arrives when it does and frequently comes from unexpected sources.

Had we not had people like John Enders, in your State, Senator, interested in cell transformation and cancer, we might not have the Sabin and Salk vaccines against polio.

Many infectious diseases were all but wiped out when a mind, trained to observe, accidentally discovered penicillin.

6. Provide the authority for research training for fiscal year 1978. The coalition is recommending a total of $200 million for the support of training by NIH and ADAMHA.

7. Provide the Division of Research Resources with the funds required to continue the biomedical research support program this year and guarantee these funds for years to come.

Some $48 million may not seem very much within the NIH budget, but the biomedical research support grants are the only funds available to institutions to recruit and to fund pilot projects.

An institution without new blood or without new ideas is dying. A society which does not provide for new blood and new ideas is already dead.

In your State there is an institution, where I work—had it not been for these biomedical research support grants, the institutions would not have been revitalized and would not exist today.

We hope that this committee, Senator, will consider for fiscal year 1978 the recommendations of the Coalition for Health Funding: $48 million for biomedical research support grants, $200 million for training and the recommended budgets for the categorical institutes.

For the future our hope lies in continued funding for the categorical institutes, a substantial increase for GMS and for the continuation of the biomedical research support and training programs.

Thank you, Senator.

Senator BROOKE. Thank you.

I thank you all for your very excellent presentations.

I think the opportunity to have public witnesses testify is important to our whole hearing process.

I apologize for coming on a day when we are having meetings on the housing supplemental, which is also important.

Thank you very much.

PREPARED STATEMENTS

Your full statement will be included in the record. We certainly appreciate your coming.

I am sure it will be very helpful to the committee in their deliberations for the fiscal 1978 budget.

Also, we will include all other statements concerning health programs in the record at this time.

[The statements follow:]

## STATEMENT OF DR. JOHN F. SHERMAN, PRESIDENT, COALITION FOR HEALTH FUNDING

I am Dr. John Sherman, and I am here today representing the Coalition for Health Funding. With me are other Coalition representatives--Dr. Mary Mullane, of the American Association of Colleges of Nursing; Dr. Federico Welsch, of the Association of Independent Research Institutes; and Mr. Mike Gemmell, of the National Association of Counties. We appreciate having the opportunity to meet with you today to discuss our views on the FY1978 funding levels for discretionary health programs.

The Coalition for Health Funding is comprised of over fifty non-profit health related organizations which are interested in funding levels for health. The Coalition has annually made recommendations to Congress on funding levels for the past five years. The Coalition formulates its suggestions through a several month process which assesses funding needs and compromises the desired amounts of funding to create the complete proposal. The Coalition publication, entitled "Appropriation Recommendations for Federal Health Programs FY1978, An Alternative to the President's Proposal," presents our recommendations in detail and in addition contains information to justify those requests. I would like to submit a copy of our booklet for the record.

My colleagues will discuss in detail the areas of provision of health services, the education and training of health professionals, and the development of new knowledge upon which advances in the diagnosis and treatment of disease are dependent. Before they begin, however, I would like to make a few general comments.

There is probably no other aspect of our national life which is so sustained in concern and widespread in its extent as health. Indeed, only national defense--and that only in time of war--has as lasting and deep an impact on so many citizens as that of our personal physical and mental well-being. Even such headliners as gun control, educational policy and debates about the welfare system cannot compete in the overall sense with health. Repeatedly, public opinion polls confirm the fact that it remains for most people thus consulted the number one issue on the national scene. In the context of funding for health programs, some of the reasons for this attitude are worthy of note.

1. Good health is of vital importance to not only the physical and mental well-being of each of us, but it also determines to a significant degree our personal progress in the economic sense.

2. Because these attitudes are so widespread within the public, good health and access to each of the services which may assure it are now viewed as a

societal goal for all rather than for only the few who could personally afford to pay for those services.

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In addition to assessing two Presidential budgets this year, we have also attempted to project funding for programs whose authorities expire in FY1977. In the Coalition's document, we have marked those programs without FY1978 authorization levels. At the time when these expiring authorizations are final, we will reaffirm or amend our recommended funding level through a letter to the Subcommittee. The Coalition is now advocating a total of $9 billion for discretionary health programs which includes $8.04 billion for the Public Health Service and $960 million for developmental disabilities and rehabilitation services. The narrative material which is contained in the booklet is intended to explain and justify the funding requests. Since there is not adequate time to duscuss all of our recommendations in depth, I hope you and your colleagues will carefully review the discussions contained in the document submitted for the record.

Health Services

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These programs provide the basis for disease prevention and health promotion efforts in this country. They are the building blocks used by state and local governments and community based voluntary agencies for provision of health services. Cost containment for medical care is certainly an issue in these hearings, and the best method for holding down skyrocketing costs is to prevent disease. If these health services programs are adequately funded, they can contribute to cost efficiencies coupled with present cost restraint proposals under consideration. Although all of these programs deserve comment, there are a few I would like to emphasize.

The health revenue sharing grants, which are also known as the 314(d) grants, are the basis for state and local public health programs. These grants are used to fund service programs for the general population as well as high risk groups such as alcoholics, cancer victims, and patients suffering from heart disease. These grants have remained at $90 million a year since 1966 and that amount only represents five percent of the national commitment to public health.

Grants for programs to identify and treat hypertensive patients are also included in the health revenue sharing authorization. This program has been responsible for a 21% decline in the number of deaths attributed to hypertension, a 9.6% decline in the death rate due to stroke, and a 14% decline in the death rate due to hypertensive heart and kidney disease. However, an estimated 30% of the population does have high blood pressure and is unaware of it. Since cost containment is an issue here, the best method of cutting costs is to prevent complications of hypertensive disease. These formula grants in addition to state and local funds provide treatment to hypertensive patients who cannot afford the medical care they need.

Maternal and child health programs are funded through state grants as well as research and training grants. These state grants are programs whereby state and local agencies match federal dollars and translate them into services. Pregnancy outcome projects, crippled children's programs, and children and youth projects are funded from this program. Care for children who are afflicted with lung and digestive diseases such as cystic fibrosis, reduction of infant mortality and teenage pregnancy rates are a few of the objectives of state grants programs. An expanded program to meet the health care needs of mothers should be administered by this program. It appears that the authorization level for maternal and child health grants might substantially increase in FY1978. The Coalition may submit a revised recommended funding level for this program.

The newly authorized genetics program has not been included in either of the President's budgets. The Genetic Diseases Act authorizes funds to establish and operate voluntary genetic testing and counseling programs to disseminate information pertaining to sickle cell anemia, Cooley's anemia, Tay Sachs disease, cystic fibrosis, hemophilia, and muscular dystrophy. The program has not been funded as of this time, and is now in need of start-up funds.

Health Maintenance Organizations are another health service which has demonstrated cost savings. Recently enacted legislation has lifted restraints which will make it easier for HMOs to compete with traditional forms of indemnity health insurance. The HMO program supports development, evaluation and research on the experience of HMOs.

Community mental health and alcoholism programs are inadequately funded in the President's budget. Community mental health centers have been funded at the FY1977 level, but funds have been redistributed so there is no funding for planning development, new starts or facilities grants. There are 35 applications for community mental health centers pending which were approved in FY1976 but have not yet been funded. Conversion grants, which are used for centers which must modify their programs to meet requirements in the new law, are much less than adequately funded. The alcoholism formula grants to states also need to be adequately funded. These funds support local alcoholism prevention and treatment programs.

Rehabilitation services and developmental disabilities programs, administered through the office of the Assistant Secretary for Human Development, provide additional health services. The availability of comprehensive individualized rehabilitation services determines how much of a patient's normal life activities can be returned to the highest level of functioning.

For every dollar invested in rehabilitating a disabled person, it has been estimated that there is a return to Federal, state and local treasuries in the form of increased taxes and decreased social service, medical, and public assistance payments. What these cost benefit studies do not reflect is the dramatic impact of the program on the self-image of the handicapped individual who has been freed from dependency on public assistance and has been restored as a contributing and productive member of society.

It is estimated that in FY1976 the $720 million authorized and appropriated for basic state grants was used by state vocational rehabilitation agencies to serve nearly 1.8 million disabled individuals, of which 331,000 cases were closed as being rehabilitated. Despite that expenditure, there still was not enough to serve all those persons who need rehabilitation and are eligible for services. A

major thrust of the program is the rehabilitation of severely disabled persons. Our request for rehabilitation services would allow the vocational rehabilitation program to focus greater resources towards these individuals without a reduction of services elsewhere. More extensive research to serve this target group is needed to develop new medical techniques, new engineering and technological improvements, and better vocational training and placement. There is also a need for health professionals who are specifically trained to work in this area.

The health planning and resources development program has five components to the planning process. This national program for health planning was established in 1974, but this is the first year that all 213 health systems agencies and 56 state agencies will be fully operational. Funding is essential to sustain this program which is designed to eliminate duplication and increase efficiency in provision of local health services. Construction funds to modernize and refurbish public hospitals is also necessary to round out the planning process, and should only be spent when it is in keeping with plans established by local planning agencies.

The preventive health services maintained at the Center for Disease Control are essential to national preventive health efforts. CDC's efforts in this area have been hampered by lack of adequate funds. The incidence of measles is 60% greater than last year and venereal diseases are still not under control. Other preventive health programs that need adequate funding include rat control, lead paint poison prevention, disease investigation surveillance and control, laboratory improvement, health education and occupational health programs. Simply, Mr. Chairman, adequate funding of these and other health promotion services mentioned in this testimony would supplement any of the proposed cost control proposals.

Health Education

Funding for health education programs has been restrained for two years under a continuing resolution. With the passage of PL 94-484 last fall, new directions for health manpower training funds have been defined. Since health professions schools have complied with directives for increased enrollments, and increased commitments to minority and low income students, these institutions have demonstrated an attempt to meet the public need for greater numbers of educated health professionals. Now that the educational institutions have expanded, are relying on the federal funding, and are producing adequate numbers of health professionals, the necessity for federal support is stronger than ever. These institutions, like the remainder of the economy, have been affected by rising fuel costs and inflation.

Federal support must be a combination of capitation, student, and special project grants in order to successfully support the institutions. Authorization

levels in the past have been far in excess of the actual appropriation. The continuing resolution level has had a further limiting effect upon the schools. For the schools of medicine, osteopathy, and dentistry, the authorization level this year would provide the FY1975 level of funding adjusted for inflation for three years. The authorization level for the pharmacy schools will support approximately 80% of the enrolled students at 72 colleges of pharmacy. The five colleges of podiatric medicine received an increase in the allocation per student under the new law, which demonstrates the special situation of the private freestanding non-profit institutions. Many schools of optometry are also private, and have been the victims of inadequate appropriations.

FY1978 is the first year that schools of public health will participate in the capitation grants system. Since 1970 the schools have experienced an annual growth rate of 11.6%. The FY1978 authorization level would only allow a growth rate of about half that much. The accredited schools depend upon these funds for existence.

Student support through the Student Loan and National Health Service Corps programs is again vital to the support of the schools. The NHSC scholarships are available only to those professions which are maldistributed, including physicians, dentists, physicians' assistants, expanded function dental auxiliarites and nurse practitioners. Since students of optometry, pharmacy and podiatry are not included, they are exclusively dependent upon loans for student support.

Training in primary care for allopathic and osteopathic physicians is one of the initiatives of the Carter budget with which the Coalition concurs. However, the support systems for residencies in primary care such as facilities development and undergraduate courses also need to be funded. The general special projects funds have been separated in the past into two separate funds--one for medicine, osteopathy, and dentistry, and a second for veterinary medicine, optometry, pharmacy and podiatry. Provisions in the new law combine this authority into a single category, and therefore the amount available to any one profession is significantly reduced. This is especially true for optometry, pharmacy, and podiatry because the general fund is the only special projects fund available to these disciplines. These funds have been used for curriculum development, interdisciplinary education, and projects to evaluate cost savings proposals.

The newly authorized level of funding for Allied Health and Public Health traineeships is less than that of the previous continuing resolution. Programs in allied health provide an opportunity for students from low income families to become involved in health professions. Training programs which were formerly

subsidized through this program will require increased tuition from their students if the President's recommendation were enacted. Reduced funding levels in combination with changing requirements to obtain the funds will create hardships on the recipients of these programs.

For the first time, programs in health administration will receive specific funding, which acknowledges the need for more and better trained health administrators. The new fund is designed to provide support for effective training programs, project grants which will improve programs, and traineeships to attract the level of talent required. The multiplicity of statutes affecting planning, provision, and financing of health care have strained the management of our health care system. The education system needs to be developed quickly to respond to this need. For years, the Congress has appropriated funds to train health manpower at various levels and functional specialties, without coordinating their roles as practitioners within the system. This appropriation would provide support for training the individuals necessary to coordinate use of manpower and to manage health service delivery.

Nursing education funds are severely cut in the President's budget. The overwhelming cut of $100 million in the current level of support is strongly opposed by the Coalition. Since all funding for these titles has been eliminated, restoration of funds to support advanced training, traineeships, loans, capitation, and nursing research is urgent. Advanced training funds have been used to support and expand the preparation of nursing specialists in all areas of clinical nursing and management of nursing services. We again bring to the Committee's attention that there are requirements for construction that cannot be met from private funds. Nursing's most urgent needs are detailed in the Coalition's booklet submitted for the record.

Finally, there is a need to expand the understaffed and overworked Bureau of Health Manpower.

Health Research

The Federal government has undertaken to support the biomedical research system in this country. As the only entity capable of supporting so large an endeavor, the Federal government has created and supported one of the most well respected research centers in the world at the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. However, because of inflation and the low rate of increased funding in recent years, the research capability has been in decline rather than continuing its original growth. The Carter budget this year worsens the pattern of recent years since it does not even allow for an increase to cover inflation over the FY 1977 level. Health, Education and Welfare may seem to Federal

budget authorities a bottomless pit. Unfortunately, there is no society with the resources to satisfy all human wants. The question, therefore, is were to allocate the available resources: To those activities which will yield some return. One activity which will yield substantial returns in the field of health is the acquisition of new knowledge through basic biomedical research. Presently we are dedicating less than one-half of one percent (about 750 million if we combine basic research funded by NIH and NSF) of the 150 billion we spend on health care as a nation. This is unbelievably shortsighted if we want to contain costs. Only new knowledge will allow us to prevent and cure those diseases which we now treat palliatively for lack of knowledge.

Therefore the Coalition proposes a budget, which providing an increase approximately equal to inflation, will allow us to continue the acquisition of new knowledge at the level of previous years, thus maintaining the not very strong momentum in research and research training be it at the basic level or clinical trial stage.

Clinical as well as basic research at the Alcohol, Drug Abuse and Mental Health Administration has been hampered by reduced funding. As at NIH, a large number of approved projects remain unfunded. Recent research developments have brought scientists now unfunded by ADAMHA to a closer understanding of the causes of schizophrenia. Schizophrenia, you know, causes longer term disability and treatment problems than many other major disorders.

As a nation we have to develop a long term policy regarding biomedical research. The necessary ingredients are:

1) To assign a certain percentage of our total health budget, projected to exceed 200 billion by 1980, to basic biomedical research.
2) To provide the office of the Directors, NIH and ADAMHA with sufficient funds so that they can clearly establish the leadership role they are mandated to exert.
3) Provide all programs and categorical institutes with a budget which covers the inflationary increase.
4) Although some basic research is funded by each of the institutes, it is the primary responsibility of the NIH Institute for General Medical Sciences. NIGMS will require in the next few years a substantial increase in budget, like NCI received some years ago.

Moneys provided to NIGMS has a particularly good change to end up providing us with new knowledge through basic research. As taxpayers we all have to realize that the prevention or cure of a given disease, be it cancer, mental illness or alcoholism, can only come after we have acquired enough knowledge of how the cells of our bodies work, and not before.

5) Do not promise the public rapid cures when we are not sure we can deliver. New knowledge cannot be mandated, it arrives when it does and frequently comes from unexpected sources. Had we not had people like John Enders, interested in cell transformation and cancer, we might not have a Salk vaccine against polio. Many infectious diseases were all but wiped out when a mind trained to observe accidentally discovered penicillin.

6) Provide the authority for research training for FY 1978. The Federal Government has accepted responsibility for support of research training as part of its commitment to research support. The Coalition is recommending a total of $200 million for the support of training by NIH and ADAMHA.

7) Provide the Division of Research Resources with the funds required to continue the biomedical research support program this year and guarantee these funds for years to come. Some forty-eight million may not seem very much within the NIH budget, but the biomedical research support grants are the only funds available to institutions to recruit and to fund pilot projects. An institution without new blood or without new ideas is dying. A society which does not provide for new blood and new ideas is already dead.

We hope that this committee will consider for fiscal 1978 the recommendations of the Coalition for Health Funding: $48 million for biomedical research support, $2 million for training and the recommended budgets for the categorical institutes. For the future our hope lies in continued funding for the categorical institutes, a substantial increase for GMS and for the continuation of the biomedical research support and training programs.

Conclusion

We have attempted, in our discussion to supply background for our recommended funding levels. We realize there is a great difference between our level and those contained in the President's request. However, our estimates are based on a professional assessment by our members of what is needed to fund adequately these programs so as to be more responsive to public expectations.

## STATEMENT OF DR. JOSEPH WILBER, PRESIDENT, GEORGIA HEART ASSOCIATION

Mr. Chairman and Members of the Committee:

As one who runs one of the largest State high blood pressure programs in the country, it is a privilege for me to appear before the Committee which provided the first Federal monies to assist State health authorities in meeting the costs of establishing programs in the field of hypertension.

As your 1975 Appropriations Report noted:

> "The Committee has provided $7,500,000 for hypertension programs. This disease afflicts millions of people, and is the prime cause of stroke and heart attacks in this country. The Committee is very anxious to get this vital program implemented, and directs the HEW to develop the proper regulations for the expenditure of these funds within 60 days following the enactment of this bill. Because of overwhelming need to provide detection, education and treatment programs to those with hypertension, the Committee further directs that these regulations allow the program to target on populations of high need as well as the general population. Further, the Committee directs the Health Services Administration to work very closely with the National Heart and Lung Institute to ensure that there is absolutely no duplication and overlap of these very important research and health service hypertension programs."

I can report to this Committee today that these Congressional directives have been rigorously followed. For example, in February of this year the Health Services Administration and the National Heart, Lung and Blood Institute co-sponsored a two-day conference at which State and local health officers met to transmit information to one another on their programs. There was a clear understanding at that meeting that there had not been, nor would there be, any duplication of effort. The Heart Institute has the responsibility for research and research training in the field of hypertension. Our responsibility at the State and local level is to carry the fruits of the Institute's research to our people in terms of detection and treatment of high blood pressure. In April of this year, the Health Services Administration and the Heart Institute will co-sponsor a National Conference on High Blood Pressure Control here in Washington. Both Government agencies and many national and local voluntary organizations will also co-sponsor High Blood Pressure Month in May, 1977.

As your previous Committee Reports have noted, there are a minimum of 23 million Americans who have high blood pressure. This is a very serious

health problem, since medical officials at the Department of Health, Education and Welfare estimate that high blood pressure causes a minimum of 200,000 deaths a year because it is a major cause of strokes, heart attacks and kidney failure.

Since the inception of the high blood pressure program in 1972, we have made considerable progress in reducing the number of people who are unaware that they have this potentially deadly disease. At the present time, we have reduced this unawareness figure to approximately 30 percent. Among thse who are aware that they have this life-threatening disease, only 29 percent are under adequate therapy and control; 23 percent are aware but receiving no treatment whatsoever, and another 19 percent are aware but receiving inadequate therapy.

Over the past two years, despite the statistics mentioned above, we have made really remarkable progress. The National Center for Health Statistics recently reported that in these last two years the death rate from hypertension alone declined a massive 21 percent; the stroke death rate declined 9.6 percent, and the death rate from hypertensive heart and kidney disease declined 14 percent.

For the first time in over a decade, and despite an increasingly aging population, the number of deaths from all cardiovascular diseases has dropped below one million, with the largest drop in the 35 - 50 age category. This decline is continuing -- for example, 50,000 fewer citizens died in 1976 as compared to 1974 of cardiovascular disease. This decline of 50,000 deaths, as noted by Doctor Robert Levy, Director of the National Heart, Lung and Blood Institute, represents more lives saved than if we had eliminated all deaths from automobile accidents.

How have these accomplishments been achieved? First of all, because so many major national organizations have taken so much of their time and spent considerable sums of money to promote early detection and treatment of high blood pressure. Among the more prominent of these are the American Heart Association, the American Medical Association, the American Nurses Association, the National Kidney Foundation, the National Medical Association, the American Hospital Association, Citizens for the Treatment of High Blood Pressure, the American College of Cardiology and the American Osteopathic Association.

As you well know, Mr. Chairman, the 1975 Health Services Act (P. L. 94-63) authorized $15 million in Fiscal 1976 and $15 million in Fiscal 1977, empowering

the Secretary of Health, Education and Welfare to make grants to designated State health agencies for the purpose of establishing and maintaining programs for the screening, detection, diagnosis and control of high blood pressure. Due to a delay in appropriations in Fiscal 1976 because of an Administration veto of the Health Services Act, formula grants received only $3,750,000. Your own State of Washington, with an estimated 300,000 hypertensives, Mr. Chairman, received the "magnificent" sum of $53,000, which wouldn't even be enough to set up an adequate hypertension clinic in Seattle alone.

For Fiscal 1977, $9 million was appropriated -- a welcome increase, but far, far below the monies needed to launch effective State programs. At this point in time, I want to put at rest any myths about the States not making a strong effort to carry out their part of the financial burden. In 1974, then-Governor Carter recognized high blood pressure as a major public health problem, and he started the first ten hypertension treatment clinics for those who had no physicians and could not afford even the relatively inexpensive drugs which are so effective against high blood pressure. Persuading the Georgia State Legislature to appropriate $500,000 in 1974 was not easy, but it was done. The South Carolina and Mississippi Legislatures soon followed with appropriations for public health clinics to detect and treat high blood pressure, and a handful of additional States followed suit.

However, it was the impetus of the passage by the Congress of the 1975 Health Services Act which gave the necessary push to the States. Today all 50 States have begun high blood pressure programs, and for the first time we are seeing an increasing national recognition that this is a common public health problem where results can be seen in terms of reduced disability, deaths and health costs immediately if the majority of the people with high blood pressure can be detected, educated and treated. It would be a tremendous step backward not to increase the funds available to the States at this time when their programs are just getting under way.

We hear a lot these days about keeping health costs down, and properly so. The greatest cost constraint you can initiate is prevention of disease. The high blood pressure program I am talking about on behalf of my fellow State health officials is the first preventive program being launched against a major chronic

disease. It keeps people out of hospitals, because 99 percent of its victims can be treated on an ambulatory basis. For example, chronic kidney failure requiring kidney dialysis costs $20,000 a year for each patient hospitalized. In our experience in Georgia, we have found that anywhere from 25 - 50 percent of those suffering end-stage kidney failure could have been treated successfully if their high blood pressure had been detected and treated earlier. I could use the same arguments in the case of stroke. High blood pressure is the major cause of strokes, and we all know that the total cost of hospitalizing a stroke victim is staggering.

What are the costs of treating hypertension?

The initial cost of detecting a hypertensive is fifty cents. The yearly cost of continuing treatment of the hypertensive averages $200, according to the National Center for Health Statistics. This sum includes laboratory costs, a minimum of three physician visits a year and the cost of medication. In other words, the total cost per patient comes to about fifty cents a day.

State and county health officials are enthusiastic about this high blood pressure program. In February of this year, they came to Washington for the specific purpose of comparing programs, costs and objectives.

In April we will hold a Third National Conference on High Blood Pressure Control. The theme of this Conference will be "long-term maintenance of therapy." We have chosen this theme because we are still getting a high dropout rate among those who have been initially detected as being hypertensives. I know the reason for this in my State of Georgia. Because, although a majority of our citizens have a private physician and can pay the cost of medications, there is a significantly large minority who do not have a private doctor and who cannot afford to pay for these drugs, no matter how inexpensive they are.

That is why we need these formula grants under 314(d). We had hoped that we would achieve considerably more than the $15 million a year authorized both in Fiscal 1976 and Fiscal 1977, but we are realists, so we ask you simply to appropriate the small sum of $15 million, so that we can bring additional States and counties who have financial problems into what will one day be a powerful national program.

In return, we expect a reasonable amount of help from our national government in conquering this staggering health problem.

APR 18 1977

THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES
SUITE 828 - 1522 "K" STREET, N.W. - WASHINGTON, D.C. 20005

April 15, 1977

The Honorable Warren G. Magnuson
127 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Senator Magnuson:

The enclosed statement has been provided for the record of hearings, and we wish to take this means of bringing it to your personal attention. The schools and colleges of veterinary medicine are serving as regional and national resources in the education of veterinarians. Capitation grant funds have permitted these institutions to expand enrollments and improve educational quality.

The deans of the schools and colleges of veterinary medicine urge you to favorably consider appropriation of the amount authorized by PL 94-484.

Sincerely,

WM Decker

W. M. Decker, D.V.M.
Washington Representative

## STATEMENT OF THE ASSOCIATION OF AMERICAN VERTINARY MEDICAL COLLEGES

Capitation Funding for Colleges of Veterinary Medicine in FY 1978

The Council of Deans of the Association of American Veterinary Medical Colleges appreciates this opportunity to comment on the continuing need for federal financial support of veterinary medical educational institutions.

There are now 21 schools and colleges of veterinary medicine with the 22nd college expected to enroll its first class of students next fall. These colleges are supported primarily by the 21 states in which they are located, yet they are national resources which provide educational opportunities for students, and veterinary manpower, for all the states. The federal capitation grant program has been most beneficial to residents of those states without veterinary colleges, because of the increased opportunities for education offered the students of those states.

In 1970, there were 18 colleges of veterinary medicine with a total enrollment of 5,006 students. In academic year 1976-77, the 21 colleges had a total enrollment of 6,571. This increase of 31 percent in 6 years should be attributed at least in part to the federal support provided through capitation and construction grants. The enclosed table shows the geographic distribution of the entering class of veterinary medical students in the 1976-77 academic year. It indicates that the colleges still give major preference to students from the states in which the school is located; however, students from every state in the nation are being admitted.

The President's budget for FY 1978 provides nothing for capitation grants for colleges of veterinary medicine. This is a serious error. While capitation grants have amounted to less than 10 percent of the cost of students' education, they have encouraged increased enrollment and acceptance of students from states that don't have colleges of veterinary medicine.

P.L. 94-484 in title III Section 301 (42 USC 293a) clearly indicates the intent to encourage regional programs in health professions education. The colleges of veterinary medicine are making progress in this direction and in offering greater opportunities for students from the states without veterinary medical colleges.

Veterinary medical education is basically as expensive as medical education, but options for funding it are much more limited. Veterinary medical teaching hospitals can rarely be self-supporting, and no third party payment system exists to assure payment for patient care and a means of supporting a house staff. Public funds are the major source of support of veterinary medical colleges.

Failure to provide for federal sharing through capitation grants would discourage progress which has been made in the past 6 years in offering greater opportunities for veterinary medical education. P.L. 94-484 authorizes capitation grants of $1450 per student. At this level the federal government would support about 10 percent of the cost of education for veterinary medical students. This is the minimum level of federal support which will continue to assure acceptance of students on a regional basis. Without this assistance state legislatures may be tempted to restrict enrollment in these expensive programs to residents of the state supporting the program. There is a strong probability that several state legislatures would order reductions in enrollment to compensate for the loss of federal financial support.

This would be a major step backward and a loss of opportunities for many students who have no other hope for a veterinary medical education.

We encourage your consideration of appropriating at a level that would provide the full authorized funding for capitation grants of $1450 per student and by doing so provide the maximum possible educational opportunities for veterinary medical students. The appropriation of $10,000,000 would provide approximately $1450 per student for the anticipated enrollment in the year ending September 30, 1978.

RECESS

Senator BROOKE. The subcommittee will stand in short recess.
[A brief recess was taken.]

PREPARED STATEMENTS

Senator BROOKE. The subcommittee will come to order.

And at this time, without objection, we will put all statements in the record for those who are here and wish to have their statement entered into the record or for those who could not be here and wish their statements entered in the record.

Because the hour is late, we will proceed with as many of you as we possibly can.

As I told you, unfortunately, due to a schedule conflict, we are having a supplemental conference. It is indeed unfortunate and regrettable, but I assure all witnesses that their statements will be given due consideration.

If there are any who wish at this time to place their statements in the record, without objection it will be done.

[The statements follow:]

## STATEMENT OF JANICE ROBINSON, RN, M.S., PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.

I am Janice Robinson, President of the National Association of Community Health Centers and Executive Director of the Neighborhood Health Services Program of St. Luke's Hospital Center, a Community Health Center in New York City serving in excess of 20,000 patients. Our National organization represents both Community and Migrant Health programs throughout the United States. As my colleague will address specific issues on Migrant Health, I shall focus on Community Health Centers.

First, I want to thank you Mr. Chairman, and the Members of this Subcommittee for their support of the Community and Migrant Health Center programs. These programs have proven their effectiveness and can be termed successful by any standard. I am here today to highlight those successes and ask for your continued support.

During the past several years, Community Health Centers (CHCs) have proven to be a singularly effective model for the provision of quality health services for the unserved and underserved throughout the country. Fiscal years 1976 and 1977 have seen a continuation of the management progress which has impressed even skeptics. The attached chart compares our progress from 1975 through fiscal 1978 (estimates based upon revised 1978 budget). Comparing FY-75 to FY-76, the number of persons served by CHCs increased from 1.4 million to 2.5 million, an increase of over 1 million patients - or 78%. The estimate for FY-77 is over 3 million - an additional increase of 31%. These significant increases - a reflection of national economic distress and need - did not retard further advancements in providing maximally cost-effective services:

1. The number of encounters (FY-75 to FY-76) increased from 6.6 million to 10 million, an increase of 52%. In FY-77, the number is expected to reach 11.7 million--an additional 17%.

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2. Cost per encounter, calculated in grant funds decreased from $30 to $20, a decrease of 33%. In FY-77, it is expected to reach $18 -- an additional 10%.

3. Annualized total cost per person served decreased from $204 to $129, a decrease of $75 or 36%. This $129 per capita cost for Community Health Center patients compares to data in the 1974 statistical abstract of the United States which indicated a per capita cost of $214 for comparable services as a national average.

4. Third-party receipts, which have increased because of improved billing and collection procedures and other management practices, rose from $62 million to $93.7 million or 51%. The increase as a percent of total operating costs rose from 22% in 75 to 29% in 76. Again, we expect to improve in 1977.

These data are particularly significant when compared to increases in the national inflation rate for health care during the same periods. Community Health Centers are clearly cost effective.

Statistics also indicate significant results in the improvement of health status for those served. DHEW's own data indicates that Community Health Center clients have a 34% lower rate of hospitalization than the overall national average. Translated into dollars, CHCs save over $178 million by reducing hospitalization in areas they serve.

University-based studies have confirmed the positive impact of CHC services. Chabot found a 28% decrease in infant mortality in areas of Denver, Colorado served by Community Health Centers. Gordis found a 60% reduction in hospitalization for rheumatic fever in areas of Baltimore, Maryland served by CHCs over a ten-year period. Klein documented a 50% reduction in hospital days for children in Rochester, New York served by Community Health Centers.

Dr. Mildred Morehead indicated a higher quality of care ratings than the 10 medical school affiliated hospital departments and 7 group practices sampled.

JUSTIFICATION

In analyzing the revised budget request, three elements should be considered:

- Amounts required to maintain current services and on-going centers;
- The budget proposal of $14 million, part of the strategy for alternatives to abortion; and
- Amounts to be made available for new centers.

Amounts required to maintain current services and on-going centers

Using data supplied by the Congressional Budget Office to determine in a realistic manner the amount required to maintain current services, the increase at which we have arrived from FY-77 to FY-78 is based upon (1)a GNP deflator factor of 5.2% applied to administrative costs (at 23% of total operating costs), and (2)the CBO medical care price index of 7.1% applied to direct or indirect medical care costs (about 77% of total operating costs). Based upon a sampling review of several centers, experience shows that costs have increased steadily from 8-12%. The Department has recently testified that the rate of inflation is in the area of 11%. We are asking for only 6.7% - or an additional $14.4 million to maintain current services. The minimum necessary to continue current services through FY-78 is $229,500,000.

I would point out, however, this calculation does not take into consideration large increases in utilization which have been experienced with consistency during the past few years. Two major causes have been (1)the large numbers of unemployed in the highest of unemployed areas--the inner city, often those who lack third-party coverage, and (2)greater numbers of people, both city dwellers and agricultural workers and their families, with inadequate incomes to afford health care if it were available or inadequate insurance coverage by employers. In both cases, these groups are defined as medically indigent, and in many cases can only rely upon the local health center for decent health care.

With respect to 3rd-party receipts, the budget projects an increase of $23.6 million for FY-78. This projection is questionable because it does not take into account proposed reductions in state Medicaid programs. As much as 85% of all CHC 3rd-party receipts are from Medicaid. New York, for example, has recently proposed a 10% across-the-board reduction in their reimbursement rates in addition to a $.50 charge for prescription drugs, elimination of some services, and a cap on its reimburseable level for out-patient care. This alone would reduce DHEWs FY-79 projection by $2.5 million to $3 million. While health centers are proud of their achievements in maximizing 3rd-party receipts, the fact remains--state budgets are strained and Medicaid appears to be a prime target. A recent survey by the National Governor's Conference notes that some 18 States are contemplating reduction in their Medicaid programs.

Moreover, a total increase in 3rd-party receipts does not clearly reflect the fact that in most States, Medicare and Medicaid do not either fully reimburse for the cost of services nor cover all necessary services. For example, the financial records of a center in Minneapolis show that on the average, the center loses $19 per visit for its Medicaid patients. So although the center may collect more dollars by treating more Title XIX eligibles, it still operates at a deficit, which must be supported by other means. Further, by law, a center must provide a range of services to all individuals in its target area, regardless of ability to pay or 3rd-party coverage.

The budget proposal of $14 million, part of the strategy for alternatives to abortion

With regard to the Department's program for alternatives to abortion, we are pleased to see the budget has targeted $14 million to go to CHCs. However, I would caution, that if approved, these funds would be used to support a specific program and population. Funds could not be used for services to the general population or to offset increased costs, and therefore, should not be considered an increase in support to the program per se.

Amounts to be made available for new centers

With respect to new starts, the revised budget projects funding 90 new centers -- at no additional cost. This is absurd. If additional sums are not made available, the only way services can be expanded to new areas is by reducing services in existing areas. I contend strongly this would be a mistake. To do so would reduce the effect of those programs and services which are characteristics of the Community Health Center program and have led to its success, i.e. keeping people well through prevention and continuity of care and therefore, avoiding more costly institutional care.

Finally, I would call to your attention the fact there are still some 44,900,000 people who are having a shortage of personal health services, according to DHEW. Currently, the Community Health Center program provides services to 4,154,000 persons. Although we have penetrated into this area, we still are serving only 9.03% of the underserved population. These figures are clear, a lot more needs to be done. Our recommendation of $258 million would provide $14.4 million for new programs. This amount would be sufficient to fund at least 90 new centers and provide high-quality care to thousands of additional needy American families.

Mr. Chairman, with your support, I feel we have demonstrated both the effectiveness and viability of Community and Migrant Health Centers. At a time when we all are concerned with the question of "COST", our programs have done something about it.

Accordingly, I urge you to support as the level of appropriation for fiscal 1978 the following:

Community Health Centers - $258,000,000

Migrant Health Centers - $ 44,000,000

CHART I COMMUNITY HEALTH CENTERS

| Category | Data | | | |
|---|---|---|---|---|
| | FY 75 ACT. | FY 76 ACT. | FY 77 EST. | FY 78 EST. |
| Total Projects | 204 | 302 | 422 | 512 |
| Budget Authority (in millions) (rounded) | $ 196.7 | $ 196.7 | $ 215.1 | $ 229.1 |
| Number of Persons Served | 1,425.000 | 2,539,160 | 3,328,000 | 4,154,000 |
| Number of Encounters | 6,555,000 | 9,984,304 | 11,727,200 | 16,509,400 |
| Annualized Total/ Cost Per Person Served | $ 204 | $ 129 | $ 112 | $ 104 |
| All Grant Funds/ Cost Per Person Served | $ 138 | $ 75 | $ 65 | $ 55 |
| All Grant Funds/ Cost Per Encounter | $ 30 | $ 20 | $ 18 | $ 14 |
| 3rd Party Receipts (in millions) (rounded) | $ 62 | $ 93.7 | $ 114.5 | $ 156.4 |
| 3rd Party Receipts as % of Total Operating | 22% | 29% | 31% | 36% |
| Primary Physician Encounter (Per Hr.) | 2.5 | 2.7 | 2.9 | 3.0 |

## Statement of Ventura Huerta, Executive Director, Federacion Rural de Salud de California

Mr. Chairman:

My name is Ventura Huerta, Executive Director of the Federacion Rural De Salud De California, an organization which represents community and migrant health centers in California. Accompanying me is Edwardo Espinosa our Board Chairman. Mr. Espinosa also is Secretary of the National Association of Community Health Centers and Board Chairman of the Family Health Center, a Migrant Health Center serving in excess of 28,000 patients in Orange Cove, California. As a first order of business, I wish to express my appreciation for having been given the opportunity to speak to you on behalf of farmworkers as you consider appropriations to continue the work of our centers, which for thousands of Americans are the only source of accessible health care.

For the past two years, those appearing before you have painted a bleak picture of the Campesinos' health status, given the fact that Migrant Health Centers reach only 10% of the eligible population, and less than 5% qualify for coverage under Titles 18 and 19. My purpose today is to bring you some good news, for a change.

During the past two years, with little more than a 25% increase in appropriations, and greater management efficiency, Migrant Health Centers have extended their services to 35% more patients, and have increased their productivity by better than 50%.[1] They have managed to reduce the overall cost per patient visit by 20%,[2] and have increased third-party revenues to equal 8%[3] of their total operating income. (The attached chart shows the progress we have made in recent years). Surely, you will agree that this is an outstanding record of achievement by the Migrant Health Centers, and that it clearly reflects the commitment to maximum efficiency on the part of the centers' management staff and Board Members.

There is, however, a continued sordid side to this issue, one which continues to affect the centers and the communities they serve. The Migrant Health program is now reaching only 15% of the eligible population.[4] Worse, less than one-tenth of one percent are served by the hospitalization program.

As you are aware, Mr. Chairman, it is difficult for Migrants to qualify for third-party programs because of state residency requirements. Moreover, there have been no legislative proposals to expand coverage for these people. Accordingly, more than 80% of the population which this program is intended to serve are presently without access to decent health services.

Thus, we again find ourselves approaching you with our collective hand extended, asking for "more"; and, while we are conscious of the difficult economic situation confronting this nation and the Congress, we cannot in good conscience continue to quietly tolerate incidents such as the recent indictment of two women on separate charges of negligent homicide--for having abandoned their newborn infants in drainage ditches, where both helpless creatures died. If it is true, as the women said that they had so acted not because the children were unwanted, but because they could not afford to care for the infants, both of whom were sick and in need of considerable medical attention, then our society must accept the role of "unindicted co-conspirator" for having allowed these incidents to occur.

At the present time, HEW's figures indicate that there are 2,700,000 members of migrant and seasonal farmworker families in the nation.[5] If one accepts the fact that the Migrant Health Centers are rendering adequate health care to their patients at an annual cost of $94 each--about 15% of the average national per capita health expenditure--then the program would require some $255 million in order to provide sufficient outpatient care to all qualifying individuals. Assuming that as much as 20% of this cost were to be met with other resources--a figure which may, in fact, be unreasonably high--we are nevertheless left with a required investment of some $204

million. Further, inpatient care needs would require an additional $217 million.[6]

There is another matter which, I believe, merits the attention of the Subcommittee: during FY-77, some $4.5 million--an amount roughly equivalent to the entire increase you voted for Migrant Health Centers--has been conscripted for use in the Administration's rural health strategy. While I do not deny the need for developing services in presently unserved or underserved rural (and urban) areas, I must, in conscience, register my protest against the use of funds intended to serve farmworkers for that purpose. I argue this point for several reasons:

- as a result of the Administration's action, existing Migrant Health Centers are faced with the prospect of continuing to function at existing or reduced funding levels, or of seeking funds under the rural health initiative strategy--which in turn requires an extension of services to a general rural population, in many instances, at the expense of serving farmworkers.
- migrant and seasonal farmworkers live and work in rural areas, it is true; but existing Migrant Health Centers have developed as much because of the failure of rural health systems to relate to the special needs of campesinos because of an insufficiency of medical manpower in those areas where migrants spend but a small part of the year will do little to accomplish the intent of this legislation.
- given the limited funding available for developmental rural health projects, and the Administration's system of measuring efficiency among such projects, it has become increasingly difficult for the projects to offer non-medical support services, such as outreach, transportation, health education, social services--services which are vitally necessary in serving farmworkers, and which have set migrant and community health centers apart from common medical care systems.

- numerous existing Migrant Health Centers face obliteration as a result of the focus on underserved areas. Consider if you will, the case of a project located in a midwest farming area which serves 2 or 3 counties, none of which are "medically underserved," and none of which meet the "high impact" requirement of PL 94-63. Yet, for several months each year, thousands of migrants enter the area to work in the crop harvest. I submit then, several on-going migrant health centers find themselves in such a predicament.

Should the Congress feel it appropriate to foster the development of health systems in rural and urban underserved areas, then I would suggest that such an effort be granted legislative authority. In the interim, we ask simply that such an effort not be undertaken at the expense of the already-downtrodden farmworker.

In sum, migrant health centers have, over the past two years made great strides toward providing more and better service to farmworkers, and have proven their worth as an integral component of this country's health delivery system. We are still, however, far short of meeting the existing need; to accomplish this formidable task, we ask you to reaffirm the Congressional commitment toward that end and to provide us with the necessary tools for the job. We ask for an appropriation of not less than $44 million for FY-78.

On behalf of the campesinos we serve, please accept my sincere gratitude for your demonstrated concern for these issues, y, que el dios les bendiga.

FOOTNOTES

[1]Justification of Appropriation Estimate for Committee on Appropriations, FY-78, Volume I, p.41.

[2]Ibid, pg.41, compared with the President's FY-77 Budget Request, p.34.

[3]Ibid, p.42

[4]Ibid, p.41

[5]Ibid, p.41

[6]Arrived at using the following formula:

| | |
|---|---|
| No. Migrants/seasonal farmworkers | 2,714,000 |
| National rate of hospitalization (%) | x.08 |
| No. of farmworkers needing hospitalization | 217,120 |
| 1977 Estimated cost/admission | x1,000 |
| Total cost for hospital services | $217,120,000 |

## MIGRANT HEALTH CENTERS

Data

| Category | FY 75 ACT. | FY 76 ACT. | FY 77 EST. | FY 78 EST |
|---|---|---|---|---|
| Total Projects | 105 | 97 | 125 | 125 |
| Budget Authority (in millions) | $ 19.2 | $ 25 | $ 30 | $ 30 |
| Number of Persons Served | 390.000 | 400.000 | 499.000 | 499.000 |
| Potential Eligible Population | 3,000,000 | 2,714.000 | 2,700.000 | 2,700.000 |
| Migrants | | 714.000 | 700.000 | 700.000 |
| Seasonals | | 2,000.000 | 2,000.000 | 2,000.000 |
| Number of Encounters | 640.000 | 800.000 | 998.000 | 998.000 |
| Annualized Total/ Cost Per Person Served | $100 | $ 98 | $ 94 | $ 94 |
| All Grant Funds/ Cost Per Person Served | $ 61 | $ 53 | $ 53 | $ 53 |
| Annualized Total/ Cost Per Encounter | | $ 49 | $ 47 | $ 47 |
| All Grant Funds/ Cost Per Encounter | $ 37 | $ 31 | $ 30 | $ 30 |
| 3rd Party Receipts | | $3,120.000 | $3,800.000 | $3,800.000 |
| 3rd Party Receipts as % of Total Operating | | 8% | 8% | 8% |
| Hospitalization Program | | | | |
| Cost | $2,256.000 | $2,500.000 | $3,000.000 | $3,000.000 |
| Persons Served | 3,040 | 3,125 | 3,333 | 3,000 |
| Cost Per Stay | $ 742 | $ 800 | $ 900 | $1,000 |

**STATEMENT OF JANICE ROBINSON, PRESIDENT, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS AND EXECUTIVE DIRECTOR, NEIGHBORHOOD HEALTH SERVICES PROGRAM, ST. LUKE'S HOSPITAL CENTER**

**ACCOMPANIED BY:**

**VENTUREA HUERTA, EXECUTIVE DIRECTOR, FEDERACION RURAL DE SALUD DE CALIFORNIA**
**EDWARD ESPINOSA, BOARD CHAIRMAN**
**MR. THOMAS**

INTRODUCTION OF ASSOCIATES

Senator BROOKE. Our next group of witnesses will discuss both the migrant and community health programs.

If you would introduce yourselves, you may proceed.

Ms. ROBINSON. Good afternoon, Senator.

First, I would like to extend my thanks for entertaining our concerns this afternoon. I would like to introduce my colleagues to my right, Senor Huerta, Mr. Espinosa, and Mr. Thomas.

I am president of the National Association of Community Health Centers and executive director of the Neighborhood Health Services Program of St. Luke's Hospital Center, a community health center in New York City serving in excess of 20,000 patients.

Our national organization represents both community and migrant health programs throughout the United States. As my colleague will address specific issues on migrant health, I shall focus on community health centers.

During the past several years, community health centers—CHC's—have proven to be a singularly effective model for the provision of quality health services for the unserved and underserved throughout the country.

Fiscal years 1976 and 1977 have seen a continuation of the management progress which has impressed even skeptics. The attached chart—and there is an attached chart in my testimony—compares our progress from 1975 through fiscal 1978—estimates based upon revised 1978 budget.

Comparing fiscal year 1975 to fiscal year 1976, the number of persons served by CHCs increased from 1.4 million to 2.5 million, an increase of over 1 million patients, or 78 percent.

The estimate for fiscal year 1977 is over 3 million, an additional increase of 31 percent.

These significant increases, a reflection of national economic distress and need, did not retard further advancements in providing maximally cost-effective services:

The number of encounters—fiscal year 1975 to fiscal year 1976—increased 52 percent. In fiscal year 1977, the number is expected to reach 11.7 million, an additional 17 percent.

Cost per encounter, calculated in grant funds, decreased from $30 to $20, a decrease of 33 percent. In fiscal year 1977, it is expected to reach $18, an additional 10 percent reduction.

Annualized total cost per person served decreased from $204 to $129, a decrease of $75 or 36 percent. This $129 per capita cost for community health center patients compares to data in the 1974 statistical abstract of the United States which indicated a per capita cost of $214 for comparable services as a national average.

Third-party receipts, which have increased because of improved billing and collection procedures and other management practices, rose from $62 million to $93.7 million or 51 percent. The increase as a percent of total operating costs rose from 22 percent in 1975 to 29 percent in 1976. Again, we expect to improve in 1977.

These data are particularly significant when compared to increases in the national inflation rate for health care during the same periods. Community health centers are clearly cost-effective.

Statistics also indicate significant results in the improvement of health status for those served. DHEW's own data indicates that community health center clients have a 34 percent lower rate of hospitalization than the overall national average. Translated into dollars, CHCs save over $178 million by reducing hospitalization in areas they serve.

University-based studies have confirmed the positive impact of CHC services. Chabot found a 28 percent decrease in infant mortality in areas of Denver, Colorado served by community health centers. Gordis found a 60 percent reduction in hospitalization for rheumatic fever in areas of Baltimore, Maryland served by CHCs over a 10-year period.

Klein documented a 50 percent reduction in hospital days for children in Rochester, New York served by community health centers. Dr. Mildred Morehead indicated a higher quality of care ratings than the 10 medical school affiliated hospital departments and seven group practices sampled.

In analyzing the revised budget request, three elements should be considered:

Amounts required to maintain current services and ongoing centers;

The budget proposal of $14 million, part of the strategy for alternatives to abortion; and

Amounts to be made available for new centers.

Using data supplied by the Congressional Budget Office to determine in a realistic manner the amount required to maintain current services, the increase at which we have arrived from fiscal year 1977 to fiscal year 1978 is based upon (1) a GNP deflator factor of 5.2 percent applied to administrative costs (at 23 percent of total operating costs), and (2) the CBO medical care price index of 7.1 percent applied to direct or indirect medical care costs (about 77 percent of total operating costs).

Based upon a sampling review of several centers, experience shows that costs have increased steadily from 8–12 percent. The Department has recently testified that the rate of inflation is in the area of 11 percent. We are asking for only 6.7 percent, or an additional $14.4 million to maintain current services.

The minimum necessary to continue current services through fiscal year 1978 is $229,500,000.

I would point out, however, this calculation does not take into consideration large increases in utilization which have been ex-

perienced with consistency during the past few years. Two major causes have been (1) the large numbers of unemployed in the highest of unemployed areas, the inner city, often those who lack third-party coverage, and (2) greater numbers of people, both city dwellers and agricultural workers and their families, with inadequate incomes to afford health care if it were available or inadequate insurance coverage by employers.

In both cases, these groups are defined as medically indigent, and in many cases can only rely upon the Federal health center for decent health care.

With respect to third-party receipts, the budget projects an increase of $23.6 million for fiscal year 1978. This projection is questionable because it does not take into account proposed reductions in State medicaid programs. As much as 85 percent of all CHC third-party receipts are from medicaid.

New York, for example, has recently proposed a 10 percent across-the-board reduction in their reimbursement rates in addition to a 50-cent charge for prescription drugs, elimination of some services, and a cap on its reimbursable level for out-patient care.

That cap, by the way, was approved by the New York State Legislature.

This alone would reduce DHEW's fiscal year 1979 projection by $2.5 million to $3 million.

While health centers are proud of their achievements in maximizing third-party receipts, the fact remains that State budgets are strained and medicaid appears to be a prime target. A recent survey by the National Governor's Conference notes that some 18 States are contemplating reduction in their medicaid programs.

Moreover, a total increase in third-party receipts does not clearly reflect the fact that in most States, medicare and medicaid do not either fully reimburse for the cost of services nor cover all necessary services.

For example, the financial records of a center in Minneapolis show that on the average, the center loses $19 per visit for its medicaid patients. So although the center may collect more dollars by treating more title XIX eligibles, it still operates at a deficit which must be supported by other means.

Further, by law, a center must provide a range of services to all individuals in its target area, regardless of ability to pay or third-party coverage.

With regard to the Department's program for alternatives to abortion, we are pleased to see the budget has targeted $14 million to go to CHC's. However, I would caution that if approved, these funds would be used to support a specific program and population.

These funds could not be used for services to the general population or to offset increased costs and, therefore, should not be considered an increase in support to the program per se.

With respect to new starts, the revised budget projects funding 90 new centers at no additional cost. This is frankly absurd.

If additional sums are not made available, the only way services can be expanded to new areas is by reducing services in existing areas. I contend strongly this would be a mistake. To do so would reduce the effect of those programs and services which are charac-

teristics of the community health center program and have led to its success, for example, keeping people well through prevention and continuity of care and, therefore, avoiding more costly institutional care.

Finally, I would call to your attention the fact there are still some 44,900,000 people who are having a shortage of personal health services, according to DHEW. Currently, the community health center program provides services to 4,154,000 persons.

Although we have penetrated into this area, we still are serving only 9.03 percent of the underserved population. These figures are clear. A lot more needs to be done.

Our recommendation of $258 million would provide $14.4 million for new programs. This amount would be sufficient to fund at least 90 new centers and provide high-quality care to thousands of additional needy American families.

Mr. Chairman, with your support, I feel we have demonstrated both the effectiveness and viability of community and migrant health centers. At a time when we are all concerned with the question of "Cost," our programs have done something about it.

Accordingly, I urge you to support as the level of appropriation for fiscal 1978 the following:

Community health centers, $258 million; migrant health centers, $44 million.

Senator BROOKE. Ms. Robinson, the last time you testified before our committee, I think it was just at the time of the New York financial crisis. I remember well your concern about what impact this would have on a number of health centers.

Ms. ROBINSON. We were able to prevent the State legislature from approving the proposed cuts at that time, therefore, no center had to close because the amounts of reductions being produced were never carried through.

We were faced with the similar situation a week ago in New York State. We were able to prevent the more devastating aspects to the cuts. There were some made.

At this time, we don't project any program closing but there will be a reduction in dollars for a number of programs, basically because of the cap of the amount of dollars you can be reimbursed on for outpatient services.

The total dollar figure in terms of loss of income we can't tell you. We are working up the statistics currently.

Senator BROOKE. Are you still serving as the executive director of St. Luke's in addition to this?

Ms. ROBINSON. Yes.

Senator BROOKE. But the situation is not as beleaguered as it was in 1976.

Ms. ROBINSON. No, sir.

Senator BROOKE. Thank you.

## STATEMENT OF VENTURA HUERTA

Mr. HUERTA. Mr. Chairman, my name is Ventura Huerta, executive director of the Federacion Rural De Salud De California, an organization which represents community and migrant health centers in

California. Accompanying me is Edwardo Espinosa our board chairman. Mr. Espinosa also is secretary of the National Association of Community Health Centers and board chairman of the Family Health Center, a migrant health center serving in excess of 28,000 patients in Orange Cove, Calif.

As a first order of business, I wish to express my appreciation for having been given the opportunity to speak to you on behalf of farmworkers as you consider appropriations to continue the work of our centers, which for thousands of Americans are the only source of accessible health care.

For the past 2 years, those appearing before you have painted a bleak picture of the Campesinos' health status, given the fact that migrant health centers reach only 10 percent of the eligible population, and less than 5 percent qualify for coverage under titles 18 and 19. My purpose today is to bring you some good news, for a change.

During the past 2 years, with little more than a 25-percent increase in appropriations, and greater management efficiency, migrant health centers have extended their services to 35 percent more patients, and have increased their productivity by better than 50 percent. They have managed to reduce the overall cost per patient visit by 20 percent and have increased third-party revenues to equal 8 percent of their total operating income. The attached chart shows the progress we have made in recent years. Surely, you will agree that this is an outstanding record of achievement by the migrant health centers, and that it clearly reflects the commitment to maximum efficiency on the part of the centers' management staff and board members.

There is, however, a continued sordid side to this issue, one which continues to affect the centers and the communities they serve. The migrant health program is now reaching only 15 percent of the eligible population. Worse, less than one-tenth of 1 percent are served by the hospitalization program.

As you are aware, Mr. Chairman, it is difficult for migrants to qualify for third-party programs because of State residency requirements. Moreover, there have been no legislative proposals to expand coverage for these people. Accordingly, more than 80 percent of the population which this program is intended to serve are presently without access to decent health services.

Thus, we again find ourselves approaching you with our collective hand extended, asking for more; and, while we are conscious of the difficult economic situation confronting this Nation and the Congress, we cannot in good conscience continue to quietly tolerate incidents such as the recent indictment of two women on separate charges of negligent homicide—for having abandoned their newborn infants in drainage ditches, where both helpless creatures died. If it is true, as the women said that they had so acted not because the children were unwanted, but because they could not afford to care for the infants, both of whom were sick and in need of considerable medical attention, then our society must accept the role of unindicted coconspirator for having allowed these incidents to occur.

At the present time, HEW's figures indicate that there are 2,700,000 members of migrant and seasonal farmworker families in the Nation. If one accepts the fact that the migrant health centers are rendering

adequate health care to their patients at an annual cost of $94 each—about 15 percent of the average national per capita health expenditure—then the program would require some $255 million in order to provide sufficient outpatient care to all qualifying individuals.

Assuming that as much as 20 percent of this cost were to be met with other resources—a figure which may, in fact, be unreasonably high—we are nevertheless left with a required investment of some $204 million. Further, inpatient care needs would require an additional $217 million.

There is another matter which, I believe, merits the attention of the subcommittee: during fiscal year 1977, some $4.5 million—an amount roughly equivalent to the entire increase you voted for migrant health centers—has been conscripted for use in the administration's rural health strategy. While I do not deny the need for developing services in presently unserved or underserved rural (and urban) areas, I must, in conscience, register my protest against the use of funds intended to serve farmworkers for that purpose. I argue this point for several reasons: As a result of the administration's action, existing migrant health centers are faced with the prospect of continuing to function at existing or reduced funding levels, or of seeking funds under the rural health initiative strategy—which in turn requires an extension of services to a general rural population, in many instances, at the expense of serving farmworkers.

Migrant and seasonal farmworkers live and work in rural areas, it is true; but existing migrant health centers have developed as much because of the failure of rural health systems to relate to the special needs of campesinos because of an insufficiency of medical manpower in those areas where migrants spend but a small part of the year will do little to accomplish the intent of this legislation.

Given the limited funding available for developmental rural health projects, and the administration's system of measuring efficiency among such projects, it has become increasingly difficult for the projects to offer nonmedical support services, such as outreach, transportation, health education, social services—services which are vitally necessary in serving farmworkers, and which have set migrant and community health centers apart from common medical care systems.

Numerous existing migrant health centers face obliteration as a result of the focus on underserved areas. Consider if you will, the case of a project located in a midwest farming area which serves 2 or 3 counties, none of which are "medically underserved," and none of which meet the "high impact" requirement of Public Law 94–63. Yet, for several months each year, thousands of migrants enter the area to work in the crop harvest. I submit then, several ongoing migrant health centers find themselves in such a predicament.

Should the Congress feel it appropriate to foster the development of health systems in rural and urban underserved areas, then I would suggest that such an effort be granted legislative authority. In the interim, we ask simply that such an effort not be undertaken at the expense of the already downtrodden farmworker.

In sum, migrant health centers have, over the past 2 years made great strides toward providing more and better service to farmworkers, and have proven their worth as an integral component of this country's health delivery system. We are still, however, far short of meeting

the existing need; to accomplish this formidable task, we ask you to reaffirm the congressional commitment toward that end and to provide us with the necessary tools for the job. We ask for an appropriation of not less than $44 million for fiscal year 1978.

On behalf of the campesinos we serve, please accept my sincere gratitude for your demonstrated concern for these issues.

PREPARED STATEMENT

Senator BROOKE. Thank you very much. Before we go to the next panel, we have a written statement to be included into the record concerning genetic diseases.

[The statement follows:]

## STATEMENT OF DR. NEIL A. HOLTZMAN, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

I seek your support for an appropriation for Section 1101 of Public Law 94-278, the National Sickle Cell Anemia, Cooley's Anemia, Tay-Sachs, and Genetic Diseases Act and for an amendment that will assure expenditure of the funds in a cost-effective manner.

Genetic diseases encompass far more than the nine mentioned in the Act. The unique combination of genes that each of us inherits influences our susceptibility to virtually every kind of disease. It is already possible to detect the genetically determined signals of certain diseases, like PKU and galactosemia, before overt illness appears. In the future, genetic screening could result in the identification of those destined to suffer from some forms of heart disease, cancer, diabetes mellitus, and other relatively common conditions. Early intervention might then prevent the development of irreversible damage.

For other diseases, individuals can be counseled about the risks of having affected offspring. Couples at risk can be offered prenatal diagnosis (amniocentesis) to determine whether their fetus is affected; if so, they may choose to terminate the pregnancy. Prenatal diagnosis of Down Syndrome, Tay-Sachs disease, and at least 75 other less common conditions is possible and practical today. This approach is now being extended to sickle cell and Cooley's anemias, and will no doubt be appled to cystic fibrosis, hemophilia, and other conditions as techniques become available.

Because of their wide applicability the genetic strategies of screening, early intervention to prevent disability, counseling, and prenatal diagnosis should be incorporated into the mainstream of medical practice. To continue to develop categorical programs will only postpone the time when physicians and other health workers realize the full potential of the genetic approaches.

But how such integration should take place remains problematical. Should those delivering primary care receive additional training in genetics? Should specially-trained personnel join teams of primary care health providers to offer counseling and other genetic services? Should regional referral centers that offer a wide range of genetic services be established? Perhaps mixtures of these options, or others, will prove cost-effective. Failure to systematically evaluate alternatives will diminish the benefits that could ultimately accrue from the Genetic Diseases Act. Unless the appropriation for the Act is accompanied by an

amendment that directs the Secretary of the Department of Health, Education and Welfare to consider alternatives and develop a comprehensive plan, money will not be most effectively spent.

Today, there is a real need to develop facilities that could provide prenatal diagnosis to every pregnant woman over 35 years of age. Only then could the occurrence of Down Syndrome -- a tragic and costly disease -- be reduced by as much as 25 per cent. The best means of providing these services remains to be determined, again emphasizing the need for evaluation and planning. In one analysis performed for the Public Health Service, it was shown that the establishment of regional centers for prenatal diagnosis would, per woman served, be more cost-effective than merely enlarging the numerous facilities that currently exist. (See PHS Amniocentesis Initiative 7/23/76). These centers might serve the same population as the Area Health Education Centers stiplulated in the Health Professions Educational Assistance Act (PL 94-484), offering training in screening and counseling to physicians, nurse practitioners, and physician assistants while providing service.

Genetic strategies represent new departures in health care Given the wide range of disorders to which they may be applied, every citizen will ultimately be affected by them. Consequently, they should not be undertaken lightly and not without the widest possible citizen participation in the decision-making process. In some programs that are already in operation (such as newborn or carrier screening) problems have been uncovered and others are potentially present (see attachments). To reduce the chance of unnecessary harm, the planning process should include evaluation of existing programs and evaluation should be an integral part of any option tested under the Act.

The Congress recognized the importance of citizen participation when it provided "for community representation where appropriate in the development and operation of voluntary genetic testing or counseling programs" in the Genetic Diseases Act. We believe that the concept of comprehensive planning, evaulation, and citizen participation can be assured by passage of the following amendment with the appropriation:

> The Secretary shall establish an independent Unit within the Department of Health, Education and Welfare whose responsibility it will be to 1) determine current and future needs for genetic services; 2) consider alternaties for meeting these needs; and 3) develop a comprehensive plan for the provision

and evaluation of the effectiveness of genetic services. The Unit may award contracts for "projects to establish and operate voluntary genetic testing and counseling programs" and the development of "information and educational materials relating to genetic diseases" as stipulated in section 1101 of the Act. The Secretary shall appoint an Advisory Board consisting of members of the scientific and general community outside of the government as well as representatives of agencies within the Department to guide the operations of the Unit.

For the purpose of implementing this amendment in the fiscal year 1978, $8,000,000 is needed. Because the initial phase involves information collection and planning, this sum rather than the $30,000,000 authorized in the Act will suffice. Included in the appropriation are funds for the establishment of pilot regional centers that would provide comprehensive prenatal diagnosis, counseling, and other genetic services. The appropriation can be itemized as follows:

| | |
|---|---|
| Information gathering, data analysis, identification of needs | $1,500,000 |
| Evaluation of existing programs, exploration of alternatives | 1,500,000 |
| Development of comprehensive plan | 1,000,000 |
| Pilot regional centers | 4,000,000 |
| Total | $8,000,000 |

I appreciate the continued interest of the Congress in this area and encourage the Appropriations Committee to adopt this amendment so that suffering from genetic diseases can be reduced in the most cost-effective manner.

**STATEMENT OF ROY F. GODDARD, PRESIDENT, PEDIATRIC PULMONARY ASSOCIATION OF AMERICA**

**ACCOMPANIED BY:**

**FREDERIC G. BURKE, PRESIDENT, ASSOCIATION OF PEDIATRIC PULMONARY CENTERS**

**JACQUELINE ZASLOW, NATIONAL DIRECTOR, PEDIATRIC PULMONARY ASSOCIATION OF AMERICA**

**IRVIN EMANUEL, DIRECTOR, CHILD DEVELOPMENT AND MENTAL RETARDATION CENTER, UNIVERSITY OF WASHINGTON**

**MARJORIE GUTHRIE**

**SELDON TODD**

INTRODUCTION OF ASSOCIATES

Senator BROOKE. We will now hear witnesses on maternal and child health.

You may introduce yourselves and begin your abbreviated statements, if you will.

Mr. GODDARD. Mr. Chairman, I am Dr. Goddard, president of the Pediatric Pulmonary Association of America. This is Dr. Emanuel, and this is Dr. Burke and to his left is Mrs. Guthrie and Mrs. Zaslow, our executive director. In the interests of trying to save your time, we will try to combine some of our reports. I call on Dr. Irvin Emanuel, who is the director of child development and mental retardation center at the university in Seattle, to make his statement first.

STATEMENT OF DR. IRVIN EMANUEL

Mr. EMANUEL. I will be addressing maternal and child health research and training appropriations and the developmental disabilities appropriations, both of which our university affiliated facility—UAF—depends on for support. I will also talk about the NICHD research support appropriations which fund most of our mental retardation research programs.

Our center is one of the 20 federally constructed university affiliated facilities or UAF's. UAF's are interdisciplinary training and demonstration centers with major mandates to train specialists in the assessment, care, and education of the developmentally disabled, and to provide services to the developmentally disabled.

We are also one of 12 federally constructed and supported mental retardation research centers. We, therefore, have a threefold responsibility—training, research, and service. I will concentrate my remarks on training and service, which are the major activities of UAF's.

The people of Washington State have been pioneers in their efforts for mentally handicapped citizens. Long ago, the first parents' group concerned with the problems of mental retardation in the United States was established in our State.

Out of this beginning grew the National Association for Retarded Citizens, now the major advocacy group in this country for retarded citizens.

One of the early clinical programs at the University of Washington, out of which the center grew, was the first mental retardation clinic west of the Mississippi. This early program served as the primary model for the development of the university-affiliated facilities. Washington was also one of the first States to pass legislation requiring an appropriate education for all children regardless of ability.

The Child Development and Mental Retardation Center at the University of Washington was the culmination of an impressive cooperative movement by State officials, private citizens, and University of Washington faculty; it received the strong support of our congressional delegation.

In this historic setting, our UAF has continued to dedicate itself to service of the handicapped people of our State and region. Goals of our center, very simply stated, are to determine ways to prevent mental retardation and other developmental disabilities and to enhance the quality of life for affected persons.

Our task has been made easier by the strong support given to our center and other UAF's by this committee and the Congress. Last year I appeared before this committee to present testimony and to support increased appropriations for UAF's.

From fiscal year 1973 until this year, title V maternal and child health research and training appropriations remained constant. Many UAF's are almost exclusively dependent upon these appropriations.

The developmental disabilities UAF appropriation had been constant since 1972 when the appropriation for the new law was first passed. Fortunately, Congress increased appropriations for both these programs last year following the recommendation of this committee.

At the present time, decisions concerning the use of the increased appropriations have not been made by the administering agencies. However, it seems clear that after these years of level funding, the increases, however spent, will not be sufficient to compensate for inflationary pressures or enhance the further development of the programs.

I would like first to address title V maternal and child health research and training appropriations, and to indicate why these funds are crucial to the UAF program nationwide. In doing so, I will use our own center at the University of Washington as an example. Our problems are indicative of the problems other UAF's are also facing.

The main obligation of UAF's is interdisciplinary training. Training of university students requires the maintenance of sufficient faculty in the pertinent range of disciplines necessary to deal with the problems of the developmentally disabled. We have faculty from 12 disciplines, including dentistry, pediatrics, psychiatry, neurology, education, nursing, nutrition, psychology, social work, occupational therapy, physical therapy, and communication disorders. Almost all these faculty are supported by title V funds. In providing a clinical teaching program, we have several clinical programs which provide services to children with a variety of developmental problems.

The primary mandate of UAF's is interdisciplinary training. Without funds for student stipends we are unable to train adequate numbers of professionals in sufficient depth to serve the developmentally disabled.

UAF's train two important types of students: No. 1, graduate and postgraduate students preparing for leadership positions in programs for the developmentally disabled, and No. 2, students who will provide direct services to the developmentally disabled in various settings. Traineeships provide the main mechanism for extending the impact of the UAF's to the community at large, which is the exact intent of the title V training program.

Eighty percent of our recent trainees are working in various capacities with handicapped individuals. The majority, 69 percent, are involved in the direct provision of services to the handicapped. Other major areas of responsibility include the training of paraprofessionals, undergraduate and graduate students, and the provision of consultative services.

Approximately one-half of our trainees remain in Washington State to work while about the same percentage have moved to other areas of the country. We provide manpower for the Nation as well as the State of Washington. Further, we have accomplished the major goals of UAF's: to train people who provide direct services and others who move into university training programs.

Without the additional MCH research and training funds appropriated by this committee over the HEW's budget request for the current fiscal year 1977, our program would have to have been severely curtailed.

For example, over the 5-year timespan from fiscal year 1973 to fiscal year 1978, our personnel expenditures will have increased from 67 percent to 82 percent of the total award. Due to inflationary factors, however, full-time equivalent professional personnel supported under this grant have decreased from 31 in 1973 to 23 in 1977.

Without this committee's action last year, we would have incurred a 31 decrease in anticipated funds for MCH trainee stipends. Because the major purpose of the grant is training, this reduction would have been a serious blow to our major mission.

Our problem is curricular; we must maintain staff to provide quality training experience for students, and we need money for stipends to support these trainees. In planning our expenditures, we have had to reach a delicate balance between maintaining sufficient staff to provide training, maintaining appropriate number of trainees, and reserving adequate funds for operations budgeting.

Since 1973, the money spent for operations has been reduced from 13 percent of the grant to 3 percent. This represents a serious loss in terms of resources available to our faculty and staff. In an interdisciplinary setting, many resources are needed to provide quality training experiences. With limited money available for operations, it is impossible to maintain and replace necesssary equipment, or purchase new equipment, training materials, and assessment tools.

In summary, without this committee's increase over the HEW's budget request last year we would have suffered a further reduction in professional staff of 8, in support staff of 3, and trainee stipends of 16. Unfortunately, once again this year, HEW's budget request is inadequate to sustain the UAF program at even a constant level. Therefore, without an appropriation increase we are once again projecting some reduction in our program, the extent of which we cannot predict at present.

Looking to the years ahead, it is becoming increasingly difficult to formulate and implement plans for the maintenance of our UAF program, let alone for its growth and development. Without additional funds, many UAF's, ours included, will have to cut and reshape their programs. Planning beyond the horizon of the coming year is impossible because of the tremendous impact inflation will have on our program. With such a high degree of uncertainty over next year's activities, it is impossible to formulate plans for even 2 years in the future.

Furthermore, fiscal uncertainties on a year-to-year basis make it increasingly difficult to recruit personnel who are needed because of resignations, changing program emphases, or program development.

Planning and development of major program innovations requires years of leadtime and the ability to commit funds well in advance of the actual implementation of an activity. I believe it is the obligation of UAF programs to be at the forefront in developing innovative programs for the developmentally disabled. If flexibility is denied us because of fiscal uncertainties, our ability to lead will be seriously compromised.

In spite of the uncertainty of next year's funding our association has made some projections for the committee's consideration. We estimate that an increase of $3.5 million is needed to maintain the MCH-supported UAF programs over the next fiscal year.

(*a*) Inflation: Inflation will certainly continue to eat away at our programs; at an estimate of 6.8 percent for inflation, we would need an increased appropriation of $1.95 million in fiscal 1978 to maintain the current level of effort.

(*b*) Traineeships: Traineeships have suffered greatly over the years because of the need to divert more and more funds to maintain faculty. An estimated $750,000 increase would restore an average of about 10 trainee stipends to each of the centers funded under this appropriation.

(*c*) Basic faculty: This year's increased appropriation will be partly used to restore the required core faculty to the UAF's which have lost staff due to inflation. However, this will not be sufficient. We estimate that $500,000 of the $3.5 million additional request will be necessary to hire needed faculty for a core staff. This actually is a bare minimum request and will provide salaries for only 20 of the most critically needed professional positions.

(*d*) Genetics programs: Genetics programs at UAF's, for a number of years, have been involved in providing diagnosis, treatment, and counseling for genetic diseases. Training students in medical genetics and genetic counseling is a further responsibility of our own genetics program.

The genetics programs in UAF's have suffered the same inflationary pressures that other programs have experienced. Because of the great importance of genetics programs to prevention of developmental disabilities, it is important that these be well maintained. Many of the UAF's are involved in prenatal diagnosis of handicapping conditions in high-risk mothers. The main technique for this is amniocentesis, which has a potential for prenatal diagnosis of more than 100 different genetic diseases, including Down's syndrome.

Down's syndrome, the result of a chromosomal error, is more common in babies of older mothers and can easily be diagnosed early in pregnancy, thereby giving a mother the option of preventing the birth of an affected baby. Down's syndrome is one of the most common causes of mental retardation.

In 1976, Congress passed the National Genetics Diseases Act, designed to provide and extend genetic services throughout the country. Clearly, prevention of genetic diseases was a major motivation for the passage of this law. This act has not yet had a specific appropriation. If this act is funded, UAF's can play a substantial supportive role in its implementation, since their genetics programs are well-established and operational.

(*e*) Applied research: One important contribution UAF's continue to make is to conduct clinical and applied research. These investigations help solve practical problems of developmentally disabled people. The UAF programs have developed with a solid base in both basic and applied research.

Further development and improvement of services to the handicapped and the continued provisions of high quality training programs for university students and others requires continuing applied research. Without research, the quality of both services and instructions will diminish. Further, applied research fills the gap between basic research and service. A portion of the suggested $3.5 million increase in appropriation would go for this purpose, $300,000.

Line item appropriation: UAF's have experienced a great deal of trouble in planning programs because of the lag time between appropriations and decisions relative to funding. Part of the problem arises from the fact that once an agency gets an appropriation it takes some time to decide how much of that money is allocated to UAF's and how much to other programs.

This could be simplified by Congress earmarking the funds that are to go to the UAF program.

For example, it appears that roughly $3 million of the $5 million increase in the MCH research and training appropriation last year will go into support of the UAF's. A UAF line item appropriation for that amount would have permitted decisions regarding funds to be made much earlier in the year, allowing better program planning.

Our association would like to express its appreciation to this committee for its successful efforts to raise the level of appropriations under the Developmental Disabilities Act for the current year. For the first time since the inception of this act, the appropriation has been raised from $4.25 million to $5.25 million.

At present, there are 46 university affiliated programs of which 37 are partially supported under section 121 of Public Law 94–103. Funds are provided to assist in paying the cost of administering and operating these interdisciplinary training programs. Such programs now receive only about 5 to 10 percent of their total budgets from the developmental disabilities programs.

This funding pattern would appear to reflect the legislative intent of providing administrative support from the Developmental Disabilities Act while having each UAF obtain direct training and service support from other programs and sources, such as the Maternal and Child Health Service, the Bureau of Education for the Handicapped, and local funds.

I have shown how the programmatic aspects of our UAF supported by title V funds have suffered through attrition. I would like to speak now about the administrative and support services which are funded under developmental disabilities appropriations. It is important to emphasize that these funds are specifically earmarked by Congress for such administrative and support activities and not for faculty salaries. Inflation has cut into these funds as much as in the case of title V moneys.

Support service are critical in the task of bringing a large number of disciplinary programs together into a unified interdisciplinary program. In order to assure that all our trainees develop sufficient acquaintance with the contributions of each discipline, an interdisciplinary training coordinator is supported by our developmental disabilities grant.

At our center, these funds also support our office of planning and evaluation, which, among other duties, is charged with evaluating the effectiveness of our training program.

The Office of Information serves a real need in a large center such as our own in disseminating important information to our faculty and staff and to the community outside.

The media service supported with these funds is important for the development and improvement of instructional techniques.

Further, video taping allows the faculty to record the sequential development of our patients and thus contribute to their improved clinical care. Computer services are essential in maintaining records on both our patients and trainees. Last, clerical assistance is needed for a variety of essential tasks.

The initial 20 UAF's were constructed under funds made available through Public Law 88–164 with a provision of a 20-year commitment on the part of both the recipient universities and the Federal Government. We believe, as we did a year ago, that increased appropriations are necessary if the UAF program is to continue efforts to develop services for the developmentally disabled.

We think that it is vital that standards, including requirements for a full interdisciplinary capability, be established and implemented for existing UAF's before any new programs are funded under this act. Furthermore, we believe that the satellite program should be developed as a means of extending services before establishing new UAF's.

We propose that appropriation language specifically request the Department of Health, Education, and Welfare to establish standards for UAF's. Further, we request the agency not be allowed to establish new programs until such standards have been developed and agreed upon. Our association is already working on the determination of standards for UAF programs. In this way, there will be some assurance that appropriated funds will be used for only the most worthwhile activities.

We believe in increased appropriations to benefit developmentally disabled individuals, but we also believe that money must be carefully spent with full accountability.

(*g*) Satellite program: The satellite program provision of Public Law 94–103—section 121—provide a potentially cost beneficial means for extending services to handicapped individuals in geographic areas

not how served by UAF's. The Association and the University of Washington UAF are committed to this concept of extended services.

We were supportive of this legislation during the time that it was under consideration and were also supportive before this committee a year ago in the request for funds to initiate this new program. The idea of one or more UAF's working in collaboration with developmental disabilities councils and other State agencies to understand the needs of a State in order to help establish appropriate services is quite appealing. We are convinced, based on our expectation that effective and reasonable guidelines will soon be issued, that Satellite feasibility studies will be concluded this year.

Finally, we would like to emphasize that the numbers and quality of HEW, Developmental Disabilities Office staff with responsibilities for administering the UAF and satellite program be strengthened.

We would like to recommend a total appropriation of $8.775 million for the Developmental Disabilities Act. Thousands of handicapped people will benefit from the expanded services made possible under this appropriation.

Maternal and Child Health and Developmental Disabilities appropriations are the two most important sources of support for the UAF's. Other Federal Agencies also impinge on UAF programs, probably the most important of which is the National Institute of Child Health and Human Development, or NICHD.

The NICHD research funds are important in two main respects.

First, much of the NICHD supported research, particularly in the mental retardation program, relates to applied and clinical problems important to educational and service programs, and is therefore directly applicable to improving UAF programs.

NICHD supports basic research related to the prevention of developmental disabilities and the improvement of services to the developmentally disabled population.

Second, NICHD support is important to the development and maintenance of comprehensive research programs in mental retardation in the 12 mental retardation research centers. Our center is one of nine which is both a UAF and a research center.

NICHD supported research has been directly applicable to improving the evaluation and care of children with developmental disabilities at our center and elsewhere. Thus, the partnership between the mental retardation research program of NICHD and the UAF's provide a natural mechanism for the translation of research into practice.

I need not remind this committee about the importance of mental retardation research support since this committee had taken such a strong stand concerning the necessity to increase support for the mental retardation programs of NICHD in its report of last year.

The statement of the research support needs in mental retardation presented by the mental retardation center directors group will be attached to this testimony. We support their recommendation for an increase of $4.5 million for the mental retardation research program, bringing the total to $27 million.

Thank you.

STATEMENT OF ROY F. GODDARD

Dr. GODDARD. Mr. Chairman, I will combine the testimony of Dr. Burke and myself for the pediatric area.

I would like to take the privilege of thanking you for the opportunity of appearing here today. I will submit for the record my testimony in detail.

[The statements follow:]

STATEMENT OF DR. ROY F. GODDARD, PRESIDENT AND MEDICAL DIRECTOR, PEDIATRIC PULMONARY ASSOCIATION OF AMERICA, LTD.

The Pediatric Pulmonary Association of America and the Association of Pediatric Pulmonary Centers appear before you today to speak in behalf of the Pediatric Pulmonary Center Program, which under its authorizing legislation of Title V, Social Security Act, is administered by the Maternal and Child Division of the Bureau of Community Health Services, and is funded from the MCHS Research and Training budget. The forward plan for action submitted by MCHS calls for eighteen (18) Centers to be established by 1978 at a cumulative cost of $6 million. Today, only eleven such Centers exist, and are struggling to keep their programs viable at a meager level of $2 million.

It has come to our attention since the preparation of this testimony, that the authorization level for MCHS may be raised in the near future. Should this come to pass, we would then like to amend our request on page four of this testimony in the following manner:

That the Research and Training budget of MCHS be increased from $30 to $35 million, and that $6 million of this sum be directed by Congress for utilization in the total enrichment of the Pediatric Pulmonary Center Program. This action would be supportive of the recommendations made in the in-depth study and report prepared by MCHS in 1974. With your permission, Mr. Chairman, I would like to submit a copy of this report for inclusion in the record.

Research in those major areas of Allergies and Asthma, Infectious Diseases, Cystic Fibrosis, and Cardio-Pulmonary complications arising from chronic pulmonary conditions in infants and children, and young adults, continues to be a must, in our fight to effectively combat those conditions in the 10 million children who suffer from respiratory disorders in the country today.

Therefore, it is most necessary that we and this Committee support the vital research programs in the National Institutes of Health, and particularly, those of the National Heart and Lung Institute, (proposed F.Y. 78, $461.6 million): National Institute of Allergies and Infectious Diseases, (F.Y. 78 proposal: $187 million) and for the National Institute of Arthritis, Metabolism, Digestive and Diabetic Diseases: (proposed F.Y. 78, $285. 1 million)

We feel that the ensuing testimony will provide adequate justification for these proposed budget increases.

We thank this Committee for its consideration of our requests.

STATEMENT OF ROY F. GODDARD, M.D.

I am Dr. Roy F. Goddard, President of the Pediatric Pulmonary Association of America and also the Medical Director of the Southwestern Pediatric Pulmonary Center in Albuquerque, New Mexico. I should like to introduce my esteemed colleague, Dr. Frederic G. Burke, President of the Association of Pediatric Pulmonary Centers, Professor of Pediatrics at Georgetown University, and the Medical Director of the Program at Georgetown University Hospital here in Washington, D. C., and Mrs. Jacqueline Zaslow, the National Director of the Pediatric Pulmonary Association of America.

INTRODUCTION

Over the last few years we have had the privilege of appearing before this Committee on behalf of our program, and I should like to take a moment to express our very deep appreciation to Congress for its constant support and understanding. Because of your concern, we have managed to survive, despite financial depression and crisis after crisis. We recognize the tremendous task with which you gentlemen are eternally faced in trying to set priorities for your annual appropriations recommendations, constantly cognizant that the dimensions of the budget do not increase commensurately with the size of ours and other programs, and that not everyone can be satisfied let alone replete.

Nonetheless, I must beseech you to look closer into the needs of our program and to determine for yourselves whether or not Pediatric Pulmonary Centers have been eking tremendous mileage out of their stipends without wasting a single crumb.

HISTORICAL BACKGROUND

As you might recall, Mr. Chairman, and the past records will so indicate, in 1974 the then existing ten Centers were transferred from the phase-out of the Regional Medical Programs to Maternal and Child Health. Since then, authorized under Title V of the Social Security Act, we have been funded out of MCH's Research and Training budget at a level of $2 million. We have been more than grateful for this renewed lease on life, for it has to some extent enabled us to continue the battle against chronic respiratory diseases in infants and children. As you know, there are in excess of 10 million young victims in the United States today, and I think you will agree that 2 cents per capita is a very small price to pay in coping with a problem of this size.

At the request of Congress, upon assumption of the Program, MCHS was charged to develop an in depth study of the ramifications and include their recommendations and options for its continuity. Arising out of this survey it was projected that by F.Y. 78, there should be 18 Centers, at a proposed accumulative cost of $6.8 million. This sum would allow for approximately $300,000 for each of the

eight new starts and the remainder to be applied incrementally to established Centers for their enrichment and to offset inflation in their overhead expenditures. As you well know, this has not happened. Only this past year was the Eleventh Center opened at the University of Florida at Gainsville, and the budget is still the same $2 million.

Most of us have had no choice but to cut back on personnel and services. We cannot, under these circumstances, keep pace with the increased costs of medical equipment, drugs and the day to day sundry necessities of life. Furthermore, we are unable to compete in today's professional labor market for the qualified staff we so urgently need. The guidelines governing our grants, for example, call for the Nurse-Teacher in the program to have a Master's Degree in Pediatric Pulmonary Diseases and possess a faculty appointment. Short of resurrecting a Florence Nightingale or a Clara Barton, I do not know where such a person could be added to our core personnel for under $18,000 per year. Yet, consistent with the achievement of optimal standards, this is one of the goals that has been set for us in F.Y. 78. Containment of escalating medical costs has always been our concern, equally as much as it bothers Congress, but our own institutions and medical schools are unable to help us bear more of the financial burden.

We are not fighting for ourselves, as physicians, to make the grossly inflated salaries that one reads about in the press. Indeed, many of us and our staff have continued over the years on frozen income levels. We are fighting for millions of children and for those yet to be born. Without the minimal means to train new people in this field, after we old ones have either been fired, retired, or expired, there will arise a new generation of very sick kids and very few persons qualified to do anything about it!

These children of whom we speak, do not pluck at the heart strings because they do not wear crutches or braces. They do not upset the intellectual equilibrium because usually, they are not brain damaged or mentally retarded. The mucus that drips down through their lungs only leaves a damp trail of their parents' tears. But we doctors are aware of this pernicious enemy, although outwardly invisible, one which saps all life from these young human beings and prevents them from realizing their true potential, as creative and productive members of society. This is a major tragedy, that through our program, we aspire to overcome.

CENTER DATA

During 1976 approximately 25,000 infants and children were seen at the eleven Pediatric Pulmonary Centers. (See Exhibit No. 1 for listing of Centers) Of these, 2,432 were admitted to Neonatal Intensive Care Units, another 7,457 were asthmatic and/or allergy victims, which entailed an aggregate of more than 16,000 visits. The remainder of the patients treated suffered from Cystic

Fibrosis, congenital respiratory disorders, cardio-pulmonary diseases, immune deficiencies and many other multiple problems, which either required surgery, hospitalization and intensive out-patient visits or a combination of all three.

TRAINING ASPECTS

Short and long term training courses are an integral part of the Center program, and are designed to stimulate interest and improve knowledge of the multidisciplinary team. Collective attendance at these seminars in 1976/77 comprised over 371 M.D.s, 1,652 Nurses, 278 Physical and Respiratory Therapists and 786 others, such as Post-Doctoral Graduates, Nutritionists, Social Workers and Technicians. Several satellite clinics have been organized in outlying areas, along with regular visitations to underserviced and remote regions by teams of expert personnel. Referrals have been steadily increasing from neighboring States who do not have similar facilities of their own. Research projects are in progress at all eleven Centers and cover a wide gamut, ranging from status asthmaticus, cellular and immunological processes in the pulmonary defense systems, bronchial lavage, to many clinical investigations into the abnormalities connected with cystic fibrosis and the effects of altitude on cardiopulmonary distress.

APPROPRIATION REQUEST FOR MATERNAL AND CHILD HEALTH

In conjunction with the recommendations of the American Academy of Pediatrics and the Coalition for Health Funding, we endorse an appropriation of $350 million for this agency in the F.Y. 78 HEW Budget. Out of this sum we would like to see the authorized level of $30 million for the Research and Training Programs sponsored by MCHS be sustained, if not increased. We further recommend to the Committee that $4 million of this $30 million be set aside SPECIFICALLY for Pediatric Pulmonary programs. $2 million of the $4 million of the Research and Training Budget would be utilized for the upgrading and expansion of Pediatric Pulmonary Center Programs. This sum is essential to enable the eleven existing Centers to maintain standards and pay their bills, and also to allow for the establishment of two more Centers this fiscal year. The University Affiliated Facilities, a very worthy program, focused upon developmental disabilities, also funded from the same budget line, concurs that any sum less than $30 million for MCHS Research and Training will cause irreparable harm to both programs.

Gentlemen, if you see fit to grant this budget request, we cannot emphasize too strongly the need for clear directives in its disposition. For it is only the language used by Congress that signifies its intent for the allocation of funds for specified purposes.

There have been changes in the key personnel of Maternal and Child Health quite recently, and these are non-connected with the political climate. However, we envisage much more reorganization, most of it, hopefully, for the good but in

the meantime there will no opportunity this year for a new educational process or for a continuum of effort unless Congress and this Committee so decrees.

THE NATIONAL INSTITUTES OF HEALTH

We are given to understand that the "Child" and "Child Health" are to be a priority issue in the new Administration and we applaud this wise decision. Although much of the research currently being sponsored by the National Institutes of Health will have tremendous impact upon tomorrow's newborn, we believe that without a coordinated approach to the overall situation, mucn time will be lost and many millions of dollars irrevocably wasted; but more importnatly, the child will be the loser and hence, our country and its major product, its youth. We have attempted, and have succeeded over the past years, to work in closer unison with those institutes whose work has a direct bearing upon the well-being of children with chronic lung diseases. We are considerably encouraged by their interest in closer involvement with targeted research and cooperative studies. For these reasons, and many others, we would urge this Committee to give very careful consideration to the increases proposed for N.I.H.
We would now like to address ourselves to those Institutes with whom we have had the privilege of being more intimately aware of their activities which relate directly to pediatric pulmonary diseases.

NATIONAL HEART, LUNG AND BLOOD INSTITUTE

We recommend that $461.6 million be appropriated for NHLBI. This figure is in line with that requested by the Health Coalition. In 1972 we worked prodigeously with Congressman Paul Rogers in an effort to bring about the expanded authority of this Institute, which was promulgated by Congress through the enactment of the Heart, Lung and Blood Act. Under this mandate, 15% of their total budget was to be committed to the pulmonary aspects of their mission. In addition, 5% or 1/3 of this 15% was to be devoted exclusively to pediatric pulmonary disease and respective research. We are very pleased to learn that NIHLB has already this current year, selected eight locations that will be funded as specialized Centers for Pediatric Pulmonary Research. This is a modification of their "SCORE" Programs and grants will total up to $3 million over a three year period. Leading medical schools are involved in this project. Another new start this year is the clinical trial of the utilization of steroids before birth in neonatal respiratory distress syndrome in infants. In order for this study to be meaningful it will entail a three year survey of the effects produced. This will eat into the budget but, hopefully, will produce some conclusive results.

Childhood asthma is also claiming attention and grants are about to be awarded to qualified teams that have the expertize to study the behavioral patterns of both the child and the family. The objective is to determine whether this educational process has merit, both as a control and deterrent to the morbidity and mortality arising out of this lung-oriented disease.

The abnormal mucus-making factor in cystic fibrosis is to be the subject of intensified research in F.Y. 77/78. Letters of interest are now being solicited from investigators who would like to renew their efforts in this connection, and to newcomers who are qualified to pursue this line of investigation.

We acknowledge that while the lung itself is the focal point of our concern, we do recognize that the heart and the blood are of equal importance and intensified research must be continued in all three of these vital areas. It is in our minds, therefore, very appropriate the the budget of NHLBI be increased by a substantial measure if objectives in improving the nation's health are to be met.

NATIONAL INSTITUTE OF ALLERGIES AND INFECTIOUS DISEASES

Last year Congress approved an increase in the F.Y. 77 budget for NIAID bringing it to $141 million. At that time, we advised the Committee that we felt there were many areas of mutual interest that could be developed between the Pediatric Pulmonary Centers and with those investigating the complexities of allergies and infection of the respiratory system. Also evidence this year indicates a great need to further pursue immunological studies, the isolation of viruses and the effects of innoculation. Dialogues have begun between our two groups and pending availability of funds, plans for cooperative studies have been mooted. We would ask you gentlemen to consider the fact that only a very modest sum is required to bring about a wedding of funded and existing facilities with those whose research expertise merit sponsorship by NIAID. This dual exposure offers great challenge, for it would provide the clinician opportunity to upgrade his knowledge through the direct participation in these kinds of trials and, similarly, the investigator would have access to patient caseloads for observation and controlled studies.

On a broader scale, it is disappointing to note that this Institute was only able to fund 24% of its top priority approved grants. In light of the fact that the tragic outbreak of the Legionnaires Disease was a repetition of a similar, but far less publicized epidemic that mysteriously erupted at St. Elizabeth's Hospital here in the Capital a few years ago, it would appear that we are sadly lacking in our knowledge of virology and bacteriology; and yet, we offer little or no encouragement for new blood to enter this field of research. We physicians know very little about the flu itself, be it the common variety or the more obscure species, nor can we always predict what toxic or other side effects will be produced by the antidotes we administer. This is quite alarming, particularly when dealing with high risk groups such as lung damaged children and senior citizens. If one day, By God's will, we are able to conquer cancer and eradicate heart disease, it will be of little avail unless we are also able to strengthen the body's defense system and control infection. Therefore, we wholeheartedly concur with the Health Coalition's recommendation of $187 million for F.Y. 78.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLIC, DIGESTIVE AND DIABETIC DISEASES

Fairly recent Acts of Congress have mandated that two new programs be added to the mission of NIAMDD. In 1977 they are planning to begin on the implementation of a comprehensive program for diabetic research, which will entail the establishment of multidisciplinary Centers and facilities for post graduate training. In 1978 there are proposals to expand and accelerate the attack upon arthritis in accordance with their directives. Additional manpower is essential for the achievement of these objectives and unless means are provided for the establishment of eighty new positions, it will be extremely unlikely that these new programs will get off the ground.

In the meantime, program balance must be maintained among the other ten research areas to which they are already committed, such as renal defects, psoriasis of the liver, etc., and ongoing investigations in metabolic malfunction. We have relied upon this Institute for its vigilance and support of meritorious studies connected with the basic defects of cystic fibrosis, which are metabolic in origin involving the pancreas and its production of enzymes and their digestive capabilities. We are observing that many youngsters with cystic fibrosis also have hypoglycemia and diabetes mellitus which are symptomatic of the problem. Since these manifestations are more easily controllable through diet and enzyme supplements, there is a great tendency to overlook their basic and serious implications as far as this lethal disease is concerned.

We are most pleased to see that the people's lobby has been effective in bringing about intensified action on behalf of arthritis and diabetes, but at the same time, the less dramatic, but equally important facets of basic research encompassed within the purview of NIAMDD, must have the benefit of parallel and consistent support, if the mission is to be meaningfully fulfilled. Along with our professional colleagues, we would like to see this Institute receive an increase to $285.1 million for F.Y. 78.

BLOCK GRANTS

For the record, we would like it to be known that we are strongly opposed to these proposals. We are aware that Congress, in its wisdom, reflected a similar attitude last year. We hope that the same conditions will prevail now and that the new Administration will take heed of the previously expressed objections in this connection.

Although the concept may have some philosophical merit, we respectfully submit, that at the present time it is neither practical, economic nor expedient. Health care delivery and its cost factor in the United States today is in the throes of a chaotic muddle, but very serious attempts by both Congress and the Federal Government to regulate the situation are beginning to have effect and impact.

To abdicate this responsibility by the endowment of "Block Grants" to the States who do not have the mechanism or the administrative capability to handle the task would, in our opinion, consstitute a grave error of judgment. Such precipitous action, without a very substantial period of education, indoctrination and qualified staff implementation, on all levels of State governments, would result in instant disaster and unwarranted dissipation of tax dollars.

SUMMATION

Thank you for your courtesy in hearing us today. We have appreciated the opportunity to present our views before you and to update the committee on the needs and the progress of pulmonary programs for infants, children and young adults.

## PEDIATRIC PULMONARY CENTERS

Orange County Pediatric Pulmonary Center
University of California at Irvine
Orange, California 92664
Director: Robert Huxtable, M.D.
(714) 538-8831 Ext. 391

Pediatric Pulmonary Center
University of Colorado Medical Center
4200 East Ninth Ave.
Denver, Colorado 80220
Director: Ernest K. Cotton, M.D.
(303) 394-7185

Regional Pediatric Pulmonary Program
Kauikeolani Children's Hospital
226 North Kuakini Street
Honolulu, Hawaii 96817
Director: Dr. Michael Light
(808) 531-3511 Ext. 164 or 180

Pediatric Pulmonary Center
Tulane University School of Medicine
Department of Pediatrics
1430 Tulane Avenue
New Orleans, Louisiana 70112
Director: William Waring, M.D.
(504) 588-5456

Southwestern Regional Pediatric Pulmonary Center
Suite 2400
8100 Constitution Place, NE
Albuquerque, New Mexico 87110
Director: Roy F. Goddard, M.D.
(505) 293-3732

Pediatric Pulmonary Center
Babies' Hospital
Columbia University
3975 Broadway at 167th St.
New York, New York 10032
Director: Carolyn R. Denning, M.D.
(212) 579-2406 or 579-2285

Pediatric Pulmonary Center
Children's Hospital of Philadelphia
1740 Bainbridge St.
Philadelphia, Pennsylvania 19146
Director: Ed Sewell, M.D.
(215) 816-2700 Ext. 287 or 467

Pediatric Pulmonary Program
UPR Medical Sciences Campus
School of Medicine
Department of Pediatrics
GPO Box 1067
San Juan, Puerto Rico 00936
Director: Pedro Mayol, M.D.
(809) 785-5861

Pediatric Pulmonary Center
Georgetown University Medical Center
3800 Reservoir Road, N.W.
Washington, D.C. 20015
Director: Frederic G. Burke, M.D.
(202) 537-0321 or 625-7298

Pediatric Pulmonary Center
C/F and Chronic Lung Diseases in Children
Children's Orthopedic Hospital and Medical Center
4800 Sand Point Way, N.E.
Seattle, Washington 98105
Director: David Woodrum, M.D.
(206) 634-5000 or 634-5373

Pediatric Pulmonary Center
University of Florida
College of Medicine
Box J 296 - Department of Pediatrics
Gainesville, Florida 32610
Director: John R. Mangos, M.D.
(904) 392-4458

STATEMENT SUMMARIZED

Dr. GODDARD. I would like to make a few points.

As you might recall, Mr. Chairman, and the past records will so indicate, in 1974 the then existing 10 centers were transferred from the phase-out of the regional medical programs to maternal and child health. Since then, authorized under title V of the Social Security Act, we have been funded out of MCH's research and training budget at a level of $2 million. That's about 2 cents per capita.

We have been more than grateful for this renewed lease on life, for it has to some extent enabled us to continue the battle against chronic respiratory diseases in infants and children.

As you know, there are in excess of 10 million young victims in the United States today, and I think you will agree that 2 cents per capita is a very small price to pay in coping with a problem of this size.

At the request of Congress, upon assumption of the program, MCHS was charged to develop an in depth study of the ramifications and include their recommendations and options for its continuity. Arising out of this survey it was projected that by fiscal year 1978, there should be 18 centers, at a proposed accumulative cost of $6.8 million. This sum would allow for approximately $300,000 for each of the eight new starts and the remainder to be applied incrementally to established centers for their enrichment and to offset inflation in their overhead expenditures.

As you well know, this has not happened. Only this past year was the eleventh center opened at the University of Florida at Gainesville, and the budget is still the same $2 million.

Most of us have had no choice but to cut back on personnel and services. We cannot, under these circumstances, keep pace with the increased costs of medical equipment, drugs and the day to day sundry necessities of life. Furthermore, we are unable to compete in today's professional labor market for the qualified staff we so urgently need.

The guidelines governing our grants, for example, call for the nurse-teacher in the program to have a master's degree in pediatric pulmonary diseases and possess a faculty appointment. Short of resurrecting a Florence Nightingale or a Clara Barton, I do not know where such a person could be added to our core personnel for under $18,000 per year. Yet, consistent with the achievement of optimal standards, this is one of the goals that has been set for us in fiscal year 1978. Containment of escalating medical costs has always been our concern, equally as much as it bothers Congress, but our own institutions and medical schools are unable to help us bear more of the financial burden.

We are not fighting for ourselves, as physicians, to make the grossly inflated salaries that one reads about in the press. Indeed, many of us and our staff have continued over the years on frozen income levels. We are fighting for millions of children and for those yet to be born. Without the minimal means to train new people in this field, after we old ones have either been fired, retired or expired, there will arise a new generation of very sick kids and very few persons qualified to do anything about it!

These children of whom we speak, do not pluck at the heart strings because they do not wear crutches or braces. They do not upset the intellectual equilibrium because usually, they are not brain damaged or mentally retarded. The mucus that drips through their lungs only leaves a damp trail of their parents' tears. But we doctors are aware of this pernicious enemy, although outwardly invisible, one which saps all life from these young human beings and prevents them from realizing their true potential, as creative and productive members of society. This is a major tragedy, that through our program, we aspire to overcome.

During 1976 approximately 25,000 infants and children were seen at the 11 pediatric pulmonary centers. I can give you the information on this, but I think it's submitted in our testimony. The remainder of the patients treated suffered from cystic fibrosis, congenital respiratory disorders, cardiopulmonary diseases, immune deficiencies and many other multiple problems, which either required surgery, hospitalization and intensive outpatient visits or a combination of all three.

Short and long-term training courses are an integral part of the center program, and are designed to stimulate interest and improve knowledge of the multidisciplinary team. Collective attendance at these seminars in 1967–77 comprised over 371 M.D.'s, 1,652 nurses.

You previously asked about nurses before. Here are nurses that are our first line of defense. 278 physical and respiratory therapists and 786 others, such as postdoctors, graduates, nutritionists, social workers, and technicians.

Several satellite clinics have been organized in outlying areas, along with regular visitations to underserviced and remote regions by teams of expert personnel. Referrals have been steadily increasing from neighboring States who do not have similar facilities of their own.

Research projects are in progress at all 11 centers and cover a wide gamut, ranging from status asthmaticus, cellular and immunological processes in the pulmonary defense systems, bronchial lavage, to many clinical investigations into the abnormalities connected with cystic fibrosis and the effects of altitude on cardiopulmonary distress.

In conjunction with the recommendations of the American Academy of Pediatrics and the Coalition for Health Funding, we endorse an appropriation of $350 million for this agency in the fiscal year 1978 HEW budget. Out of this sum we would like to see the authorized level of $30 million for the research and training programs sponsored by MCHS be sustained, if not increased.

We further recommend to the committee that $4 million of this $30 million be set aside specifically for pediatric pulmonary programs. $2 million of the $4 million of the research and training budget would be utilized for the upgrading and expansion of pediatric pulmonary center programs. This sum is essential to enable the 11 existing centers to maintain standards and pay their bills, and also to allow for the establishment of 2 more centers this fiscal year.

The university affiliated facilities, a very worthy program, focused upon developmental disabilities, also funded from the same budget line, concurs that any sum less than $30 million for MCHS research and training will cause irreparable harm to both programs.

Gentlemen, if you see fit to grant this budget request, we cannot emphasize too strongly the need for clear directives in its disposition. For it is only the language used by Congress that signifies its intent for the allocation of funds for specified purposes.

There have been changes in the key personnel of maternal and child health quite recently, and these are nonconnected with the political climate. However, we envisage much more reorganization, most of it, hopefully, for the good but in the meantime there will be no opportunity this year for a new educational process or for a continuum of effort unless Congress and this committee so decrees.

I would like to speak to the National Institutes of Health, namely the Heart Association, also requested by the health coalition and many of these programs are involved in pediatric pulmonary areas.

We are given to understand that the child and child health are to be a priority issue in the new administration and we applaud this wise decision. Although much of the research currently being sponsored by the National Institutes of Health will have tremendous impact upon tomorrow's newborn, we believe that without a coordinated approach to the overall situation, much time will be lost and many millions of dollars irrevocably wasted; but more importantly, the child will be the loser and hence, our country and its major product, its youth.

We have attempted, and have succeeded over the past years, to work in closer unison with those Institutes whose work has a direct bearing upon the well-being of children with chronic lung diseases. We are considerably encouraged by their interest in closer involvement with targeted research and cooperative studies. For these reasons, and many others, we would urge this committee to give very careful consideration to the increases proposed for NIH.

We would like now to address ourselves to those Institutes with whom we have had the privilege of being more intimately aware of their activities which relate directly to pediatric pulmonary diseases.

We recommend that $461.6 million be appropriated for NHLBI. This figure is in line with that requested by the health coalition. In 1972 we worked prodigiously with Congressman Paul Rogers in an effort to bring about the expanded authority of this Institute, which was promulgated by Congress through the enactment of the Heart, Lung and Blood Act. Under this mandate, 15 percent of their total budget was to be committed to the pulmonary aspects of their mission. In addition, 5 percent or one-third of this 15 percent was to be devoted exclusively to pediatric pulmonary disease and respective research.

We are very pleased to learn that NHLBI has already this current year, selected eight locations that will be funded as specialized centers for pediatric pulmonary research. This is a modification of their "score" programs and grants will total up to $3 million over a 3-year period. Leading medical schools are involved in this project.

Another new start this year is the clinical trial of the utilization of steroids before delivery in neonatal respiratory distress syndrome in infants. In order for this study to be meaningful, it will entail a 3-year survey of the effects produced. This will eat into the budget but, hopefully, will produce some conclusive results.

Childhood asthma is also claiming attention and grants are about to be awarded to qualified teams that have the expertise to study the behavorial patterns of both the child and the family. The objective is to determine whether this educational process has merit, both as a control and deterrent to the morbidity and mortality arising out of this lung-oriented disease.

The abnormal mucusmaking factor in cystic fibrosis is to be the subject of intensified research in fiscal year 1977–78. Letters of interest are not being solicited from investigators who would like to renew their efforts in this connection, and to newcomers who are qualified to pursue this line of investigation.

We acknowledge that while the lung itself is the focal point of our concern, we do recognize that the heart and the blood are of equal importance and intensified research must be continued in all three of these vital areas. It is in our minds, therefore, very appropriate that the budget of NHLBI be increased by a substantial measure if objectives in improving the Nation's health are to be met.

Last year Congress approved an increase in the fiscal year 1977 budget for NIAID bringing it to $141 million. At that time, we advised the committee that we felt there were many areas of mutual interest that could be developed between the pediatric pulmonary centers and with those investigating the complexities of allergies and infection of the respiratory system.

Also evidence this year indicates a great need to further pursue immunological studies, the isolation of viruses, and the effects of inoculation. Dialogs have begun between our two groups and pending availability of funds, plans for cooperative studies have been mooted.

We would ask you gentlemen to consider the fact that only a very modest sum is required to bring about a wedding of funded and existing facilities with those whose research expertise merit sponsorship by NIAID. This dual exposure offers great challenge, for it would provide the clinician opportunity to upgrade his knowledge through the direct participation in these kinds of trials and, similarly, the investigator would have access to patient caseloads for observation and controlled studies.

On a broader scale, it is disappointing to note that this Institute was only able to fund 24 percent of its top priority approved grants. In light of the fact that the tragic outbreak of the Legionnaires disease was a repetition of a similar, but far less publicized epidemic that mysteriously erupted at St. Elizabeths Hospital here in the Capital a few years ago, it would appear that we are sadly lacking in our knowledge of virology and bacteriology; and yet, we offer little or no encouragement for new blood to enter this field of research.

We physicians know very little about the flu itself, be it the common variety or the more obscure species, nor can we always predict what toxic or other side effects will be produced by the antidotes we administer. This is quite alarming, particularly when dealing with high-risk groups such as lung-damaged children and senior citizens. If one day, by God's will, we are able to conquer cancer and eradicate heart disease, it will be of little avail unless we are also able to strengthen the body's defense system and control infection. Therefore, we wholeheartedly concur with the health coalition's recommendation of $187 million for fiscal year 1978.

Fairly recent acts of Congress have mandated that two new programs be added to the mission of NIAMDD. In 1977 they are planning to begin on the implementation of a comprehensive program for diabetic research, which will entail the establishment of multidisciplinary centers and facilities for postgraduate training.

In 1978 there are proposals to expand and accelerate the attack upon arthritis in accordance with their directives. Additional manpower is essential for the achievement of these objectives and unless means are provided for the establishment of 80 new positions, it will be extremely unlikely that these new programs will get off the ground.

In the meantime, program balance must be maintained among the other 10 research areas to which they are already committed, such as renal defects, cirrhosis of the liver, et cetera, and ongoing investigations in metabolic malfunction.

We have relied upon this Institute for its vigilance and support of meritorious studies connected with the basic defects of cystic fibrosis, which are metabolic in origin involving the pancreas and its production of enzymes and their digestive capabilities.

We are observing that many youngsters with cystic fibrosis also have hypoglycemia and diabetes mellitus which are symptomatic of the problem. Since these manifestations are more easily controllable through diet and enzyme supplements, there is a great tendency to overlook their basic and serious implications as far as this lethal disease is concerned.

We are most pleased to see that the people's lobby has been effective in bringing about intensified action on behalf of arthritis and diabetes, but at the same time, the less dramatic, but equally important facets of basic research encompassed within the purview of NIAMDD, must have the benefit of parallel and consistent support, if the mission is to be meaningfully fulfilled. Along with our professional colleagues, we would like to see this Institute receive an increase to $285.1 million for fiscal year 1978.

For the record, we would like it to be known that we are strongly opposed to these proposals. We are aware that Congress, in its wisdom, reflected a similar attitude last year. We hope that the same conditions will prevail now and that the new administration will take heed of the previously expressed objections in this connection.

Although the concept may have some philosophical merit, we respectfully submit, that at the present time it is neither practical, economic, nor expedient. Health care delivery and its cost factor in the United States today are in the throes of a chaotic muddle, but very serious attempts by both Congress and the Federal Government to regulate the situation are beginning to have effect and impact. To abdicate this responsibility by the endowment of block grants to the States who do not have the mechanism or the administrative capability to handle the task would, in our opinion, constitute a grave error of judgment. Such precipitous action, without a very substantial period of education, indoctrination and qualified staff implementation, on all levels of State governments, would result in instant disaster and unwarranted dissipation of tax dollars.

Thank you for your courtesy in hearing us today. We have appreciated the opportunity to present our views before you and to

update the committee on the needs and the progress of pulmonary programs for infants, children, and young adults.

STATEMENT OF MARJORIE GUTHRIE

Senator BROOKE. I would like now to call on Marjorie Guthrie, the founder of the Committee To Combat Huntington's Disease, and she will speak on behalf of Public Law 94–278 of the genetics program.

Ms. GUTHRIE. Thank you, Senator, I did prepare a statement. It will be submitted.

[The statement follows.]

STATEMENT OF MRS. MARJORIE GUTHRIE, PRESIDENT, COMMITTEE TO COMBAT HUNTINGTON'S DISEASE

Several years ago when I first testified before this committee, I was deeply concerned with the difficult problems confronting families with Huntington's Disease, an inherited neurological disorder. I had watched my husband, Woody Guthrie, deteriorating slowly, 15 years in a mental hospital.

Today, I appear before you because I am learning that I can no longer address my concerns only to Huntington's Disease. What about Cystic Fibrosis, Dysautonomia, Hemophilia and Muscular Dystrophy, to name just a few of the many genetic diseases. I know that we are all in this together. I know that every family who lives with an inherited disease in their family has certain similar problems. We are all struggling... trying to cope....but when these families begin to see that we are all related...that your disease is like my disease....that my problems are very much like your problems....then we will begin to coordinate our efforts and approach the study of inherited disease....GENETICS...as a national priority.

I believe the public is ready and eager for knowledge. Some families' problems may be more severe than others, but all families with genetic disorders need HELP! We want to know more about the cause of the disease. What alternatives are available? Is there progress in the treatment? Is there a knowledgeable, sympathetic person we can talk to? Are there programs being considered to alleviate the suffering of this large population? What kind, if any, care facilities are available? Should we try to keep the patient at home? What will this do to the rest of the family? We know that we each have our own special needs, but how do my needs relate to yours? How are we related? Is there a program for evaluating and planning the best possible strategies? How are we coping? Could we do better?

When the GENETIC DISEASES bill PL 94-278 was passed, I was encouraged! At last there was concern for all of these families....and through this legislation we could begin the non-categorical approach to inherited diseases of man! Here was the opportunity to educate the involved families to work TOGETHER to promote basic biomedical research and begin to utilize what we know in a clinical setting and apply our knowledge to those who need help.

The bill called for "planning, establishing, demonstrating and developing special programs for the training of genetic counselors, social and behavioral scientists and other health professionals." Here is the opportunity for pilot programs, new approaches, a system of evaluation. Here is the opportunity for planning short and long term goals. We could raise the consciousness of the public and health professionals towards a better understanding of genetic processes "the inheritance patterns of genetic diseases" and we could begin to plan how we might establish "facilities...to diagnose, control, counsel and treat genetic diseases."

I want to see all these approaches begin. To date, no funds have been appropriated to carry out the intent of this legislation. I believe this is vital legislation which in the long run is not only going to alleviate human suffering, but is going to save millions which are now being misspent. The authorization called for $30 millions to be appropriated for each of the first three years. I am sure that with careful planning we could well spend the full appropriation...but I came today to request that at least a minimum of $10 millions be appropriated to get these programs started.

We are talking about major problems....problems that cost society billions for the care of patients who require a life time of care. In Huntington's Disease a diagnosis at 35 or 40 years of age means spending 15 to 20 years trying to cope with neurological deterioration. Huntington's is only one of many whose late onset poses so many problems. The scientific literature is beginning to suggest that the role of man's genes is becoming more and more responsible for more illnesses than most people believed possible.

I do hope that we can begin NOW! This bill makes it possible to begin research for the delivery of health care through demonstration and control programs. We must and should plan for how we are going to deal with all these inherited diseases and to get the best services to those who need them in the most efficient way. I hope that we will call upon those in and out of the government to plan in a responsible fashion, to set up the mechanism that will help families cope with their reality....to LIVE with their reality. Every member of a family is affected when we speak of genetic diseases and the time to plan is NOW. We applauded the GENETIC BILL. We believe the time has come to set into motion the intent of the bill by appropriating the needed dollars.

ABSTRACT OF STATEMENT

Ms. GUTHRIE. The important thing of my presence here I can say in a few words. The fact is I'm here on a panel that represents maternal and child health.

In the past, I have come before this committee for other reasons. What is exciting is there is something that crosses all of these institutes. That is what is happening in genetics today.

I think the Congress was very forward-thinking when it did arrange finally to have a decent bill, it isn't a great big one, it calls for $30 million for 3 years each, but the idea was innovative.

At last we will get rid of the people who come and you plead with that, I hear it over and over again, we don't want to hear about the disease of the month. Here's a chance to get rid of the disease of the month, here's a chance to get a categorical approach and cut across all of these things we hear about.

I know, sitting in your seat you have the same problems every day. The bill called for $30 million. I'm saying put your foot in the door, get started, let's talk about genetic disease, let's get something going.

I'm willing to ask for a mere $10 million and get started and if we do that, I think it will be a tremendous step forward for all of the people that come before you because so many of them are involved in the phase of genetic disease.

Thank you for the opportunity to come and say it to you in person.

Dr. GODDARD. Thank you.

We are available for questions.

Senator BROOKE. All right.

I think we will get those statements in the record and the committee will avail itself of them, I'm sure.

We are very grateful to you for testifying before us.

Thank you again.

FAMILY PLANNING PROGRAM

**STATEMENTS OF:**

**CAROL WERNER, LEGISLATIVE DIRECTOR, NATIONAL ABORTION RIGHTS ACTION LEAGUE**

**MARY SINGLETARY, EXECUTIVE DIRECTOR, PLANNED PARENTHOOD, ESSEX COUNTY, N.J.**

Senator BROOKE. Next is the family planning program.

Come forward, please, and introduce yourselves.

Ms. WERNER. Mr. Chairman, I am Carol Werner, legislative director of the National Abortion Rights Action League—NARAL—a national membership organization dedicated to the preservation of all women's right to choose safe and legal abortion as an alternative to unwanted pregnancy.

We welcome this opportunity to appear before the Senate Appropriations Subcommittee for the Departments of Labor and Health, Education, and Welfare, and to testify on behalf of the need for continued Federal funding of abortions for poor women desiring to terminate unwanted pregnancies.

The National Abortion Rights Action League is testifying on behalf of continued Federal funding of abortions for low-income women.

We are requesting the Labor-HEW Appropriations Subcommittee to insure continued funding through defeat of any language, including that of the Hyde amendment to last year's Labor-HEW appropriations bill for 1977, which would restrict the availability of legal abortion services to the indigent.

NARAL believes that poor women should have equal access to abortion services as do their wealtheir counterparts in society and should be allowed to fully exercise their constitutionally guaranteed right to choose safe, legal abortion or to choose to continue their pregnancy.

Under a Hyde amendment, pregnant low-income women would be compelled to bear unwanted children or resort to self-induced or illegal abortion procedures which are severely damaging in terms of risks to the woman's life and health.

The public health benefits of legal abortion have been dramatic in terms of reduced death and medical complications statistics.

Certainly the taxpayer cost is much less if poor women are allowed the right to terminate unwanted pregnancies.

Lower Federal courts have consistently found that denial by States of abortion services to the poor is in contravention to the equal protection clause of the Constitution when the State will fund only prenatal and delivery care.

The Government can remain neutral only by allowing poor women both options—to either continue or terminate a pregnancy.

Such restrictions are also discriminatory in that the right to choose is allowed only to those who can afford it; the civil rights of the poor are ignored.

We urge the Congress to increase the funding levels for the proliferation of family planning services, contraceptive research, and sex education programs. This is the only means thorugh which to help reduce the need for abortion.

A table has been appended to outline the unmet need for family planning services to low-income women in the States represented by the members of this Subcommittee.

Thank you.

Senator BROOKE. Ms. Werner, we had an opportunity on the supplemental, offered by Senator Heinz, which called for an additional $5 million for family planning. It was on the floor Friday of last week, if I recall correctly, and both the chairman and I and the ranking member of the full committee voiced opposition to the amendment.

The funding level for 1976, if I recall, was $100 million; for 1977, $113 million; and I think the Carter administration came in for 123 million for 1978.

One of the arguments used by Senator Heinz was that there were some projects in the country that were not being funded. We called HEW to find out what the situation was, because it was my impression that they had sufficient money, that there was $145 million that could be used for these projects. We asked Senator Heinz if he would propose this amendment for 1978 and we would have hearings—obviously we have had some already—and if there were any problems we would have time to give the amendment due consideration.

We felt very strongly about it.

There was a vote taken on the floor and there developed about 72 Senators voted in opposition to it.

The opposition, mine and I think many others, does not indicate in any sense an opposition to family planning. We are very much in favor of it.

I think our record speaks for itself.

But if you have any information relative to the projects presently being funded, where there are not available funds, I would like to know about it.

Ms. WERNER. OK.

Senator BROOKE. Because that would be very important.

You have well pointed out that the increase of the administration is very modest, the projected increase in budget request.

Ms. WERNER. That's true.

Senator BROOKE. I am very much concerned about the funding level for fiscal 1978 and therefore I hope that in your full statement you have addressed that.

Ms. WERNER. I did.

Senator BROOKE. If you have addressed it at some length, that would be very helpful to the staff and to the committee.

Ms. WERNER. I might also add, one reason the Carter administration's position with regard to Federal funding has been a particular concern, in that they seem to be willing to cast away the rights of the poor people very lightly, but at the same time we have been talking about alternatives to abortion are so low, what are they going to do about the immense amount of unmet need in the country?

They have not addressed that question.

Senator BROOKE. That concerns me. Of course they will obey the law. We have had Secretary Califano before us. In fact, I talked to him even before his confirmation on this very delicate and important position.

It is his position, though he opposes the use of Federal funds for abortion purposes and would in fact support a Hyde amendment, that he would nevertheless carry out the law. Of course, we are now facing litigation that ultimately may decide that matter.

Ms. WERNER. Does the Congress act before——

Senator BROOKE. The Congress has to act before that litigation has been concluded.

I presume the Congress will be faced with the same amendments on the fiscal 1978 bill that we were faced with in the fiscal 1977 bill.

We have got that problem facing us, but at least I wanted to know what a proper funding level would be. It seems you can't have it both ways. If you are going to be in favor of the Hyde amendment, and at the same time not provide money for family planning, the program is really going to be in a worse situation than this year.

Ms. WERNER. HEW in its impact statement said it would cost half a billion dollars more in impact costs alone.

Senator BROOKE. I am glad you treated that in your statement.

All right. That is your statement, then. Thank you.

Mrs. Singletary.

## STATEMENT OF MARY SINGLETARY

Mrs. SINGLETARY. I know you are under pressure and it makes it very difficult.

My name is Mary Singletary from Newark, N.J. I am executive director of planned parenthood of Essex County, N. J., one of the 189 affiliates of the Planned Parenthood Federation of America.

Today I am here to present the views not only of our local group, but that of the national organization.

I have been directly involved in the administration and delivery of family planning services for more than 12 years, and serve as the president of the National Family Planning Forum, an organization which represents all types of family planning projects and their administration. Therefore, I believe I am qualified to speak to you concerning the definite needs of the field.

We presently have our annual meeting going on at this time, so I had the vice chairman take over so I could address this important issue.

Six years ago when the first title X family planning funds were appropriated, those of us who were working in the field felt that there was good reason for optimism, and we were right.

We watched the Federal funds for the provision of family planning to women in need of subsidized services grow from a minimal level to a significant amount in the short span of years from 1970 to 1973.

Unfortunately, the funding for title X project grants became frozen in 1973 and remained frozen for 4 long fiscal years until, at long last, the Senate increased the family planning appropriation by $13 million for this fiscal year, bringing the current total to $107.5 million.

However, these funds were not adequate to offset the 10 to 12½ percent inflation rate the projects had experienced annually during the 4-year lean period.

Perhaps the best way for me to illustrate the problem is by using my own affiliate as an example.

We were funded at the same level—$553,964—from 1973 to 1976. Of course, there were some adjustments which could be made, our administration tightened, but by the time we reached 1976, we were experiencing severe financial difficulties. In June of 1976 we were forced to freeze all salary levels.

By January of 1976 we had to face the fact that if HEW did not increase our budget we would have to terminate the employment of 10 staff members; we received no increase so we did, in fact, lose the employees.

In June of 1976 we realized that our budget projections earlier in the year were being overrun by a record growth in new patient population—which reached a total of 3,000 by the end of the year, a nearly 20-percent increase—mainly attributable to unemployment and inflation in our area, and the attendant increased demand for services.

We were then forced to terminate the services of an additional 10 employees and to completely close down one of our most important facilities, a multilingual clinic in the ironbound section of Newark.

We wanted to have enough money in our budget to service the new patients coming to us.

Thus far in fiscal 1977 we have received no increase in HEW funds, and we face the possibility of again reducing our staff, this time by closing our community educational department and letting five people go.

Senator BROOKE. Mrs. Singletary, if you could abbreviate it, I would appreciate it.

If you cannot, I will have to recess.

I am holding up the Senate Banking Committee.

Your whole statement will be in the record.

Mrs. SINGLETARY. The key thing is that family planning across the country needs additional funds.

The patients are coming to us, all programs are being expanded, and we are unable to service them.

President Carter and Secretary Califano talked about innovative services for teenagers. There is no way that we can do this without funds. We are running in competition with all of the other services, as you are well aware, and so we are, but when you have expertise in the field, it is certainly cheaper to give it to the agency with the experience than to start new health services to do a service that could have been done by someone else.

Senator BROOKE. Are you turning people away presently?

Mrs. SINGLETARY. We have to.

See, Newark, just about half of our population are teenagers and you get at least one out of every four patients coming in is a teenager. We have started services for the teenage boy because they are a bigger complication, and that is a service going on quite effectively. We do need funds for that.

But I understand you are in a hurry. My material is here. I appreciate your listening to us.

Senator BROOKE. I don't want you to feel we are short-changing you.

I am going to come back. I appreciate your understanding and your very excellent statement. I will read it in full. I think you made your case very well.

PREPARED STATEMENTS

Thank you, Ms. Werner and Mrs. Singletary. We will submit your written statements into the record.

[The statements follow:]

# STATEMENT OF CAROL WERNER, LEGISLATIVE DIRECTOR, NATIONAL ABORTION RIGHTS ACTION LEAGUE

## SUMMARY OF BUDGET REQUEST

The National Abortion Rights Action League is testifying on behalf of continued federal funding of abortions for low-income women. We are requesting the Labor-HEW Appropriations Subcommittee to ensure continued funding through defeat of any language, including that of the Hyde Amendment to last year's Labor-HEW Appropriations bill for 1977, which would restrict the availability of legal abortion services to the indigent.

NARAL believes that poor women should have equal access to abortion services as do their wealthier counterparts in society and should be allowed to fully exercise their constitutionallly guaranteed right to choose safe, legal abortion or to choose to continue their pregnancy. Under a Hyde Amendment, pregnant low-income women would be compelled to bear unwanted children or resort to self-induced or illegal abortion procedures which are severely damaging in terms of risks to the woman's life and health. The public health benefits of legal abortion have been dramatic in terms of reduced death and medical complications statistics. Certainly the taxpayer cost is much less if poor women are allowed the right to terminate unwanted pregnancies.

Lower federal courts have consistently found that denial by states of abortion services to the poor is in contravention to the equal protection clause of the Constitution when the state will fund only prenatal and delivery care. The government can remain neutral only by allowing poor women both options - to either continue or terminate a pregnancy. Such restrictions are also discriminatory in that the right to choose is allowed only to those who can afford it; the civil rights of the poor are ignored.

We urge the Congress to increase the funding levels for the proliferation of family planning services, contraceptive research, and sex education programs. This is the only meana thrqugh which to help reduce the need for abortion. A Table has been appended to outline the unmet need for family planning services to low-income women in the states represented by the Members of this Subcommittee.

Mr. Chairman, I am Carol Werner, Legislative Director of the National Abortion Rights Action League (NARAL), a national membership organization dedicated to the preservation of all women's right to choose safe and legal abortion as an alternative to unwanted pregnancy. We welcome this opportunity to appear before the Senate Appropriations Subcommittee for the Departments of Labor and Health, Education and Welfare and to testify on behalf of the need for continued federal funding of abortions for poor women desiring to terminate unwanted pregnancies.

An underlying premise of the Department of HEW is to promote equalization of access of health services to all of America's people regardless of their economic station in life. Health care has long been recognized as a prerequisite for any lasting general improvement in the standard of living of our people. Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396, recognizes this need in its authorization of funding for the provision of medical care to individuals and families "whose income and resources are insufficent to meet the cost of necessary medical services." With this long-standing commitment in mind, one is bound to ask upon what basis could funding for abortions be denied to individuals dependent solely upon publicly funded medical assistance and for whom abortion is indeed a necessary medical service?

Last year restrictive legislation was enacted into law which would prohibit the use of any federal funds for abortions except when the life of the woman would be endangered if the fetus were carried to term. An injunction calling this ban unconstitutional and discriminatory prevented the implementation of this prohibition (usually referred to as the Hyde amendment). The Supreme Court has twice denied motions requesting a stay of the injunctive order. This matter is now before the Supreme Court but the Congress is faced once again with attempts to ban any federal funding of abortions in the Fiscal Year 1978 Labor-HEW appropriations bill and timewise must necessarily act before any definitive ruling will be forthcoming from the Supreme Court.

What has been abundantly clear, however, is the manner in which similar actions by states to prohibit reimbursement for abortion services under Medicaid or similar government programs, have been perceived by lower Federal courts. The courts have consistently (in at last thirteen cases) held that when prenatal/delivery care is available under publicly financed medical programs,

that denial of abortion services to the beneficiaries of such programs is in contravention to the equal protection clause of the Fourteenth Amendment to the U.S. Constitution.

Government refusal to fund abortions for those low-income women desiring them indicates that one course of action, i.e., continuation of pregnancy is morally preferable to the government over pregnancy termination. As long as the government is involved in funding for maternity care, it can remain neutral only if access to prenatal care and abortion services are both provided, as pregnancy is a condition requiring medical treatment regardless if the pregnancy is continued or terminated. According to the Supreme Court, it is not the government's business to either prohibit or encourage abortion but to essentially leave the right to limit childbearing where it should be, beyond the ambit of unnecessary governmental intervention. (See Roe v. Wade)

The picture becomes clearer if we ask what the effects are of denying abortion services to low-income women. As the report of the U.S. Commission on Civil Rights (April, 1975) indicates, denial of abortion rights is an abrogation of the civil rights of the poor, among whom racial and ethnic minority women are disproportionately represented. Such action is discriminatory in two fundamental ways: (1) it denies the right of poor women to equal protection under the law if they are not allowed equal access to medical care should they decide to terminate a pregnancy rather than continue it, and (2) denial of funding for abortion services openly discriminates against the indigent in that it prohibits the exercise of their constitutionally guaranteed right to choose legal abortion, making it available only for those who can afford to pay. Such a prohibition against funding of abortion services blatantly discriminates against those who need medical care and protection of their civil rights the most--and who are the least able to fight back. We are then back to the situation where rights are for those who can afford them, if one is poor ones rights are foregone.

The rights of the poor can not be overlooked in this most basic and private domain--the right to make a decision about ones own childbearing. This is an individual, personal decision about which no one has the knowledge, nor should even want the right, to make a decision for anyone else. Clearly, none of us would want anyone making the decison for us as to whether or when

a child should be borne, how then can we make that decision for others when the only difference is that they are dependent upon federally-assisted programs for all their medical care?

The public health benefits of legalized abortion speak for themselves. The number of abortion-related deaths has dropped dramatically since the legalization of abortion in 1973, making abortion in the first trimester of pregnancy more than eight times safer than childbirth. Infant mortality rates have also decreased significantly. We also know that abortions will occur regardless of their legal status. Women faced with unwanted pregnancies have found means to terminate them throughout history (the first recorded abortion being in 2000 B.C.). Dr. Christopher Tietze of the Population Council has ascertained that 70 percent of all women having legal abortions would have had abortions even if it were an illegal procedure. Since approximately one-third of all women obtaining abortions (250,000-300,000) are recipients of Medicaid assistance, the ramifications of denying funding--essentially making abortion illegal for these women--are clear in terms of health risks to them. According to unpublished data from the Center for Disease Control, Atlanta, Georgia, statistical projections of what would happen to the 250,000 (approx.) women who would be denied Medicaid assistance for abortion under a "Hyde amendment" are as follows:

1) If all had legal abortions there would be 8.6 deaths;

2) If all had legal abortions but were forced into a two-week delay in an attempt to find funding, etc., there would be 13.6 deaths;

3) If 70% had illegal abortions (as indicated by Tietze's data) and 30% continued their pregnancies, there would be 84 deaths;

4) If all had illegal abortions, there would be 100 deaths;

5) If all continued their pregnancies, there would be 44 deaths.

An impact statement issued in 1974 by Dr. Louis Hellman, formerly of DHEW, when a similar restriction was under consideration by the Congress, estimated there would be 125-250 deaths resulting from self-induced abortions if they could not be obtained legally. In addition, DHEW estimated that up to 25,000 cases involving serious medical complications from self-induced abortions would result. This represents a tremendous risk in terms of health costs to poor women. To knowingly set aside this risk by enacting a ban of any federally funded abortions is cruel and unthinkable.

In terms of fiscal arguments as well, it is obvious that expense to the taxpayer is much less if indigent women requesting abortions are allowed them as opposed to being forced to continue an unwanted pregnancy and bearing an unwanted child. Again, DHEW itself estimates the cost of federal funding of abortions at $45-50 million annually, whereas the first-year cost after birth for medical care and public assistance would run between $450-565 million. For each pregnancy among Medicaid-eligible women that is brought to term, DHEW estimates the first-year costs to be $2200 for maternity and pediatric care and public assistance. The 25,000 cases of medical complications (referred to on the previous page) resulting from illegal procedures were estimated by Dr. Hellman over two years ago to cost in the range from $375 to $2000 per patient. Medical costs have continued to climb in the last two years as we all are very much aware. These figures do not take into consideration any future cost relative to AFDC or other welfare payments or any societal burdens resulting from extra strain on public services or complications often linked with the unwanted child in dealing with society. We cannot believe that the majority of Americans would knowingly inflict this kind of cost upon either indigent women or upon themselves. There is no way in which a fiscal conservative could justify a ban of federal funding on the basis of cost to the taxpayer.

The whole question of federal funding for abortions has arisen because there are people who feel abortion is wrong--period. We now often hear about "alternatives to abortion" and reducing the need for abortion. We would posit that the best and certainly the most logical manner in which to reduce the need for abortions is to discover the cause of abortion need and then attempt to treat that cause. Certainly any historian can illustrate that to attempt treatment of a symptom rather than dealing with the root cause of the issue itself will only provoke greater societal unrest and friction and will not in any way alleviate the problem. The abortion issue is a case in point. Abortions occur because women are faced with unwanted pregnancies. They will not cease to occur through application of a band-aid treatment, i.e., attempting to prohibit women from obtaining them. The only way in which to lessen the need for abortion services is to find ways of preventing unwanted pregnancies. This can come only from increased and better sex education programs, much more contraceptive research, and provision of family planning services to all who

want and need them. Needless to say, we have a long way to go in all of these areas.

NARAL commends the Carter administration and the past Congresses for their commitment and initiatives in these areas, but unfortunately the new budget requests will not go far in providing substantive gains in the areas listed above. It is particularly alarming to us that the Administration could so emphatically oppose abortion services for the indigent in view of the principles of basic human rights involved and in view of the great unmet needs this country faces in pregnancy prevention for the middle class and rich, but most importantly for the poor who historically have always suffered the most from being unable to control their fertility. There is no foolproof and safe method of contraception presently available. Everyone is familiar with the studies showing serious health risks related to usage of the "pill" and intra-uterine devices. We need to encourage the development of contraception that is safe, simple, effective (failsafe), and inexpensive. A table is attached for your information detailing how acute the unmet need for family planning services still remains in the states represented by the members of this Subcommittee. A great amount of effort is required simply to proliferate the available family planning information to those in need of it. Since teenagers account for approximately one-third of all abortions performed, it is imperative that sex education and contraception be made increasingly available to them. Clearly, non-access has not worked, teenagers are instead becoming sexually active at ever younger ages.

Even if the appropriations request were greatly increased to facilitate the meeting of all these needs, what about the people in the meantime? What about those women who simply do not have access to family planning services yet; what about the women have have contraceptive failure; what about those women who become pregnancy simply because of lack of information; what about those women who cannot for health reasons use the most effective methods of birth control now available; what about victims of rape and incest; what about women who find they are carrying a genetically defective fetus; and what about those women who are suffering from serious diseases at the same time they are pregnant? The need for abortion will probably never be totally eradicated--and certainly not within this year! That is why it is so disconcerting to

hear Secretary Califano speak of the compassion the government must feel for the poor and his belief that DHEW is the "People's Department" but yet be so ready to cast away the rights and the needs of the poor in advocating denial of their access to abortion services. It is imperative that the human rights of the poor in this country be remembered as well as the human rights of those in other countries.

The final point to be made is that those individuals seeking to ban federal funding of abortions are doing so because of their own profound moral/religious convictions against abortion. They are not willing to tolerate the differing moral viewpoints of others in our society, let alone recognize the real-life situation with regard to abortion and unwanted pregnancies as outlined above. Indeed, it is ironic that the majority of those who are most anxious to prohibit abortion are strongly opposed to contraception and sex education and appear to dismiss quite lightly the constitutional rights of individuals to make their own decisions about childbearing. This is especially interesting since no one is being compelled to do anything against ones own will. This is a serious challenge to the First Amendment rights of all Americans which guaranteesfreedom of (as well as from) religion and which makes separation of church and state a fundamental tenet of our pluralistic, democratic society. In such a society it is expected that never will everyone agree. Moreover, no religious body has the right to impose its own conception of morality upon the society through secular law. For all those who are morally opposed to government funding of abortions, there are others who are equally opposed to forcing people to bear unwanted children and having to pay the resultant financial and societal cost. Probably everyone resents some ways in which the government has expended public funds. In such instances, decisions must be made upon the criteria of what is the fairest to those involved and the closest akin to the principles embodied in our Constitution. With regard to the question before us, the answer is clear--that federal funding of abortion services for the indigent should continue.

NARAL strongly urges the Subcommittee to continue federal funding of abortions for low-income women and to reject any language seeking to prohibit or limit access of such services to the poor.

| STATE OF SUBCOMMITTEE MEMBER | Number of Women in Need (15-44); below 200 % of Poverty A | Number of Women in Need (age: 15-19) B | Number of Low-Income Patients Served in FY 74 (15-44) C | Percentof Patients Served in FY 74 (age: 15-19) D | Percent of Those in Need Served in FY 74 (15-44) E |
|---|---|---|---|---|---|
| FLORIDA | 357,027 | 129,790 | 112,743 | 34.5% | 31% |
| INDIANA | 218,398 | 107,974 | 45,643 | 31.1% | 20% |
| MARYLAND | 158,991 | 79,034 | 81,316 | 32.7% | 51% |
| MASSACHUSETTS | 203,913 | 102,136 | 60,298 | 29.2% | 29% |
| MISSOURI | 227,856 | 93,817 | 81,969 | 32.0% | 35% |
| NEW JERSEY | 230,463 | 131,028 | 80,834 | 29.9% | 35% |
| NORTH DAKOTA | 38,882 | 13,676 | 6,547 | 17.5% | 16% |
| PENNSYLVANIA | 510,010 | 221,143 | 128,081 | 31.7% | 25% |
| SOUTH CAROLINA | 188,290 | 59,025 | 61,431 | 31.5% | 32% |
| WASHINGTON | 140,274 | 66,233 | 66,384 | 36.7% | 47% |
| WEST VIRGINIA | 118,155 | 35,961 | 21,657 | 23.0% | 18% |
| WISCONSIN | 180,071 | 37,690 | 2,324 | 11.7% | 1% |

Data is from the Alan Guttmacher Institute, Research & Development Division of the Planned Parenthood Federation

STATEMENT OF MRS. MARY SINGLETARY, EXECUTIVE DIRECTOR PLANNED PARENTHOOD--ESSEX COUNTY, N.J.

Mr. Chairman:

My name is Mrs. Mary Singletary of Newark, New Jersey. I am the Executive Director of Planned Parenthood of Essex County, New Jersey one of the 189 affiliates of the Planned Parenthood Federation of America. Today, I am here to present the views not only of our local group but that of the national organization. I have been directly involved in the administration and delivery of family planning services for more than 12 years, and serve as the President of the National Family Planning Forum, an organization which represents all types of family planning projects and their administration. Therefore, I believe I am qualified to speak to you concerning the definite needs of the field.

Six years ago when the first Title X family planning funds were appropriated those of us who were working in the field felt that there was good reason for optimism, and we were right. We watched the federal funds for the provision of family planning to women in need of subsidized services grow from a minimal level to a significant amount in the short span of years from 1970 to 1973. As a staff person for Planned Parenthood, I watched and welcomed other provider agencies which entered the field. Programs became capable of delivering truly excellent service including not only contraception but also such vital and basic preventive health services as gynecological examinations, breast and cervical cancer examinations, and venereal disease, diabetes and kidney disease screening, among others. Patient rolls grew from less than a million to its current total of close to 4.0 million. Today, Planned Parenthood, which is still the largest, single private organization in the country providing family planning services, accounts for only about 25 percent of the patients being served by organized family planning services programs in the United States; health departments and other nonprofit organizations which entered the field and developed a family planning capacity via the federal program serve the rest of patients currently participating in the service.

Unfortunately, the funding for Title X project grants became frozen in 1973 and remained frozen for four long fiscal years until, at long last, the Senate increased the family planning appropriation by $13 million for this fiscal year,

bringing the current total to $107.5 million. However, these funds were not adequate to offset the 10/12-1/2 percent inflation rate the projects had experienced annually during the four-year lean period. Perhaps the best way for me to illustrate the problem is by using my own affiliate as an example. We were funded at the same level -- $553,964 -- from 1973 to 1976. Of course, there were some savings which could be made, our administration tightened, but by the time we reached 1976 we were experiencing severe financial difficulties. In June of 1975 we were forced to freeze all salary levels. By January of 1976, we had to face the fact that if HEW did not increase our budget we would have to terminate the employment of ten staff members; we received no increase so we did, in fact, lose the employees. In June of 1976, we realized that our budget projections earlier in the year were being overun by a record growth in new patient population (which reached a total of 3,000 by the end of the year, a nearly 20 percent increase), mainly attributable to unemployment and inflation, and the attendant increased demand for services. We were then forced to terminate the services of an additional ten employees and to completely close down one of our most important facilities, a multi-lingual clinic in the iron-bound section of Newark. Thus far, in fiscal year 77 we have received no increase in HEW funds, and we face the possibility of again reducing our staff, this time by closing our community educational department and letting five people go. At the same time we are scrambling to find the necessary funds to serve more than 16,000 patients at three clinic sites -- Newark, Montclair, and the Northward area. We estimate that it would take about $160,000 in additional funds just to return us to the 1975 status quo in terms of staff to patient ratio. Furthermore, we estimate that we could wisely use another $73,000 in this fiscal year to enroll an additional 1,000 low-income and teenage patients for services in our currently ongoing clinics. Therefore, to restore services back to the 1975 level and make a truly minimal expansion would require a 50 percent increase over our current budget.

Mr. Chairman, the organized family planning services programs have contributed greatly already to the general health and welfare of low-income American families. All the provider agencies, including my own, stand ready to expand their services and accomplish the goal of reaching with services all those women who want and need them. We cannot accomplish this goal by relying on third-party

payment mechanisms for any substantial increases for the program. I know that each year you receive greatly inflated estimates from HEW with regard to how much the states are spending through the Title XIX (Medicaid) and Title XX (Social Services) authorities of the Social Security Act. I believe this year those estimates total about $177 million. I would like to point out that these are estimates, which do not appear to be based on adequate data. In many instances, they include large expenditures for abortion services as well as family planning services. I would also like to point out that in my own state of New Jersey, there are all sorts of administrative limitations on such funds which prevent our being able to use them to augment our Title X program. Furthermore, in some states family planning clinics have been unable to obtain certification as providers under the Medicaid program. With regard to expanded services for teenagers, there are also considerable problems with the Medicaid program.

Mr. Chairman, that is why I am here today. Our first and foremost need in this field is for additional funding. The Senate Committee on Human Resources will probably recommend a $130 million authorization for section 1001 family planning services project grants for FY 78 and additional sums for training, evaluation and educational materials. The Coalition for Health Funding, an organization composed of professional and service agencies involved in the delivery of health care services, has recommended a minimum level of $140 million in expenditures for family planning services in FY 78 which is compatible with these authorization levels. I would like to suggest that your subcommittee provide for full funding of the authorization for family planning services project grants.

I would also like to point out to the subcommittee that President Carter and HEW Secretary Califano have called for additional expenditures for family planning services in FY 78 in their "Alternatives to Abortion" package. While I would consider the HEW approach inadequate -- both as to dollar amounts and contents -- it is indicative, I believe, of the high degree of support for expanded services which exists today in the United States. In introducing this package HEW Secretary Califano pointed to nearly epidemic "teenage pregnancies" as one of our most alarming social problem and one of the underlying reason for the formulation of his proposal. I know that this subcommittee and, indeed, the full Senate Committee in its report last year urged that HEW begin to provide services to

deal with this problem and appropriated additional funds, in fact, for this purpose. The House Appropriations Committee also indicated its concern. Secretary Califano's proposal to increase the budget of the Title X project grant program for FY 78 falls far short of what the Congress did last year when it, not only rejected a substantial proposed cut back but provided a $13 million increase.

The Administration's budget proposal is disturbing in several other respects. $14 million are being proposed for family planning services under the Community Health Center Program. I certainly believe that Community Health Centers -- which have not experienced adequate growth in their budgets during the past few fiscal years -- should receive a budget increase in order to be able to continue providing the urgently needed health care services. I believe, at the same time, that Title X projects and other organized family planning services programs, which are already in place, and already have experience in programs especially designed for teens, would be the more appropriate and more efficient vehicles for the expansion of teen services. Their patient rolls indicate that already one out of every three of their patients are teens. In this context, I would like to tell you of my own experience in Newark with the capacity of Neighborhood Health Centers to participate in a family planning program. Last year Planned Parenthood of Essex County became involved in a joint program with Neighborhood Health Centers in the Newark area, which, under the provisions of each of their contracts, had to provide monthly family planning patient projections so as to receive stated amounts of federal funds. During the year, two centers were unable to meet their monthly patient projections. They could not reach the women who needed the service. Furthermore, they experienced start-up costs for providing their patients with family planning resulting in a per patient cost estimate of $300 or more. Therefore, they decided to withdraw from the program. Furthermore, I know, from discussions with other family planning providers around the country that this is by no means unusual. To me this does not indicate that a major approach to the development of new initiatives for the provision of family planning services to teens should be implemented through the community health program.

However, I would also like to point out that at hearings before your subcommittee, the Bureau of Community Health Services Director stated that it

would close some free-standing family planning clinics and move them into the comprehensive health centers when such clinics are located in the same areas. This arbitrary approach would seem to be counterproductive. For example, in Newark, there are family planning clinics located in areas near the centers I have just discussed. But, for whatever reasons, women and men come to these family planning clinics and not to the community health centers for the service. Our staff ability to provide them with family planning services differs greatly from those of the Centers. The centers have not demonstrated that they could now or at sometime in the near future deliver family planning services as effectively and efficiently as we do, rather the evidence goes in the other direction.

Congress authorized Title X because comprehensive programs had, with some significant exceptions, displayed massive disinterest in the provision of family planning services. Recently, the Congress amended the legislation authorizing community health and migrant health centers to require that they provide family planning services to their own patient populations. Nevertheless, a recent survey by the Alan Guttmacher Institute indicated that while 79 percent of community health centers responding to a questionnaire reported providing some family planning services, 21 percent said they did not. Perhaps more significant, most respondents indicated that they had no statistics on the number of family planning patients they served -- only 59 could supply even the total number of all female patients, regardless of the ages of those who received any kind of medical services.

While some community health centers do provide a significant amount of family planning services, it can be safely said that most give family planning low, or no, priority at all. In this context, BCHS's current position must be viewed with considerable alarm. Therefore, I urge that this committee, in its report, instruct HEW to utilize the increases in Title X funds to further and expand services through the existing network of family planning clinics rather than closing down existing clinics and starting new services through other health agencies.

Mr. Chairman, I would like to point out that we have both a domestic and an international need for safer easier-to-use and effective methods of fertility control. In the "Alternatives to Abortion" package President Carter recognized

this need and recommended a $5 million increase in the amount of funds available for population research. However, Secretary Califano has indicated that a substantial portion of this sum be focused on normal neo-natal development rather than on contraception. As valuable as such investigations are, I think you would have a hard time convincing a woman who is involuntarily pregnant that such research could have helped prevent her pregnancy. If we are talking about alternatives to abortion, Mr. Chairman, I think that women and men would urge us to concentrate on promising, unexplored research leads--and there are dozens -- in the area of fertility control. The inadequacy of the government's effort in this area has been brought into sharp focus by the public's concern for abortion. It is time to respond directly and honestly with increased funding for research on birth control and reproductive physiology within the NICHD Center for Population Research.

Senator Cranston's proposed extension of the Family Planning Services and Population Research Act would authorize $70 million for population research. I would, therefore, urge that this subcommittee appropriate no less than $70 million explicitly designated for biomedical research to be used by the Center for Population Research in developing improved means of family planning so that progress may be made toward the end goal of development of improved methods of family planning which will ultimately result in families having healthier, happier and wanted children.

Finally, Mr. Chairman, in reference to all of the items contained in HEW's "Alternatives to Abortion" package, we would like to recommend the following:

- Full funding for family planning services and related activities authorized under Title X, the Family Planning Services and population Research Act. The exact authorization figures are still subject to action in both the House and Senate but it is already certain that they will reflect realistic estimates of immediate program needs. Full funding would permit a modest but meaningful expansion of the family planning program and would reinforce the commitment Congress made last year in approving, for the first time in four years, an increase in appropriations for family planning project grants.

-Approval of the administration's recommendation of $14 million in increased funding for community health centers, with the understanding that it is needed to maintain the crucial, ongoing work of the program.

-Explicit designation of the $10 million increase in biomedical research funding to ensure it is used to support the work of the Center for Population Research in developing improved means of family planning.

-Expansion of earmarked support for sex education to a minimum level of $4 million. This figure falls far short of the existing need, but it would establish a realistic start toward meeting a long-neglected priority.

-More appropriate assessment of adoption and foster care needs with consideration of expanded financial assistance for families and agencies providing essential services.

In closing, Mr. Chairman, I would like to state that all of us are concerned with making sure that true "Alternatives to Abortion" are available to the woman who experiences an unwanted pregnancy. In such a sensitive area, it is important that the public and the Congress not be misled with promises of action through programs that are not designed to focus on fertility control services nor capable of an effective response. American women and men have the right to expect that promises of major national undertakings will not be followed up by only token funding. If we are to live up to that expectation, this committee must apply its knowledge of health programs to ensure that money intended to provide "Alternatives to Abortion" is neither inadequate to the point of meaninglessness nor misdirected.

On behalf of all women and men who confront unwanted pregnancy and are forced to make difficult personal choices as a result, I ask you to recognize that progress depends on realistic funding for reproductive research, sex education and family planning services.

**STATEMENT OF THOMAS MORSE, PRESIDENT, AMERICAN TRAUMA SOCIETY**

**ACCOMPANIED BY:**

**CURTIS ARTZ**

**VAN B. ELLIOTT, DIRECTOR OF EMERGENCY MEDICAL SERVICES, RICHLAND MEMORIAL HOSPITAL, COLUMBIA, S.C.**

INTRODUCTION OF WITNESSES

Senator BROOKE. We will hear emergency medical services. If you would introduce yourselves, you may begin.

Mr. MORSE. I am Dr. Thomas Morse, president of the American Trauma Society. On my left is Dr. Curtis Artz; on my right, Dr. Van Elliott. Unlike the other groups that testified before you today, we are not repeaters. We are here for the first time.

Since your hearings were convened this morning at 9:00 o'clock, about 91 Americans have died of injury, and about 80,000 have been injured and 3,000 will not recover. Trauma is not a household word. The average citizen didn't see how he can do much about it.

In the years past, the same was true of the heart disease and cancer. Through the efforts of two volunteer health agencies, American Cancer Society and the American Heart Association, nearly everyone knows how to contribute time, talent and money or effort to defeating these two diseases.

The American Trauma Society is for the injured patient what the American Cancer Society is to the victim of cancer: people and doctors from all walks of life try improve the care and reduce the toll of accidents and to inform the public as to what the problem is and what can be done about it and finally to enhance and sponsor research.

Dr. Artz will be talking to you about our research.

Dr. ARTZ. I am Curtis Artz, head of the department of surgery in Charleston, S.C., at our university.

My interest in the injured man started first in Korea when I served as head of the surgical research team in a mobile Army research hospital and came back to the Brook Army Medical Center and started its burn program. Since that time, I have been interested in burn centers, trauma centers and emergency medical services as a means of improved care.

I think we would like to leave you with the impression today that you have done a wonderful job in supporting trauma through the National Institute of General Medical Sciences and we would hope you would continue with this.

We would ask, though, that you look and support through general medical sciences, some demonstration centers throughout the country. Unfortunately—fortunately in trauma, we know an awful lot about trauma. We just don't know enough about the delivery of health care to do the most for the largest number of citizens, so we need some studies in epidemiology, the causes of trauma; we need to find out the impact of biomedical data transmission systems.

In other words, is it good for somebody to be able to transmit the EKG from the field into the emergency department; is this worth the time and effort and the like? What is the feasibility of establishing trauma as a reportable disease, and above all, is there a way that maybe you could specially utilize some of the funds now going to the Institute of General Medical Sciences for use of demonstration centers in trauma, rather than what it is currently used for, which is biomedical and physiological data.

PREPARED STATEMENT

Senator BROOKE. Thank you. We will submit your written statement into the record.

[The statement follows:]

# STATEMENT OF THE AMERICAN TRAUMA SOCIETY

## RECOMMENDATIONS FOR APPROPRIATIONS

## FISCAL YEAR 1978

### Trauma Research

### National Institute of General Medical Sciences

Recommendation 1

Trauma research programs at the National Institute of General Medical Sciences, of which $250,000 shall be for extramural research, as described in Recommendation 2 — $6,500,000

Recommendation 2

Creation of intramural and extramural initiatives for producing data necessary to assess current and future trauma research programs

The American Trauma Society is pleased to have this opportunity to present its comments and views on fiscal year 1978 appropriations for the National Institute of General Medical Sciences (NIGMS) before the Senate Appropriations Subcommittee on Labor, Health, Education, and Welfare. Mr. Chairman, we fully appreciate the extent and magnitude of your deliberations concerning a highly complex range of issues, and commend you and your colleagues on the Subcommittee for your diligent pursuit of effective resolution of such a variety of matters. As representatives of the Society, we will confine our remarks to our concerns for trauma and federally-funded trauma research programs.

## THE AMERICAN TRAUMA SOCIETY

The American Trauma Society represents dedicated people--distinguished physicians, capable paraprofessionals, and interested lay persons--who want to protect the 1,300 Americans who every hour suffer disabling injuries, who want to save the 13 Americans who every hour die by accident, who want to restore to their normal, creative lives the 457 Americans who now every hour are permanently maimed at home, on the job or on the road.

Of the many groups concerned with one or a few aspects of trauma, the American Trauma Society is organized with the single mission of mobilizing all concerned about trauma with developing a comprehensive system of trauma response. With national headquarters in Chicago, the Society, together with divisions chartered in 34 states has more than 5,000 members who have committed themselves to conquering the "neglected disease of modern society."

At the top of its organization, the American Trauma Society has brought together a board of directors which represents a potent assembly of those individuals who have long understood the life-or-death importance of promoting trauma prevention, supporting trauma research and fighting for specialized trauma care.

It is from this dedicated group that the formal purposes of American Trauma Society have been established. Better than goals, the following are the continuing responsibilities of the Society:

1) Increasing public knowledge and understanding of trauma and motivating each person so that the toll of trauma is reduced through personal action at the community and national level.
2) Organizing and coordinating all persons--lay and professional--involved in trauma response and care for the acceptance, promotion and support of optimal trauma response and care within the community.
3) Promoting and supporting the initial and continuing education of physicians, nurses, and allied health personnel involved in trauma response and care.
4) Supporting research and the systematic gathering of data to determine the effects of trauma and to improve the care of the trauma patient.

The purposes of the American Trauma Society are having increasing meaning as we witness their being transformed, albeit slowly, into actions. For example, Public Law 93-154, the Emergency Medical Services Systems Act of 1973, together with its successor, Public Law 94-573, the Emergency Medical Services Amendments of 1976, have provided landmark investments by the federal government toward impacting general emergency medical services throughout America, consistent with the overall purposes of the Society. It is very much to the credit of the members of this distinguished Senate Subcommittee that PL 93-154 was provided sufficient appropriations to begin this important work. The Society very much appreciates the difficult choices faced by the members of this Subcommittee as they consider fiscal year 1978 appropriations for PL 94-573, the continuation of this important program.

However, today it is to the continuation of the vitally important role of the National Institute of General Medical Sciences trauma research program about which we wish to speak. The unique characteristics of the American Trauma Society, we are sure you will agree, make it uniquely qualified to speak about the important accomplishments of trauma research to date and, at the same time, the clear rationale for continuing the NIGMS trauma research activities.

The American Trauma Society was formed in 1968 as a not-for-profit voluntary health organization in which physicians, nurses, allied health personnel and lay persons throughout the nation participate. It is a growing network of 34 state divisions, and an additional number of local units, assisted by a professional staff at the national level. At each level of the Society, there are dedicated individuals volunteering countless hours of their time to tell Americans that trauma is one disease which can be combatted by direct personal action.

In calling for the formation of the American Trauma Society, the National Academy of Sciences/National Research Council declared in 1966 that trauma is the "neglected disease of modern society--an epidemic second only to the ravages of ancient plagues or world wars." As a centralized, coordinating agency, the American Trauma Society seeks to create a truly national movement to deal with accidental injury.

The Board of Directors was at first heavily weighted with physicians, as was true in the early days of the American Heart Association and the American Cancer Society, but rapid progress has been made toward a Board composed of 30 lay members and 30 physician members.

Those who have worked closely with the American Trauma Society know that its progress has been relatively rapid compared to the early days of the Heart Association and the Cancer Society. Officials of both of those agencies have been extraordinarily helpful in providing information, advice, and cooperation. In one sense, the Society poses a threat to

them since it will be competing with them for health dollars. On the other hand, there are many areas of potential cooperation, such as the development of community emergency medical services which will serve the need of heart disease and cancer, as well as those of trauma. All parties involved clearly recognized that what those two agencies are doing for heart disease and cancer, the American Trauma Society can do for accidental death and disability, the neglected disease of our modern society.

## TRAUMA AND ITS INSIDIOUS COST

Trauma means injury, any kind of injury. Often we think of an injury as "just an accident," but 105,000 Americans did not call their injuries "just an accident" in 1974. They died by accident. They died from trauma.

Trauma is the leading cause of death among persons from the age of 1 to 38. It is the fourth leading cause of death among persons of all ages. Only heart disease, cancer, and stroke are responsible for more deaths than trauma, but they exact their heaviest tolls during life's twilight years.

The four top trauma killers are motor-vehicle accidents, falls, drowning, and burns or deaths associated with fires. Every one of these killers could be tamed by judicious personal action and appropriate preventive measures. In every category, the number of disabilities could be reduced significantly if every American knew how to respond when a serious injury occurred. Moreover, according to the National Academy of Sciences, 15 to 20 percent of the deaths due to trauma could be prevented each year by improved care for these victims.

Because trauma is so pervasive in our society, we tend to accept its presence and leave unestimated its toll. America mourned for the 56,000 young Americans who lost their lives during the years of our involvement in Vietnam. Yet, each year in this country, almost twice that number lose their lives through trauma.

In 1974, according to the National Center for Health Statistics, 11,000,000 Americans suffered disabling injuries, and 380,000 of these persons suffered permanent impairment from their injuries. The U.S. Public Health Service estimated that the annual average number of injuries that occurred between 1971 and 1973 was 64,257,000. These injuries were those which had to be attended medically or which caused the victim one full day or more of restricted activity.

Deaths on this nation's highways, city streets, rural roads and suburban avenues numbered 46,200 in 1974, and 1,800,000 Americans suffered disabling injuries through motor-vehicle accidents. Lost wages, medical expenses, and property damage totalled $19.3 billion. While most of us take to the road with the notion that we are careful drivers, improper driving causes 84.6 percent of all motor-vehicle accidents.

Every 21 minutes a person dies in an accident in or around his own home. More than 25,000 persons died in home accidents in 1974, usually from falls, or from burns or trauma associated with fires. One person in every 52 suffered a home injury which caused disability for one or more days. Home repairs done with faulty equipment, failure to plan for household fires, or just inadequate care in working around the house caused Americans to lose $2.3 billion in wages and to spend $1.4 billion in medical expenses in 1974 alone.

Although many American companies and corporations, large and small, have worked to promote job safety, 45,000,000 man-days of productivity were lost in 1974 through accidents on the job. The Social Security Administration pays more than $5.0 billion each year to disabled workers for medical expenses and wage compensation. Workmen's Compensation and private programs pay millions more.

In total, an estimated $43.0 billion is spent each year in the United States to pay trauma's toll. One out of every eight hospital beds is occupied by a trauma victim. These are more beds than are required for

all births and for all cardiac patients, and four times the number needed for all cancer patients.

During the fiscal year 1976, trauma research programs conducted by the National Institute of General Medical Sciences had $5,750,000 with which to work. This figure increased ever so slightly to $6,250,000 for the current fiscal year. By way of contrast, government support for cancer research is nearly $1.0 billion and federal support for heart research is only slightly less than that given for cancer. To put these figures in another perspective, federally supported funding for trauma research amounts to only 50 cents per trauma victim each year.

## THE WAY TO COMBAT THE EPIDEMIC OF TRAUMA

The National Research Council in 1966 published the recommendations of its committees on trauma, shock and anesthesia, plus those of special task forces of the Division of Medical Sciences, on the subject of accidental death and disability. Because of the importance of the subject to the national welfare and the minimal efforts being made to solve the problems involved, they stated that trauma was "the neglected disease of modern society."

This action has lead to improved support for trauma research, treatment and rehabilitation of individuals suffering from the effects of trauma. The progress that has been made in the United States during the past ten years is evident when you review the scope of the program presented at the 1976 Bicentennial Emergency Medical Services and Traumatology Conference. The American Trauma Society has played a major role in these improvements.

The Department of Health, Education and Welfare's Public Health Service, and its National Institute of Health, especially NIGMS, have played a major role in improving our knowledge and ability to handle

trauma. This has been accomplished by the actions of study committees and grants to finance research and training in traumatology.

At the same time, however, it must be recognized that only minimal efforts are being made in the field of traumatology education. Medical schools and other health education institutions are paying very little attention to the subject of traumatology.

The University of Maryland Medical School has a pilot program in traumatology under the leadership of R. Adams Cowley, M.D. This is an excellent program operating on a statewide basis, and it is the type of program that should be considered for implementation on a national basis. Such programs should receive adequate funding for support of research in the fields of trauma prevention, treatment and rehabilitation. The armed forces and the Department of Health, Education and Welfare should also greatly increase their financial support of research in the field of trauma.

We are especially in need of more fundamental research on the psychological reactions to trauma, and we should recognize the value of observation by skilled physicians involved in the treatment of trauma. These observations and their analysis, when grouped with similar work being done, may lead us to fundamental truths of great value in the treatment of trauma in human patients.

Literally volumes could be said about the state of the art, or the lack thereof, and the vast toll which this lack extracts from our society's most vital membership: <u>trauma is America's leading killer of our under 38 population</u>.

The American Trauma Society firmly supports congressional concern for the unending stream of requests for additional funds at a time when our economy is screaming for constraint. We do not wish to be a part of the perennial clamor for "more! more! more!". At the same time, we wish

to assure that the rapidly growing epidemic of trauma does not find us even farther behind next year. Trauma research needs federal support for interesting, productive projects, which will produce data and findings of practical use to waging the war on this intolerable disease. The Society looks forward to working with this Subcommittee in future years to evaluate the cost-benefit return of federal dollars invested in trauma research; we can all see from the statistics that the potential returns are enormous.

The American Trauma Society also looks forward to continuing work with the National Institute of General Medical Sciences as it approaches new and productive research projects. The personnel of NIGMS are to be commended for the conduct of extremely fine work in recent years regarding trauma, on what some would refer to as "shoestring budgets". It is obvious through the conduct of numerous trauma-research projects through NIGMS, or funded by the Institute, as well as by some not funded by the Institute, that the staff has sought to substantially improve the quality of research efforts.

In conclusion, Mr. Chairman, the American Trauma Society wishes to make two recommendations for fiscal year 1978 appropriations for trauma research.

Recommendation 1

The American Trauma Society endorses the President's budget recommendation of $6,500,000 for trauma research programs at the National Institute of General Medical Sciences. This amount represents an increase of 4 percent over the 1977 program, a nominal increase, at best. This increase would assist to partially offset the effects of inflation, while still permitting the Institute to maintain its present level of programmatic activity in trauma research.

Recommendation 2

It is the opinion of the American Trauma Society that current efforts into trauma research desperately need to be evaluated on the basis of epidemiological data not presently available. It would be illogical to

recommend expanded programmatic activities, or increased funding of a significant nature, when there are so many questions which need to be answered about where we are today. Years of research have affected the quality of care which trauma patients may receive. However, we do not know specific and contemporary epidemiologies of trauma. Therefore, in order to overcome this basic lack of data, the Society recommends that the Committee on Appropriations suggest that the National Institute of General Medical Sciences create initiatives for intramural and extramural studies in areas of:

1) Incidence of trauma--the epidemiology and demographics of the disease and its treatment modalities
2) Causes of trauma and the nature of resultant injuries
3) Impact of biomedical data transmission systems
4) Feasibility of establishing trauma as a reportable disease
5) Feasibility of expanding the role of already established trauma centers to become research demonstration centers on techniques for improving care of the critically injured
6) Determination and feasibility of training health professionals in the management and treatment of trauma patients.

While this list is by no means exhaustive, it does represent the type of studies which will produce data extremely useful to our ability to assess trauma and trauma research. Such an assessment is vital to be undertaken, if we are to accomplish what was suggested earlier, specifically, ". . . working with this Subcommittee (as well as with NIGMS) in future years to evaluate the cost-benefit return of federal dollars invested. . . ." Toward this end, we further recommend that $250,000 of the trauma research appropriation be specified for extramural studies of the nature specified earlier.

The American Trauma Society is pleased to have had the opportunity to present this statement to the Senate Appropriations Subcommittee on Labor, Health, Education and Welfare. The Society would welcome the opportunity to provide answers for any questions which the Chairman, or his distinguished colleagues, may have at this, or any future time.

STATEMENT OF VAN B. ELLIOTT

Dr. ELLIOTT. Mr. Chairman, I am Van B. Elliott, director of emergency services at Richland Memorial Hospital in Columbia, S.C. Also, the regional director for emergency medical centers in South Carolina.

Public Law 93–154 (November 16, 1973) and its amendment; Public Law 94–573 (October 2, 1976)—with particular emphasis towards application in South Carolina and other rural emergency medical service regions. The statement of my testimony being the aforementioned acts of the 93d and 94th Congress respectively; copies are attached.

My recommendations are consistent with and in full support of these congressional acts, therefore, I feel further elaboration in this area unnecessary. My purpose here is to encourage recommendation from your committee that full fiscal authorization as contained in the appropriate sections (1202, 1203, 1204, 1206, 1207) be implemented.

A brief summary for support of emergency medical services in South Carolina is attached. We in South Carolina and other rural emergency medical service regions thank you for your time and consideration.

I would like to read a brief summary. I have enclosed in the rear of my booklet a life expectancy chart: (enclosure 1). Please note that South Carolina life expectancy rates are the lowest in the United States. Identified also are the three leading causes of death.

The leading causes of death in South Carolina are being dealt with directly by the Emergency Medical Services Act of 1973 and a general health care upgrading has been the direct result.

In a rural area it is impossible to separate emergency and primary care medicine. The more urban areas of those rural regions can more satisfactorily deal with emergency medicine as an immediate life-threatening condition (i.e., cardiac arrest)—30 miles away emergency medicine may well mean the repair of a simple laceration or the treatment of a child's pneumonia and the reassurance given that child's family.

We now are working to insure appropriate medical control will be available in that rural area for the more immediate life-threatening problems. These are the systematic approach problems in the Emergency Medical Services Act. Emergency medical services addresses both the urban and rural area.

Thus far, in South Carolina, and other regional areas, the emergency medical services' Federal dollar has been that Federal money most visible to the public. This money has had the greatest impact in gaining local, fiscal, political and medical support. We are becoming more able to interface the critical life support capabilities of a regional medical center with the primary care physicians of our State.

We desperately need the full authorization as provided for in the 1976 amendement to the Emergency Medical Services Act.

Federal region IV is comprised of eight States—North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee, and Kentucky. At present, we expect only approximately $4 million available to Federal region IV.

In South Carolina, we have applications for region I for section 1204, from our region II for section 1203 (second year) from our region III for section 1202, and from our region IV for section 1203. (See attached South Carolina regional map) (enclosure 2).

Our total grant request for all South Carolina regions is less than $1 million nationwide. We compare favorably, if we are not lower than other rural areas.

With full fiscal authorization we would be much more capable of implementing more efficient emergency medical services and complement, indirectly, primary medical care.

South Carolina physicians are not seeking full Federal support for medical problems. We realize our responsibilities. The Emergency Medical Services Act is not designed to fully subsidize any local emergency medical service program, but to begin a systematic approach to better medical control and care. Had the Emergency Medical Services Act, thus far not been so successful in the fulfillment of its basic philosophy, I and others, would not be here. Thank you very much.

Senator BROOKE. What was the fiscal year 1977 funding level?

Dr. ELLIOTT. For systems and training together, the authorization amount was, if I am not mistaken, $62 million.

Senator BROOKE. The President has come in with a budget request of $65 million?

Dr. ELLIOTT. No, sir. As I understand it, it is going to be closer to $40 million.

Dr. ARTZ. For EMS.

Dr. ELLIOTT. Right. We have not received the latest figures, so we don't know.

Senator BROOKE. Under emergency services, the budget request is $33 million.

Dr. ELLIOTT. That is the systems. That is the money that actually goes back to the county as equipment, and vehicles——

Senator BROOKE. I see. You are basically in agreement with that.

Dr. ELLIOTT. There is room under the authorization for approximately $6 million. I understand it is for additional funding. That means approximately 18 more regions could be funded under the present amendment.

PREPARED STATEMENT

Senator BROOKE. All right. Thank you. Thank you very kindly. Please leave your written statement and it shall be included in the record.

[The statement follows:]

# STATEMENT OF DR. VAN B. ELLIOTT, JR., DIRECTOR, SOUTH CAROLINA REGIONAL EMERGENCY MEDICAL SERVICES

REPRESENTING: Emergency Medical Services

BUDGET SUBJECT: Public Law 93-154 (November 16, 1973) and its amendment; Public Law 94-573 (October 2, 1976) - with particular emphasis towards application in South Carolina and other rural Emergency Medical Service regions. The statement of my testimoney being the aforementioned acts of the 93rd and 94th Congress respectively; copies are attached.

RECOMMENDATIONS: My recommendations are consistent with and in full support of these Congressional Acts, therefore, I feel further elaboration in this area unnecessary. My purpose here is to encourage recommendation from your committee that full fiscal authorization as contained in the appropriate sections (1202, 1203, 1204, 1206, 1207) be implemented.

A brief summary for support of Emergency Medical Services in South Carolina is attached. We in South Carolina and other rural Emergency Medical Service regions thank you for your time and consideration.

Public Law 93-154
93rd Congress, S. 2410
November 16, 1973

# An Act

To amend the Public Health Service Act to provide assistance and encouragement for the development of comprehensive area emergency medical services systems.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

SHORT TITLE

Emergency Medical Services Systems Act of 1973.

SECTION 1. This Act may be cited as the "Emergency Medical Services Systems Act of 1973".

EMERGENCY MEDICAL SERVICES SYSTEMS

58 Stat. 682; 86 Stat. 137. 42 USC 201 note.

SEC. 2. (a) The Public Health Service Act is amended by adding at the end thereof the following new title:

## "TITLE XII—EMERGENCY MEDICAL SERVICES SYSTEMS

"DEFINITIONS

"SEC. 1201. For purposes of this title:

"(1) The term 'emergency medical services system' means a system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery in an appropriate geographical area of health care services under emergency conditions (occurring either as a result of the patient's condition or of natural disasters or similar situations) and which is administered by a public or nonprofit private entity which has the authority and the resources to provide effective administration of the system. 87 STAT. 594 87 STAT. 595

"(2) The term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

"(3) The term 'modernization' means the alteration, major repair (to the extent permitted by regulations), remodeling, and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"(4) The term 'section 314(a) State health planning agency' means the agency of a State which administers or supervises the administration of a State's health planning functions under a State plan approved under section 314(a). 80 Stat. 1181; 84 Stat. 1304. 42 USC 246.

"(5) The term 'section 314(b) areawide health planning agency' means a public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b), and the term 'section 314(b) plan' means a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b). 84 Stat. 340, 1304.

"GRANTS AND CONTRACTS FOR FEASIBILITY STUDIES AND PLANNING

"SEC. 1202. (a) The Secretary may make grants to and enter into contracts with eligible entities (as defined in section 1206(a)) for projects which include both (1) studying the feasibility of establishing (through expansion or improvement of existing services or otherwise) and operating an emergency medical services system, and (2) planning the establishment and operation of such a system.

Post, p. 598.

Geographical area, limitation.

"(b) If the Secretary makes a grant or enters into a contract under this section for a study and planning project respecting an emergency medical services system for a particular geographical area, the Secretary may not make any other grant or enter into any other contract under this section for such project, and he may not make a grant or enter into a contract under this section for any other study and planning project respecting an emergency medical services system for the same area or for an area which includes (in whole or substantial part) such area.

Reports.

"(c) Reports of the results of any study and planning project assisted under this section shall be submitted to the Secretary and the Interagency Committee on Emergency Medical Services at such intervals as the Secretary may prescribe, and a final report of such results shall be submitted to the Secretary and such Committee not later than one year from the date the grant was made or the contract entered into, as the case may be.

87 STAT. 595
87 STAT. 596

Application requirements.

"(d) An application for a grant or contract under this section shall—

"(1) demonstrate to the satisfaction of the Secretary the need of the area for which the study and planning will be done for an emergency medical services system;

"(2) contain assurances satisfactory to the Secretary that the applicant is qualified to plan an emergency medical services system for such area; and

"(3) contain assurances satisfactory to the Secretary that the planning will be conducted in cooperation (A) with each section 314(b) areawide health planning agency whose section 314(b) plan covers (in whole or in part) such area, and (B) with any emergency medical services council or other entity responsible for review and evaluation of the provision of emergency medical services in such area.

"(e) The amount of any grant under this section shall be determined by the Secretary.

"GRANTS AND CONTRACTS FOR ESTABLISHING AND INITIAL OPERATION

Contracts with eligible entities.

"SEC. 1203. (a) The Secretary may make grants to and enter into contracts with eligible entities (as defined in section 1206(a)) for the establishment and initial operation of emergency medical services systems.

Coordination with statewide system.

"(b) Special consideration shall be given to applications for grants and contracts for systems which will coordinate with statewide emergency medical services system.

Modernization of emergency facilities.

"(c)(1) Grants and contracts under this section may be used for the modernization of facilities for emergency medical services systems and other costs of establishment and initial operation.

"(2) Each grant or contract under this section shall be made for costs of establishment and operation in the year for which the grant or contract is made. If a grant or contract is made under this section for a system, the Secretary may make one additional grant or contract for that system if he determines, after a review of the first nine months' activities of the applicant carried out under the first grant or contract, that the applicant is satisfactorily progressing in the establishment and operation of the system in accordance with the plan contained in his application (pursuant to section 1206(b)(4)) for the first grant or contract. Additional grant or contract. Post, p. 599.

"(3) No grant or contract may be made under this section for the fiscal year ending June 30, 1976, to an entity which did not receive a grant or contract under this section for the preceding fiscal year. Limitation.

"(4) Subject to section 1206(f)— Post, p. 601.

"(A) the amount of the first grant or contract under this section for an emergency medical services system may not exceed (i) 50 per centum of the establishment and operation costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 75 per centum of such costs for such year; and Cost limitation. 87 STAT. 596

"(B) the amount of the second grant or contract under this section for a system may not exceed (i) 25 per centum of the establishment and operation costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 50 per centum of such costs for such year. 87 STAT. 597

"(5) In considering applications which demonstrate exceptional need for financial assistance, the Secretary shall give special consideration to applications submitted for emergency medical services systems for rural areas (as defined in regulations of the Secretary). Rural area systems, financial assistance.

"GRANTS AND CONTRACTS FOR EXPANSION AND IMPROVEMENT

"SEC. 1204. (a) The Secretary may make grants to and enter into contracts with eligible entities (as defined in section 1206(a)) for projects for the expansion and improvement of emergency medical services systems, including the acquisition of equipment and facilities, the modernization of facilities, and other projects to expand and improve such systems. Ante, p. 598.

"(b) Subject to section 1206(f), the amount of any grant or contract under this section for a project shall not exceed (i) 50 per centum of the cost of that project (as determined pursuant to regulations of the Secretary), or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 75 per centum of such costs. Cost limitation.

"GRANTS AND CONTRACTS FOR RESEARCH

"SEC. 1205. (a) The Secretary may make grants to public or private nonprofit entities, and enter into contracts with private entities and individuals, for the support of research in emergency medical techniques, methods, devices, and delivery. The Secretary shall give special consideration to applications for grants or contracts for research relating to the delivery of emergency medical services in rural areas. Rural area systems, research.

Cost limitation.

"(b) No grant may be made or contract entered into under this section for amounts in excess of $35,000 unless the application therefor has been recommended for approval by an appropriate peer review panel designated or established by the Secretary. Any application for a grant or contract under this section shall be submitted in such form and manner, and contain such information, as the Secretary shall prescribe in regulations.

Reports to HEW.

"(c) The recipient of a grant or contract under this section shall make such reports to the Secretary as the Secretary may require.

87 STAT. 597
87 STAT. 598

"GENERAL PROVISIONS RESPECTING GRANTS AND CONTRACTS

"Eligible entity."

"SEC. 1206. (a) For purposes of sections 1202, 1203, and 1204, the term 'eligible entity' means—

Ante, pp. 595-597.

"(1) a State,

"(2) a unit of general local government,

"(3) a public entity administering a compact or other regional arrangement or consortium, or

"(4) any other public entity and any nonprofit private entity.

"(b)(1) No grant or contract may be made under this title unless an application therefor has been submitted to, and approved by, the Secretary.

Priority consideration.

"(2) In considering applications submitted under this title, the Secretary shall give priority to applications submitted by the entities described in clauses (1), (2), and (3) of subsection (a).

Ante, p.595.

"(3) No application for a grant or contract under section 1202 may be approved unless—

"(A) the application meets the application requirements of such section;

"(B) in the case of an application submitted by a public entity administering a compact or other regional arrangement or consortium, the compact or other regional arrangement or consortium includes each unit of general local government of each standard metropolitan statistical area (as determined by the Office of Management and Budget) located (in whole or in part) in the service area of the emergency medical services system for which the application is submitted;

"(C) in the case of an application submitted by an entity described in clause (4) of subsection (a), such entity has provided a copy of its application to each entity described in clauses (1), (2), and (3) of such subsection which is located (in whole or in part) in the service area of the emergency medical services system for which the application is submitted and has provided each such entity a reasonable opportunity to submit to the Secretary comments on the application;

"(D) the—

80 Stat. 1181; 84 Stat. 1304. 42 USC 246.

"(i) section 314(a) State health planning agency of each State in which the service area of the emergency medical services system for which the application is submitted will be located, and

84 Stat. 340, 1304.

"(ii) section 314(b) areawide health planning agency (if any) whose section 314(b) plan covers (in whole or in part) the service area of such system,

have had not less than thirty days (measured from the date a copy of the application was submitted to the agency by the applicant) in which to comment on the application;

Recordkeeping; reports to HEW.

"(E) the applicant agrees to maintain such records and make such reports to the Secretary as the Secretary determines are necessary to carry out the provisions of this title; and

"(F) the application is submitted in such form and such manner and contains such information (including specification of applicable provisions of law or regulations which restrict the full utilization of the training and skills of health professions and allied and other health personnel in the provision of health care services in such a system) as the Secretary shall prescribe in regulations.

Prohibitions.
Ante, pp. 595, 596.
Ante, p. 598.

"(4)(A) An application for a grant or contract under section 1203 or 1204 may not be approved by the Secretary unless (i) the application meets the requirements of subparagraphs (B) through (F) of paragraph (3), and (ii) except as provided in subparagraph (B)(ii), the applicant (I) demonstrates to the satisfaction of the Secretary that the emergency medical services system for which the application is submitted will, within the period specified in subparagraph (B)(i), meet each of the emergency medical services system requirements specified in subparagraph (C), and (II) provides in the application a plan satisfactory to the Secretary for the system to meet each such requirement within such period.

Grants or contract period.

"(B)(i) The period within which an emergency medical services system must meet each of the requirements specified in subparagraph (A) is the period of the grant or contract for which application is made; except that if the applicant demonstrates to the satisfaction of the Secretary the inability of the applicant's emergency medical services system to meet one or more of such requirements within such period, the period (or periods) within which the system must meet such requirement (or requirements) is such period (or periods) as the Secretary may require.

Alternate plan, submittal to HEW.

"(ii) If an applicant submits an application for a grant or contract under section 1203 or 1204 and demonstrates to the satisfaction of the Secretary the inability of the system for which the application is submitted to meet one or more of the requirements specified in subparagraph (C) within any specific period of time, the demonstration and plan prerequisites prescribed by clause (ii) of subparagraph (A) shall not apply with respect to such requirement (or requirements) and the applicant shall provide in his application a plan, satisfactory to the Secretary, for achieving appropriate alternatives to such requirement (or requirements).

Emergency medical services system requirements.

"(C) An emergency medical services system shall—

"(i) include an adequate number of health professions, allied health professions, and other health personnel with appropriate training and experience;

"(ii) provide for its personnel appropriate training (including clinical training) and continuing education programs which (I) are coordinated with other programs in the system's service area which provide similar training and education, and (II) emphasize recruitment and necessary training of veterans of the Armed Forces with military training and experience in health care fields and of appropriate public safety personnel in such area;

"(iii) join the personnel, facilities, and equipment of the system by a central communications system so that requests for emergency health care services will be handled by a communications facility which (I) utilizes emergency medical telephonic screening, (II) utilizes or, within such period as the Secretary prescribes will utilize, the universal emergency telephone number 911, and (III) will have direct communication connections and interconnections with the personnel, facilities, and equipment of the system and with other appropriate emergency medical services systems;

87 STAT. 600

"(iv) include an adequate number of necessary ground, air, and water vehicles and other transportation facilities to meet the individual characteristics of the system's service area—

"(I) which vehicles and facilities meet appropriate standards relating to location, design, performance, and equipment, and

"(II) the operators and other personnel for which vehicles and facilities meet appropriate training and experience requirements;

"(v) include an adequate number of easily accessible emergency medical services facilities which are collectively capable of providing services on a continuous basis, which have appropriate nonduplicative and categorized capabilities, which meet appropriate standards relating to capacity, location, personnel, and equipment, and which are coordinated with other health care facilities of the system;

"(vi) provide access (including appropriate transportation) to specialized critical medical care units in the system's service area, or, if there are no such units or an inadequate number of them in such area, provide access to such units in neighboring areas if access to such units is feasible in terms of time and distance;

"(vii) provide for the effective utilization of the appropriate personnel, facilities, and equipment of each public safety agency providing emergency services in the system's service area;

"(viii) be organized in a manner that provides persons who reside in the system's service area and who have no professional training or financial interest in the provision of health care with an adequate opportunity to participate in the making of policy for the system;

"(ix) provide, without prior inquiry as to ability to pay, necessary emergency medical services to all patients requiring such services;

"(x) provide for transfer of patients to facilities and programs which offer such followup care and rehabilitation as is necessary to effect the maximum recovery of the patient;

"(xi) provide for a standardized patient recordkeeping system meeting appropriate standards established by the Secretary, which records shall cover the treatment of the patient from initial entry into the system through his discharge from it, and shall be consistent with ensuing patient records used in followup care and rehabilitation of the patient;

"(xii) provide programs of public education and information in the system's service area (taking into account the needs of visitors to, as well as residents of, that area to know or be able to learn immediately the means of obtaining emergency medical services) which programs stress the general dissemination of information regarding appropriate methods of medical self-help and first-aid and regarding the availability of first-aid training programs in the area;

"(xiii) provide for (I) periodic, comprehensive, and independent review and evaluation of the extent and quality of the emergency health care services provided in the system's service area, and (II) submission to the Secretary of the reports of each such review and evaluation;

"(xiv) have a plan to assure that the system will be capable of providing emergency medical services in the system's service area during mass casualties, natural disasters, or national emergencies; and

"(xv) provide for the establishment of appropriate arrangements with emergency medical services systems or similar entities serving neighboring areas for the provision of emergency medical services on a reciprocal basis where access to such services would be more appropriate and effective in terms of the services available, time, and distance.

The Secretary shall by regulations prescribe standards and criteria for the requirements prescribed by this subparagraph. In prescribing such standards and criteria, the Secretary shall consider relevant standards and criteria prescribed by other public agencies and by private organizations.

"(5) The Secretary shall provide technical assistance, as appropriate, to eligible entities as necessary for the purpose of their preparing applications or otherwise qualifying for or carrying out grants or contracts under sections 1202, 1203, or 1204, with special consideration for applicants in rural areas.

Ante, pp. 595, 596.

"(c) Payments under grants and contracts under this title may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary determines will most effectively carry out this title.

"(d) Contracts may be entered into under this title without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(e) No funds appropriated under any provision of this Act other than section 1207 or title VII may be used to make a new grant or contract in any fiscal year for a purpose for which a grant or contract is authorized by this title unless (1) all the funds authorized to be appropriated by section 1207 for such fiscal year have been appropriated and made available for obligation in such fiscal year, and (2) such new grant or contract is made in accordance with the requirements of this title that would be applicable to such grant or contract if it was made under this title. For purposes of this subsection, the term 'new grant or contract' means a grant or contract for a program or project for which an application was first submitted after the date of the enactment of the Act which makes the first appropriations under the authorizations contained in section 1207.

Post, p. 602.

"New grant or contract."

"(f)(1) In determining the amount of any grant or contract under section 1203 or 1204, the Secretary shall take into consideration the amount of funds available to the applicant from Federal grant or contract programs under laws other than this Act for any activity which the applicant proposes to undertake in connection with the establishment and operation or expansion and improvement of an emergency medical services system and for which the Secretary may authorize the use of funds under a grant or contract under sections 1203 and 1204.

"(2) The Secretary may not authorize the recipient of a grant or contract under section 1203 or 1204 to use funds under such grant or contract for any training program in connection with an emergency medical services system unless the applicant filed an application (as appropriate) under title VII or VIII for a grant or contract for such program and such application was not approved or was approved but for which no or inadequate funds were made available under such title.

58 Stat. 711; 70 Stat. 721; 77 Stat. 164. 42 USC 201 note. 42 USC 292 note.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 1207. (a)(1) For the purpose of making payments pursuant to grants and contracts under sections 1202, 1203, and 1204, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1974, and $60,000,000 for the fiscal year ending June 30, 1975; and for the purpose of making payments pursuant to grants and contracts under sections 1203 and 1204 for the fiscal year ending June 30, 1976, there are authorized to be appropriated $70,000,000.

"(2) Of the sums appropriated under paragraph (1) for any fiscal year, not less than 20 per centum shall be made available for grants and contracts under this title for such fiscal year for emergency medical services systems which serve or will serve rural areas (as defined in regulations of the Secretary under section 1203(c)(5)).

"(3) Of the sums appropriated under paragraph (1) for the fiscal year ending June 30, 1974, or the succeeding fiscal year—

"(A) 15 per centum of such sums for each such fiscal year shall be made available only for grants and contracts under section 1202 (relating to feasibility studies and planning) for such fiscal year;

"(B) 60 per centum of such sums for each such fiscal year shall be made available only for grants and contracts under section 1203 (relating to establishment and initial operation) for such fiscal year; and

"(C) 25 per centum of such sums for each such fiscal year shall be made available only for grants and contracts under section 1204 (relating to expansion and improvement) for such fiscal year.

"(4) Of the sums appropriated under paragraph (1) for the fiscal year ending June 30, 1976—

"(A) 75 per centum of such sums shall be made available only for grants and contracts under section 1203 for such fiscal year, and

"(B) 25 per centum of such sums shall be made available only for grants and contracts under section 1204 for such fiscal year.

"(b) For the purpose of making payments pursuant to grants and contracts under section 1205 (relating to research), there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1974, and for each of the next two fiscal years.

"ADMINISTRATION

"SEC. 1208. The Secretary shall administer the program of grants and contracts authorized by this title through an identifiable administrative unit within the Department of Health, Education, and Welfare. Such unit shall also be responsible for collecting, analyzing, cataloging, and disseminating all data useful in the development and operation of emergency medical services systems, including data derived from reviews and evaluations of emergency medical services systems assisted under section 1203 or 1204.

"INTERAGENCY COMMITTEE ON EMERGENCY MEDICAL SERVICES

"SEC. 1209. (a) The Secretary shall establish an Interagency Committee on Emergency Medical Services. The Committee shall evaluate the adequacy and technical soundness of all Federal programs and activities which relate to emergency medical services and provide for

the communication and exchange of information necessary to maintain the coordination and effectiveness of such programs and activities, and shall make recommendations to the Secretary respecting the administration of the program of grants and contracts under this title (including the making of regulations for such program).

"(b) The Secretary or his designee shall serve as Chairman of the Committee, the membership of which shall include (1) appropriate scientific, medical, or technical representation from the Department of Transportation, the Department of Justice, the Department of Defense, the Veterans' Administration, the National Science Foundation, the Federal Communications Commission, the National Academy of Sciences, and such other Federal agencies and offices (including appropriate agencies and offices of the Department of Health, Education, and Welfare), as the Secretary determines administer programs directly affecting the functions or responsibilities of emergency medical services systems, and (2) five individuals from the general public appointed by the President from individuals who by virtue of their training or experience are particularly qualified to participate in the performance of the Committee's functions. The Committee shall meet at the call of the Chairman, but not less often than four times a year.

"(c) Each appointed member of the Committee shall be appointed for a term of four years, except that—

"(1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and

"(2) of the members first appointed, two shall be appointed for a term of four years, two shall be appointed for a term of three years, and one shall be appointed for a term of one year, as designated by the President at the time of appointment.

Appointed members may serve after the expiration of their terms until their successors have taken office.

"(d) Appointed members of the Committee shall receive for each day they are engaged in the performance of the functions of the Committee compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, including traveltime; and all members, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as such expenses are authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. 5 USC 5332. Travel expenses. 83 Stat. 190.

"(e) The Secretary shall make available to the Committee such staff, information (including copies of reports of reviews and evaluations of emergency medical services systems assisted under section 1203 or 1204), and other assistance as it may require to carry out its activities effectively.

"ANNUAL REPORT

"SEC. 1210. The Secretary shall prepare and submit annually to the Congress a report on the administration of this title. Each report shall include an evaluation of the adequacy of the provision of emergency medical services in the United States during the period covered by the report, and evaluation of the extent to which the needs for such services are being adequately met through assistance provided under this title, and his recommendations for such legislation as he determines is required to provide emergency medical services at a level Report to Congress.

adequate to meet such needs. The first report under this section shall be submitted not later than September 30, 1974, and shall cover the fiscal year ending June 30, 1974."

58 Stat. 682; 86 Stat. 137. 42 USC 201 note.

(b)(1) Section 1 of the Public Health Service Act is amended by striking out "titles I to XI" and inserting in lieu thereof "titles I to XII".

(2) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title XII (as in effect prior to the date of enactment of this Act) as title XIII, and by renumbering sections 1201 through 1214 (as in effect prior to such date), and references thereto, as sections 1301 through 1314, respectively.

TRAINING ASSISTANCE

Scholarship grants. 85 Stat. 448. 42 USC 295g.

SEC. 3. (a) Part E of title VII of the Public Health Service Act is amended by inserting after section 775 the following new section:

"TRAINING IN EMERGENCY MEDICAL SERVICES

"SEC. 776. (a) The Secretary may make grants to and enter into contracts with schools of medicine, dentistry, osteopathy, and nursing, training centers for allied health professions, and other appropriate educational entities to assist in meeting the cost of training programs in the techniques and methods of providing emergency medical services (including the skills required in connection with the provision of ambulance service), especially training programs affording clinical experience in emergency medical services systems receiving assistance under title XII of this Act.

"(b) No grant or contract may be made or entered into under this section unless (1) the applicant is a public or nonprofit private entity, and (2) an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(c) The amount of any grant or contract under this section shall be determined by the Secretary. Payments under grants and contracts under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary. Grantees and contractees under this section shall make such reports at such intervals, and containing such information, as the Secretary may require.

"(d) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(e) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1974."

Special project grants, contracts. 85 Stat. 445.

(b) Section 772(a) of such Act (42 U.S.C. 295f-2(a)) is amended—

(1) by striking out "or" at the end of paragraph (12),

(2) by striking out the period at the end of paragraph (13) and inserting in lieu thereof "; or", and

(3) by inserting after paragraph (13) the following new paragraph:

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"(14) establish and operate programs in the interdisciplinary training of health personnel for the provision of emergency medical services, with particular emphasis on the establishment and operation of training programs affording clinical experience in emergency medical services systems receiving assistance under title XII of this Act."

(c) Section 774(a)(1)(D) of such Act (42 U.S.C. 295f-4(a)(1)(D)) is amended by inserting "(including emergency medical services)" after "services" each time it appears. 85 Stat. 446.

STUDY

SEC. 4. The Secretary of Health, Education, and Welfare shall conduct a study to determine the legal barriers to the effective delivery of medical care under emergency conditions. The study shall include consideration of the need for a uniform conflict of laws rule prescribing the law applicable of the provision of emergency medical services to persons in the course of travels on interstate common carriers. Within twelve months of the date of the enactment of this Act, the Secretary shall report to the Congress the results of such study and recommendations for such legislation as may be necessary to overcome such barriers and provide such rule. Report to Congress.

Approved November 16, 1973.

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LEGISLATIVE HISTORY:

HOUSE REPORT No. 93-601 accompanying H.R. 10956 (Comm. on Interstate and Foreign Commerce).
SENATE REPORT No. 93-397 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
Sept. 19, considered and passed Senate.
Oct. 25, considered and passed House, amended, in lieu of H.R. 10956.
Oct. 30, Senate agreed to House amendment with amendments.
Oct. 31, House concurred in Senate amendments.

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# Public Law 94-573
# 94th Congress

## An Act

To revise and extend the provisions of title XII of the Public Health Services Act relating to emergency medical services systems, and for other purposes.

Oct. 21, 1976
[S. 2548]

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

Emergency Medical Services Amendments of 1976.

SHORT TITLE AND REFERENCES IN ACT

SECTION 1. (a) This Act may be cited as the "Emergency Medical Services Amendments of 1976". 42 USC 201 note.

(b) Except as otherwise specifically provided in this Act, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act. 42 USC 201 note.

DEFINITIONS

SEC. 2. Paragraphs (4) and (5) of section 1201 are amended to read as follows: 42 USC 300d.

"(4) The term 'section 1521 State health planning and development agency' means the agency of a State designated under section 1521 (b)(3). 42 USC 300m.

"(5) The term 'section 1515 health systems agency' means a health systems agency designated under section 1515, and the term 'health systems plan' means a health systems plan referred to in section 1513 (b)(2).". 42 USC 300*l*-4. 42 USC 300*l*-2.

STUDY AND PLANNING GRANTS

SEC. 3. (a) Section 1202 is amended— 42 USC 300d-1.

(1) by inserting "(1)" in subsection (a) after "(a)";

(2) by striking out "projects" in subsection (a) and all that follows through "such a system" and inserting in lieu thereof "projects which include both studying the feasibility of and planning (A) the establishment and operation of an emergency medical services system, (B) the expansion and improvement of such a system, or (C) both";

(3) by redesignating subsection (b) as paragraph (2) of subsection (a);

(4) by striking out "this section" each place it appears in paragraph (2) (as so redesignated) of subsection (a) and inserting in lieu thereof "paragraph (1)"; and

(5) by inserting after subsection (a) the following new subsection:

"(b)(1) The Secretary may make a grant to or enter into a contract with an eligible entity (as defined in section 1206(a)) with respect to an emergency medical services system for the purpose of enabling the entity— 42 USC 300d-5.

"(A) to study the feasibility of, or plan for, the expansion and improvement of such system to provide for the use in such system of advanced life-support techniques, or

"(B) if such system is the system of a State for which system a study and planning grant or contract has been made or entered into under subsection (a) and if the entity is that State, to update the plan of such system to improve the delivery of emergency medical services in rural areas and to medically underserved populations of the State.

Certain geographical areas, exclusion.

"(2) If the Secretary makes a grant or enters into a contract under paragraph (1) respecting an emergency medical services system for a particular geographical area, the Secretary may not make any other grant or enter into any other contract under paragraph (1) respecting such system, or respecting any other such system for the same area or for an area which includes (in whole or substantial part) such area.".

42 USC 300d-1.

(b) Section 1202 is amended—

(1) by amending subsection (c) to read as follows:

Reports to HEW and Interagency Committee on Emergency Medical Services. 42 USC 300d-8.

"(c) An eligible entity which has received a grant from or entered into a contract with the Secretary under this section shall submit to the Secretary and the Interagency Committee on Emergency Medical Services (established under section 1209) a report on the results of such grant or contract at such intervals as the Secretary may prescribe, and shall submit to the Secretary and such Committee a final report on the results of such grant or contract not later than one year after the date the grant was made or the contract was entered into, as the case may be.";

(2) by amending paragraph (1) of subsection (d) to read as follows:

"(1) demonstrate to the satisfaction of the Secretary the need of the area for the emergency medical services system for which the application is made;";

42 USC 300*l*-4.

(3) by amending clause (A) of subsection (d)(3) to read as follows: "(A) with each section 1515 health systems agency whose health systems plan covers or will cover (in whole or in part) such area, and"; and

(4) by adding at the end thereof the following new subsection:

"(f) The Secretary may not obligate or expend in any fiscal year for grants and contracts made or entered into under subsection (b)(1) an amount greater than 50 per centum of the sums appropriated in such year for grants and contracts made or entered into under this section.".

INITIAL OPERATION AND ESTABLISHMENT GRANTS

42 USC 300d-2.

SEC. 4. Section 1203 is amended—

(1) by inserting "at least" in subsection (c)(2) before "nine months'", and by striking out "his" in such subsection and inserting in lieu thereof "its";

(2) by striking out "June 30, 1976" in subsection (c)(3) and inserting in lieu thereof "September 30, 1979"; and

(3) by adding at the end thereof the following new subsections:

"(d) A grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless the entity submits with its application for such grant or contract assurances of the participation in and support of the system by the public, private, and volunteer organizations and entities which are associated with and involved in activities essential to the effective provision of emergency medical services in the system's service area.

"(e)(1) A first grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless the entity submits with its application for such grant or contract assurances, from the executive or legisla-

tive governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, of each such bodies' support of and cooperation with the system.

"(2) A second grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless—

"(A) the Secretary has made the required determination under subsection (c)(2);

"(B) the application for such grant or contract includes specific plans for the step-by-step achievement of compliance with each of the requirements of section 1206(b)(4)(C) within the period specified in section 1206(b)(4)(B)(i); and 42 USC 300d-5.

"(C) the application for such grant or contract includes assurances, evidenced by copies of formal resolutions, proclamations, or other acts of the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, of such bodies'—

"(i) continued support and cooperation with the system, and

"(ii) financial support of the system, in the year after the conclusion of the period of support under the grant or contract, sufficient to maintain the system at the level at which such system is to be maintained during the period of the grant or contract.

"(f) An eligible entity which has received a grant from or has entered into a contract with the Secretary under this section shall submit to the Secretary and the Interagency Committee on Emergency Medical Services (established under section 1209) a report on the results of such grant or contract at such intervals as the Secretary may prescribe, and shall submit to the Secretary and such Committee a final report on the results of grants made to or contracts entered into with the entity under this section not later than one year after the completion of the second such grant or contract under this section.". Report to HEW and the Interagency Committee on Emergency Medical Services. 42 USC 300d-8.

EXPANSION AND IMPROVEMENT GRANTS

SEC. 5. Section 1204 is amended by striking out subsection (b) and inserting in lieu thereof the following: 42 USC 300d-3.

"(b)(1) Each grant or contract for a project under this section shall be made for the project's costs of expansion and improvement in the year for which the grant or contract is made or entered into. If a grant or contract is made or entered into under this section for a system, the Secretary may make one additional grant or contract for that system if he determines, after a review of at least the first nine months' activities of the applicant carried out under the first grant or contract, that the applicant is satisfactorily progressing in the expansion and improvement of the system in accordance with the plan contained in its application (pursuant to section 1206(b)(4)) for the first grant or contract. Additional grant or contract.

"(2) Subject to section 1206(f)—

"(A) the amount of the first grant or contract under this section for an emergency medical services system may not exceed (i) 50 per centum of the expansion and improvement costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) First grant or contract, cost limitation.

in the case of applications which demonstrate an exceptional need for financial assistance, 75 per centum of such costs for such year; and

Second grant or contract, cost limitation.

"(B) the amount of the second grant or contract under this section for a system may not exceed (i) 25 per centum of the expansion and improvement costs (as determined pursuant to regulations of the Secretary) of the system for the year for which the grant or contract is made, or (ii) in the case of applications which demonstrate an exceptional need for financial assistance, 50 per centum of such costs for such year.

"(c) A grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless the entity submits with its application for such grant or contract assurances of the participation and support of the system by the public, private, and volunteer organizations and entities which are associated with and involved in activities essential to the effective provision of emergency medical services in the system's service area.

"(d)(1) A grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless—

"(A) the application for such grant or contract includes specific plans for the step-by-step achievement of compliance with each of the requirements of section 1206(b)(4)(C) within the period specified in section 1206(b)(4)(B)(i); and

42 USC 300d-5.

"(B) the application for such grant or contract includes assurances, evidenced by copies of formal resolutions, proclamations, or other acts of the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, of such bodies'—

"(i) support and cooperation with the system, and

"(ii) endorsement and support of a specific financial plan which provides for the maintenance of the financial support of the system, after the conclusion of the period of the grant or contract, at the level required to maintain the level of expanded or improved activity to be achieved during the period of the grant or contract.

"(2) A second grant or contract may not be made to or entered into with an entity under this section with respect to an emergency medical services system unless—

"(A) the Secretary has made the required determination under subsection (b)(1), and

"(B) the application for such grant or contract includes assurances, of the executive or legislative governmental bodies of political subdivisions located in the system's service area which govern a substantial proportion of the population residing in such area, that substantial progress is being made toward achieving the financial support to implement the plan described in paragraph (1)(B)(ii).

Report to HEW and the Interagency Committee on Emergency Medical Services.

"(e) An eligible entity which has received a grant from or has entered into a contract with the Secretary under this section shall submit to the Secretary and the Interagency Committee on Emergency Medical Services (established under section 1209) a report on the results of such grant or contract at such intervals as the Secretary

may prescribe, and shall submit to the Secretary and such Committee a final report on the results of grants made to or contracts entered into with the entity under this section not later than one year after the completion of the second such grant or contract under this section.".

RESEARCH GRANTS

SEC. 6. Section 1205 is amended— 42 USC 300d-4.

(1) by inserting "and enter into contracts with" in subsection (a) before "public";

(2) by inserting "and especially research which emphasizes the identification and utilization of techniques and methods to apply the results of such research to improve the delivery of emergency medical services in such areas" in subsection (a) after "in rural areas";

(3) by inserting at the end of subsection (c) the following new sentence: "Such reports shall contain recommendations and a plan of action for applying the results of the research assisted by such grant or contract to improve the delivery of emergency medical services."; and

(4) by adding at the end thereof the following new subsection:

"(d)(1) Before any grant or contract may be made or entered into by the Secretary under this section the Secretary shall consult, concerning such grant or contract, with the identifiable administrative unit described in section 1208.

*Post*, p. 2715.

"(2) No regulation, guideline, funding priority, or application form shall be established under this section without the full participation in the development of such regulation, guideline, priority, or form, by the identifiable administrative unit described in section 1208.".

GENERAL PROVISIONS

SEC. 7. Section 1206 is amended— 42 USC 300d-5.

(1) by inserting "(A)" in subsection (b)(1) before "No grant";

(2) by inserting after subsection (b)(1) the following new subparagraph:

"(B) No applicant may receive more than a total of five years of grant or contract assistance under this part, except that, in determining the number of years of grant or contract assistance which an applicant received under this part, the Secretary shall not include any period during which the applicant received grant or contract assistance under section 1202(b)(1) or section 1205.";

*Ante*, p. 2709.

(3) by amending clauses (i) and (ii) of subsection (b)(3)(D) to read as follows:

"(i) section 1521 State health planning and development agency of each State in which the service area of the emergency medical services system for which the application is submitted will be located, and 42 USC 300m.

"(ii) section 1515 health systems agency whose health systems plan covers or will cover (in whole or in part) the service area of such system,"; 42 USC 300*l*-4.

(4) by striking out "An" in subsection (b)(4)(A) and inserting in lieu thereof "No", and by striking out "not" after "section 1203 or 1204 may" in such subsection; 42 USC 300d-2, 300d-3.

(5) by inserting "the respective section and of" in subsection (b)(4)(A)(i) after "requirements of";

(6) by striking out "(A)" in subsection (b)(4)(B)(i) and inserting in lieu thereof "(C)";

(7) by striking out "the period of the grant or contract for which application is made" in subsection (b)(4)(B)(i) and inserting in lieu thereof "the total period of eligibility for assistance under the section for which the application for assistance is made";

(8) by striking out "and" before "(III)" in clause (iii) of subsection (b)(4)(C), and by inserting before the semicolon at the end of such clause the following: ", (IV) will have the capability to communicate with individuals having auditory handicaps and to communicate in the language of the predominant population groups with limited English-speaking ability in the system's service area, and (V) makes maximum use of communications equipment and systems acquired under any highway safety program approved under chapter 4 of title 23, United States Code, and of such equipment and system acquired under title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3701 et seq.)";

23 USC 401.

(9) by inserting "(making maximum use of vehicles acquired under any highway safety program approved under chapter 4 of title 23, United States Code)" in subsection (b)(4)(C)(iv) after "include";

(10) by striking out "standardized" in subsection (b)(4)(C)(xi) and inserting in lieu thereof "coordinated";

(11) by amending clause (xiii) of subsection (b)(4)(C) to read as follows:

Review or evaluation; submitted to HEW.

"(xiii) provide the Secretary with such information as he may require to conduct periodic, comprehensive, and independent reviews and evaluations of the extent and quality of the emergency health care services provided in the system's service area, and submit to the Secretary the results of any review or evaluation which may be conducted by such system of the extent and quality of the emergency health care services provided in the system's service area;";

42 USC 241, 281, 292, 300d-6.

(12) by striking out "section 1207 or title VII" in subsection (c) and inserting in lieu thereof "section 301, title IV, title VII, section 1207, or section 1221";

Post, p. 2718.

(13) by striking out "1207" in clause (1) of subsection (e) and inserting in lieu thereof "1207(a)";

(14) by inserting "(other than basic training of emergency medical technicians, training of paramedics, and short-term specialized training or retraining of physicians, nurses, and other health care professionals)" in subsection (f)(2) after "training program";

(15) by inserting "(A) has" in subsection (f)(2) after "unless the applicant"; and

(16) by inserting before the period at the end of paragraph (2) of subsection (f) the following: ", or (B) has demonstrated to the satisfaction of the Secretary that the filing of such an application would be futile or unreasonably burdensome".

AUTHORIZATION OF APPROPRIATIONS

42 USC 300d-6.

SEC. 8. (a) Subsection (a) of section 1207 is amended—

(1) by striking out "and" after "1974," and inserting after "1975" the following: ", $35,000,000 for the fiscal year ending

June 30, 1976, $5,083,000 for the period beginning July 1, 1976, and ending September 30, 1976, $45,000,000 for the fiscal year ending September 30, 1977, and $55,000,000 for the fiscal year ending September 30, 1978";

(2) by striking out "for the fiscal year ending June 30, 1976, there are authorized to be appropriated $70,000,000" and inserting in lieu thereof ", there are authorized to be appropriated $70,000,000 for the fiscal year ending September 30, 1979"; and

(3) by adding at the end thereof the following new paragraph:

"(5)(A) Of the sums appropriated under paragraph (1) for the fiscal year ending September 30, 1977, and for the succeeding fiscal year, at least 2½ per centum but not more than 5 per centum of such sums for each such fiscal year shall be used for grants and contracts under section 1202. 42 USC 300d-1.

"(B) Of the sums appropriated under paragraph (1) for the fiscal year ending September 30, 1977, and for each of the two succeeding fiscal years, (i) not less than 20 per centum of such sums for each such fiscal years shall be used for grants and contracts under section 1203, and (ii) not less than 20 per centum of such sums for each such fiscal year shall be used for grants and contracts under section 1204.". 42 USC 300d-2. 42 USC 300d-3.

(b) Section 1207(b) is amended by striking out "two" and inserting in lieu thereof "five". 42 USC 300d-6.

ADMINISTRATION

SEC. 9. Section 1208 is amended to read as follows: 42 USC 300d-7.

"SEC. 1208. (a) The Secretary shall administer the program of grants and contracts (except for grants and contracts under section 1205) authorized by this part through an identifiable administrative unit specializing in emergency medical services within the Department of Health, Education, and Welfare. 42 USC 300d-4.

"(b) Such administrative unit shall—

"(1) be responsible for collecting, analyzing, cataloging, and disseminating all data useful in the development and operation of emergency medical services systems, including data derived from reviews and evaluations of emergency medical services systems assisted under sections 1202, 1203, and 1204;

"(2) publish suggested criteria for collecting necessary information for the evaluation of projects and programs funded under this title;

"(3) participate fully in the development of regulations, guidelines, funding priorities, and application forms relating to activities carried out under sections 776, 1205, and 1221;

"(4) be consulted in advance of the awarding of grants and contracts under sections 776, 1205, and 1221;

"(5) be consulted in advance of the issuance of regulations, guidelines, and funding priorities relating to research or training in the area of emergency medical services carried out under any other authority of this Act; 42 USC 295f-6, 300d-4. *Post*, p. 2718.

"(6) provide technical assistance (with special consideration for applicants in rural areas) and monitoring with respect to grant and contract activities under sections 1202, 1203, 1204, and 1221; and

"(7) provide for periodic, independent evaluations of the effectiveness of, and coordination between, the programs carried out

under this part and the programs carried out under sections 776 and 1221.

42 USC 295f-6.

Post, p. 2718.

"(c) In addition, such administrative unit shall, through the Interagency Committee on Emergency Medical Services (established under section 1209)—

42 USC 300d-8.

"(1) study on a continuing basis (including evaluating the adequacy, technical soundness, and redundancy of) the roles, resources, and responsibilities of all Federal programs and activities relating to emergency medical services;

"(2) annually update (A) the Federal emergency medical services funding and resource-sharing plan, (B) the description of sources of Federal support, and (C) the recommended uniform standards with respect to emergency medical services equipment and training, all initially developed and published by the Committee under section 1209(b);

Infra.

"(3) make recommendations to the Secretary respecting steps he might take, using the authorities available to him, to encourage States to implement the recommended uniform standards described in paragraph (2)(C); and

"(4) make recommendations to the Secretary respecting the administration of, and regulations under, the programs of grants and contracts under this title.

Report to Congress.

Such unit shall report to the Congress the results of studies made under paragraph (1). The first such report shall be made not later than June 15, 1977, the second such report shall be made not later than February 1, 1978, and subsequent reports shall be made not later than February 1 of each year after 1978.".

INTERAGENCY COMMITTEE

42 USC 300d-8.

SEC. 10. (a) The second sentence of subsection (a) of section 1209 is amended to read as follows: "The Committee shall coordinate and provide for the communication and exchange of information among all Federal programs and activities relating to emergency medical services, and shall carry out its responsibilities under section 1208(c).".

Ante, p. 2715.

(b) Section 1209(b) is amended by striking out "the National Academy of Sciences," and inserting "and from the National Academy of Sciences" after "Education, and Welfare)".

(c) Section 1209(e) is amended by striking out "1203" and inserting in lieu thereof "1202, 1203,".

(d) Section 1209 is amended by redesignating subsections (b), (c), (d), and (e) as subsections (c), (d), (e), and (f), respectively, and by inserting after subsection (a) the following new subsection:

"(b) The Committee shall, not later than July 1, 1977, develop and publish:

Federal emergency medical services funding and resource-sharing plan.

"(1) A coordinated, comprehensive Federal emergency medical services funding and resource-sharing plan, designed to promote the coordination between, and enhance the effectiveness of, Federal, State, and local funding and operation of programs and agencies relating to emergency medical services and related activities (including communication and transportation systems of public safety agencies).

"(2) A description of sources of Federal support for the purchase of vehicles and communications equipment and for training activities related to emergency medical services.

"(3) Recommended uniform standards of quality, health, and safety with respect to all equipment (including communications and transportation equipment) and training related to emergency medical services.

The plan described in paragraph (1) shall include a report containing recommendations for any legislation which would enhance the capability of Federal, State, and local governments to provide an integrated response in medical emergencies. The description described in paragraph (2) shall be disseminated to the regional offices of Federal agencies which provide financial support in the purchase of vehicles and equipment or in training activities related to emergency medical services for distribution to appropriate entities and the public.". Report.

ANNUAL REPORTS

SEC. 11. Section 1210 is amended by inserting at the end thereof the following: "The report under this section covering the fiscal year ending June 30, 1976, shall also cover the period beginning July 1, 1976, and ending September 30, 1976, and shall be submitted to Congress not later than February 1, 1977. The report under this section covering the fiscal year ending September 30, 1977, and each report covering each subsequent fiscal year, shall be submitted to Congress not later than February 1, in the fiscal year following each such fiscal year.". 42 USC 300d-9. Reports to Congress.

TRAINING GRANTS

SEC. 12. (a) Section 776(a) is amended— 42 USC 295f-6.

(1) by inserting "(1)" after "(a)";

(2) by inserting "hospitals having training programs which meet requirements established by the Secretary," before "schools of medicine";

(3) by striking out "and" before "other appropriate";

(4) by inserting ", and other appropriate public entities (as defined in paragraph (2))" after "educational entities";

(5) by inserting "and to assist in meeting the cost of training, and establishment of programs for the training, of physicians in emergency medicine" after "ambulance service)"; and

(6) by adding at the end thereof the following new paragraph:

"(2) For the purposes of paragraph (1), the term 'other appropriate public entity' means a State, unit of general local government, or any other public entity which—

"(A) has established an emergency medical services system (as defined in section 1201(1)), and 42 USC 300d.

"(B) except with respect to the basic training of emergency medical technicians, has entered into an agreement with an appropriate educational entity for a training program under this section.".

(b) Section 776 is amended—

(1) by redesignating subsection (e) as subsection (g) and amending such subsection (as so redesignated)—

(A) by inserting "(1)" after "(g)";

(B) by inserting ", and each of the next five fiscal years" after "1974"; and

(C) by inserting at the end thereof the following new paragraph:

"(2) Not less than 30 percent of the funds appropriated under paragraph (1) for any fiscal year shall be used in that fiscal year to

assist in meeting the cost of training, and of establishment of programs for the training, of physicians in emergency medicine."; and

(2) by inserting after subsection (d) the following new subsections:

"(e) No regulation, guideline, funding priority, or application form shall be established with respect to this section without the full participation in the development of such regulation, guideline, priority, or form, by the administrative unit described in section 1208.

*Ante*, p. 2716.

"(f) To the maximum extent practicable, the Secretary shall establish a uniform funding cycle so as to coordinate the submission and review of applications for grants and contracts under title XII and under this section and to coordinate funding policies among programs carried out under such authorities.".

42 USC 300d.

EXPENSES OF ADMINISTRATION

42 USC 300d-7 note.

SEC. 13. Not later than 60 days after the date of enactment of the annual appropriations Act making appropriations for the programs under title XII of the Public Health Service Act for each fiscal year ending after September 30, 1976, the Secretary of Health, Education, and Welfare shall allocate an amount of expenditures and a number of personnel positions sufficient for the identifiable administrative unit (described in section 1208 of such Act) to—

(1) provide support (including salaries of unit personnel and costs of administration, data gathering and dissemination, technical assistance, monitoring, and independent evaluation) for it to carry out its functions under title XII of such Act for such fiscal year; and

(2) provide support for the Interagency Committee on Emergency Medical Services established under section 1209 of such Act for such fiscal year,

42 USC 300d-8.

Report to congressional committees.

and shall immediately report to the appropriate Committees of Congress a statement of the amount of expenditures and the number of personnel positions so allocated for such fiscal year.

BURN INJURY PROGRAM AND CONFORMING AMENDMENTS

42 USC 300d.

SEC. 14. Title XII is amended—

(1) by inserting "PART A—ASSISTANCE FOR EMERGENCY MEDICAL SERVICES SYSTEMS" after the heading for the title;

42 USC 300d, 300-5.

(2) by striking out "this title" each place it appears in section 1201 and in subsections (b) and (e) of section 1206 and inserting in lieu thereof "this part"; and

42 USC 300d-9.

(3) by inserting after section 1210 the following new part:

"PART B—BURN INJURIES

"PROGRAMS RELATING TO BURN INJURIES

Grants.
42 USC 300d-21.

"SEC. 1221. (a)(1) The Secretary may make grants to, and enter into contracts with, public or private nonprofit entities for the support of, and may conduct, programs for the establishment, operation, and improvement of activities to (A) demonstrate the effectiveness of different methods for the treatment and rehabilitation of individuals injured by burns, (B) conduct research in the treatment and rehabilitation of such individuals, and (C) provide training in such treatment and rehabilitation and in such research.

"(2) The Secretary may enter into contracts with entities and individuals for the support of research in the treatment and rehabilitation of individuals injured by burns.

"(b) No grant or contract may be made or entered into under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be submitted in such form and manner and contain such information as the Secretary may require. In considering applications under this section, the Secretary shall give priority to applications for programs which (1) will provide services within a geographical area in which services are not currently being adequately provided, and (2) are in or accessible to the service area of an emergency medical services system (as defined in section 1201(1)). Applications.

"(c) For purposes of carrying out subsection (a), there are authorized to be appropriated $5,000,000 for the fiscal year ending September 30, 1977, $7,500,000 for the fiscal year ending September 30, 1978, and $10,000,000 for the fiscal year ending September 30, 1979.". 42 USC 300d. Appropriation authorization.

TRANSFER OF EQUIPMENT

SEC. 15. Notwithstanding any other provision of law, the Secretary of Health, Education, and Welfare may vest title to equipment purchased— 42 USC 242b note.

(1) with funds under the seven contracts for emergency medical services demonstration projects entered into in 1972 and 1973 under section 304 of the Public Health Service Act (as in effect at the time the contracts were entered into), and 42 USC 242b.

(2) by contractors with the United States under such contracts or subcontractors under such contracts,

in such contractors or subcontractors without further obligation to the Government or on such terms as the Secretary considers appropriate.

UNIFORM PATIENT REPORTING SYSTEM

SEC. 16. The Secretary of Health, Education, and Welfare shall conduct studies to identify the categories of patients which should be included in a uniform reporting system to be used to evaluate the effectiveness of emergency medical services systems and burn injury programs supported under title XII of the Public Health Service Act in reducing death and disability. Not later than 18 months after the date of enactment of this Act, the Secretary shall report to the Congress the results of such studies. Such report shall include such recommendations for legislation relating to such a uniform reporting system as the Secretary determines are appropriate. 42 USC 300d-9 note. 42 USC 300d.

EXTENSION OF ARTHRITIS COMMISSION

SEC. 17. Section 3(j)(2) of the National Arthritis Act of 1974 (Public Law 93-640) is amended to read as follows: 42 USC 289c-1 note.

"(2) The Commission shall cease to exist on December 31, 1976.".

EXTENSION OF THE COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS

SEC. 18. (a) Section 204(d) of the National Research Act (Public Law 93-348) is amended by striking out "24-month period" each place it appears and inserting in lieu thereof "36-month period". 42 USC 289l-1 note.

42 USC 218 note.

(b) Section 211(b) of such Act is amended by striking out "January 1, 1977" and inserting in lieu thereof "January 1, 1978".

REVIEW OF ALCOHOLISM GRANTS

SEC. 19. (a) Section 311(c)(2) of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4577) is amended—

(1) by inserting "(A)" after "(2)";

(2) by striking out the last two sentences thereof; and

(3) by inserting at the end thereof the following new subparagraph:

Submittal to National Advisory Council on Alcohol Abuse and Alcoholism.

"(B)(i) Except as provided in clause (ii), each application for a grant under this section shall be submitted by the Secretary to the National Advisory Council on Alcohol Abuse and Alcoholism for his review. The Secretary may approve an application for a grant under this section only if it is recommended for approval by such Council.

"(ii) Clause (i) shall not apply to an application for a grant under this section for a project or program for any period of 12 consecutive months for which period payments under such grant will be less than $250,000, if an application for a grant under this section for such project or program and for a period of time which includes such 12-month period has been submitted to, and approved by, the Secretary.".

Effective date. 42 USC 4577 note.

(b) The amendment made by subsection (a) shall apply with respect to applications for grants under section 311 of such Act after June 30, 1976.

EFFECTIVE DATE

42 USC 300d note.

SEC. 20. Amendments and repeals made to the Public Health Service Act by this Act shall not apply with respect to grants made or contracts entered into before the date of enactment of this Act, except that the amendments made by sections 4(3) and 5 of this Act with respect to adding a new subsection (f) to section 1203 and a new subsection (e) to section 1204, respectively, of the Public Health Service Act shall apply to grants made and contracts entered into after June 1, 1976.

*Ante*, p. 2711.

Approved October 21, 1976.

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LEGISLATIVE HISTORY:

HOUSE REPORT No. 94-1089 accompanying H.R. 12664 (Comm. on Interstate and Foreign Commerce).

SENATE REPORT No. 94-889 (Comm. on Labor and Public Welfare).

CONGRESSIONAL RECORD, Vol. 122 (1976):

June 10, considered and passed Senate.

Aug. 24, considered and passed House, amended, in lieu of H.R. 12664.

Oct. 1, Senate agreed to House amendments with an amendment; House agreed to Senate amendment.

Note.—A change has been made in the slip law format to provide for one-time preparation of copy to be used for publication of both slip laws and the United States Statutes at Large volumes. Comments from users are invited by the Office of the Federal Register, National Archives and Records Service, Washington, D.C. 20408.

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SUMMARY:

Enclosed is a South Carolina life expectancy chart: (enclosure 1) Please note that South Carolina life expectancy rates are the lowest in the United States. Identified also are the three leading causes of death.

The leading causes of death in South Carolina are being dealt with directly by the Emergency Medical Services Act of 1973 and a general health care upgrading has been the direct result. In a rural area it is impossible to separate emergency and primary care medicine. The more urban areas of those rural regions can more satisfactorily deal with emergency medicine as an immediate life threatening condition (i.e. cardiac arrest) - 30 miles away emergency medicine may well mean the repair of a simple laceration or the treatment of a childs pneumonia and the reassurance given that childs family. We now are working to ensure appropriate medical control will be available in that rural area for the more immediate life threatening problems. These are the systematic approach problems in the Emergency Medical Services Act. Emergency Medical Services addresses both the urban and rural area. Thus far, in South Carolina, the Emergency Medical Services federal dollar has been that federal money most visible to the public. This money has had the greatest impact in gaining local fiscal, political and medical support. We are becoming more able to interface the critical life support capabilities of a regional medical center with the primary care physicians of our state.

We desperately need the full authorization as provided for in the 1976 amendment to the Emergency Medical Services Act.

Federal Region IV is comprised of 8 states - North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee and Kentucky. At present, we expect only approximately 4 million dollars available to Federal Region IV. In South Carolina we have applications from our Region I for section 1204, from our Region II for section 1203 (second year), from our Region III for section 1202 and from our Region IV for section 1203. (see attached South Carolina Regional Map) (enclosure 2). Our total grant request for all South Carolina Regions is less than 1 million dollars. With full fiscal authorization we would be much more capable of implementing more efficient Emergency Medical Services and complement, indirectly, primary medical care.

South Carolina physicians are not seeking full federal support for medical problems. We realize our responsibilities. The Emergency Medical Services Act is not designed to fully subsidize any local Emergency Medical Service program, but to begin a systematic approach to better medical control and care. Had the Emergency Medical Services Act thus far not been so successful in the fulfillment of its basic philosophy, I would not be here on its behalf requesting full fiscal authorization.

We in South Carolina and other rural areas sharing similar medical problems thank you for your time, consideration, and support.

Sincerely,

Van B. Elliott, Jr., M.D.

Enclosure 1

Life Expectancy Charts

The following charts indicate South Carolina's relative position in life expectancy for five-year age increments between 0 and 60.

| Age Category | State With Highest Ranking | Years Remaining | State With Lowest Ranking | Years Remaining | National Average |
|---|---|---|---|---|---|
| 0-4 | Hawaii | 70.24 | South Carolina | 64.85 | 67.29 |
| 5-9 | Hawaii | 69.56 | South Carolina | 64.23 | 66.61 |
| 10-14 | Hawaii | 65.65 | South Carolina | 60.37 | 62.73 |
| 15-19 | Hawaii | 60.74 | South Carolina | 55.52 | 57.84 |
| 20-24 | Hawaii | 55.98 | South Carolina | 50.83 | 53.15 |
| 25-29 | Hawaii | 51.20 | South Carolina | 46.24 | 48.51 |
| 30-34 | Hawaii | 46.43 | South Carolina | 41.64 | 43.84 |
| 35-39 | Hawaii | 41.77 | South Carolina | 37.15 | 39.19 |
| 40-44 | Hawaii | 37.16 | South Carolina | 32.74 | 34.66 |
| 45-49 | Hawaii | 32.64 | South Carolina | 28.66 | 30.29 |
| 50-54 | Hawaii | 28.31 | South Carolina | 24.77 | 26.11 |
| 55-59 | Hawaii | 24.21 | South Carolina | 21.15 | 22.17 |

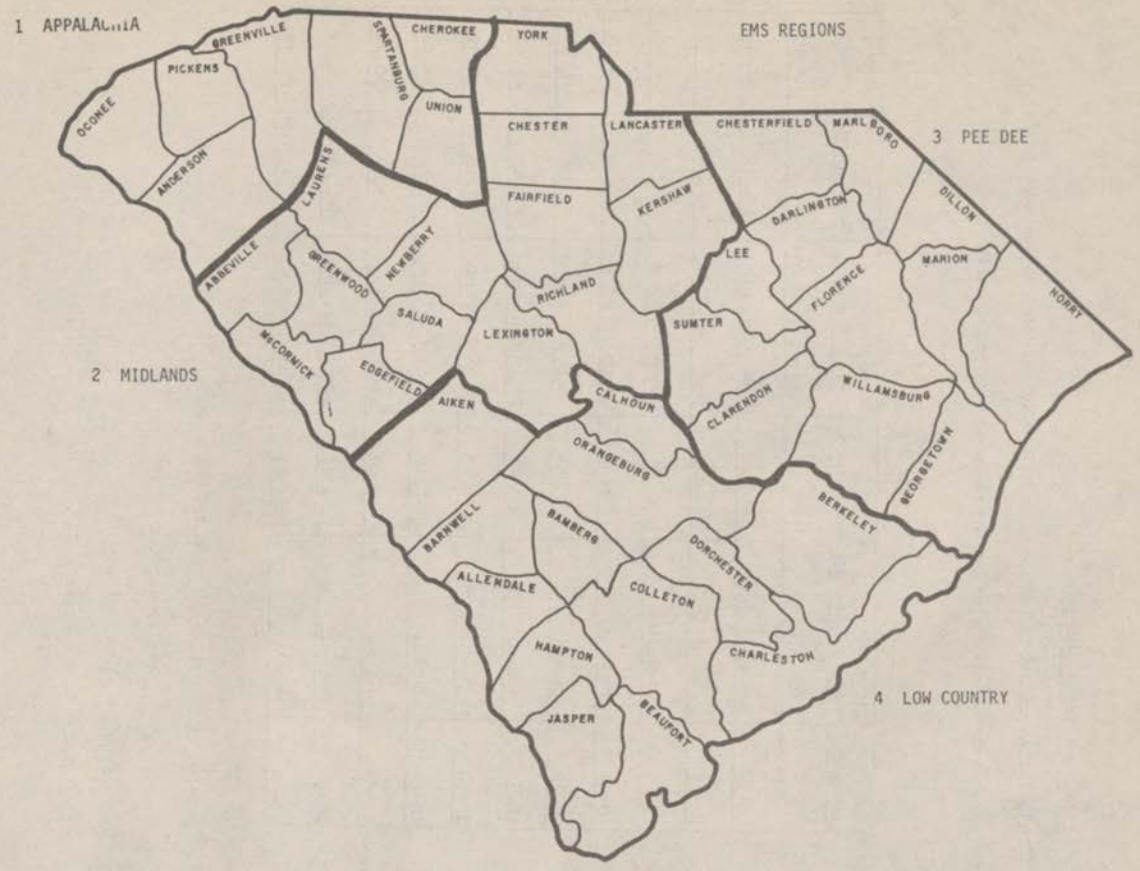
LEADING CAUSES OF DEATH IN SOUTH CAROLINA:

FIRST - cardiovascular disease

SECOND - neonatal deaths

THIRD - accidents

Enclosure 2




2908

AMERICAN SOCIAL HEALTH ASSOCIATION

**STATEMENT OF SAMUEL R. KNOX, NATIONAL PROGRAM DIRECTOR**

PREPARED STATEMENT

Senator BROOKE. All right. The American Social Health Association is our last group this afternoon.

Come forward, please. Your written statement will be included in the record. You have the very dubious honor of being last; you have persevered to the end.

[The statement follows:]

## STATEMENT OF SAMUEL R. KNOX, NATIONAL PROGRAM DIRECTOR, AMERICAN SOCIAL HEALTH ASSOCIATION

### VENEREAL DISEASE APPROPRIATIONS

I first wish to thank the Chairman and Members of the Committee for inviting the testimony of the American Social Health Association on the issue at hand.

I've had an opportunity to review the reports submitted to this Committee by the Center for Diseases Control (CDC) and the National Institute of Allergy and Infectious Diseases (NIAID), the operational agencies charged with implementation of the Venereal Disease Prevention and Control Act. Though accurate and informative, these reports fail to convey a sense of the true nature of the VD problem in America, and the extent of the educational, research and control needs that are remaining unaddressed by either CDC or NIAID. I therefore think I can be of most service to you by focusing on aspects of the issue thus far not adequately covered or wholly omitted, thereby encouraging a more complete picture of VD in America to emerge.

VD is not just a "dose of clap" or a "touch of syph"—but rather a complex of many highly infectious diseases—that happen to be sexually transmissible—and that affect over 8½ million Americans each year. At least five of these diseases are significant public health threats, not just in the sense that they are highly prevalent, but also (and primarily) in that they are directly responsible for the death and/or life-long disability of an estimated 100,000 babies and young women of child bearing age, annually. Two of these five serious diseases are caused by viral agents and are incurable. A third, and perhaps the one with which you're most familiar —gonorrhea— has already begun to elude our therapeutic grip—and is rapidly moving toward incurability. These diseases, far from being merely bothersome nuisances, are clear and present threats to the health and welfare of millions of Americans—far more so than Swine Flu and many other conditions that have been previously adjudged public health priorities.

Why does venereal disease continue to be this nation's most prevalent serious infectious disease problem? Why is this problem getting worse and more complicated each year?

The answer is really quite simple. When it comes to financing, when it comes to bold initiatives, when it comes to consistently applying common sense—venereal disease has been and continues to be the step-child of public health. This, despite the fact that more Americans are affected in more serious ways by venereal disease than nearly any other infectious disease problem.

Assuming a commitment to solve our venereal disease problem, sheer common sense would have it that we adopt and unswervingly support a balanced, program of research, education and control. Instead, what have we? An underfinanced casefinding and control program that was operationalized 30 years ago, and which in its present form and financial condition has about as much of a chance to succeed as a termite trying to find a meal in a petrified forest.

Our VD research program, touted to be the best in the world, is actually little more than a token effort. Of the total NIH investment in biomedical research, the discretionary allocation for VD amounts to about two-tenths of one percent. At a time when we should be encouraging investigators to focus on such problems as incurability, lack of adequate diagnostic tests, vaccine development, the present investment of $5,000,000 to support an alleged "special emphasis" VD research program is a barrier rather than an invitation. Each year NIH must turn away many applications for VD research support—not on the basis of lack of merit—but because of the paucity of funds. In addition to the NIH sum of $5 million, we, the voluntary sector amass and distribute over $870,000 annually to support VD research. That's nearly 20% of the NIH VD research expenditure—all coming from private individuals—alarmed and concerned about VD to the extent of willingly donating their money to support research. And even this is not enough.

An education program, the most immediately benefical element of a balanced approach—simply doesn't exist within the framework of CDC or any other agency

of government. What has developed though—because common sense mandated that it must—was a preemptive decision on the part of the voluntary sector to attempt, as best it could with miniscule community resources, to fill the VD educational void and not wait for the hoped-for day when someone, somewhere would wake up to the need for VD education.

In over 40 metropolitan areas throughout this country, educators, concerned laymen, business leaders, private and public practitioners have coalesced around this glaring void, and with limited resources and no help from CDC, have given of themselves to further VD education and awareness. They are doing a credible job despite seemingly insurmountable odds. With adequate resources they could be doing an exemplary job. It has recently become within your purview to furnish these needed resources. It is most important that you begin to do so at this time.

The time has come—the time has long since come—for us to begin to perceive VD as the serious public threat that it is. And doing that, we must begin to seek solutions, real and permanent solutions. And, unfortunately, there's no getting away from the fact that an expanded program requires additional money.

I've attempted to put myself in your place in developing a balanced recommendation for VD appropriations. Wishing to harmonize short-term objectives with long term goals, I can only conclude that education, control and research must be the three key elements of a total problem solving program.

Education is perhaps the easiest to address because it is the most glaring void. We're currently doing nothing—we must do something. We must also consider the untapped capabilities of the 40 or more voluntary VD organizations currently in existence. To ignore them would be wasteful. Since section 317 of the Public Health Service Act now permits the expenditure of federal dollars by not-for-profit VD organizations to further VD educational objectives, I recommend utilizing that authority and appropriating $5,000,000 in fiscal 1978. ASHA would be willing to serve in an advisory or consultative capacity to this Committee or CDC to help assure the smooth and productive implementation of such a program.

With regard to the casefinding and control element, I recommend that you at least restore the level of program that existed in fiscal year 1975, which at that time amounted to $28,000,000. This would require that you appropriate at least $30,000,000 for fiscal year 1978, due to inflation.

Finally, because the permanent solutions to the VD problem will ultimately be found in the laboratory, I urge you to prioritize and energize the research element in two ways. First, I recommend that the status of VD research be elevated from a discretionary program to a line item within NIAID. Secondly, I recommend that you mandate an immediate doubling of the investment in VD biomedical research — to $10,000,000 in fiscal year 1978. It's time we serve notice on the research community that we seriously intend to conquer VD and invite their active and sustained participation.

In closing, I'd like to call attention to an incongruity that has stymied the adoption of a serious and energetic attempt to eliminate VD. It's simply this—those who are at risk of acquiring VD are by-and-large under age 35 and have yet to achieve a position of personal and professional stature. Those who have achieved such stature, who occupy positions of leadership and influence, are over 35 and rarely perceive VD as a personal risk to their health. I therefore ask you —our leaders— to reflect seriously on those 8½ million people who are at risk—students, laborers, aspiring professionals, and others—tax payers and your constituents—and formulate funding patterns in their best interests which ultimately are in the best interests of this nation.

END

STATEMENT HIGHLIGHTED

Mr. KNOX. Sam Knox, National Director of the American Social Health Association.

I have some very brief testimony. I won't take but 5 minutes.

I have had an opportunity to review the reports submitted to this committee by the Center for Diseases Control, CDC, and the National Institute of Allergy and Infectious Diseases, NIAID, the operational agencies charged with implementation of the Venereal Disease Prevention and Control Act, both 1973 and 1976. Though accurate and informative, these reports fail to convey a sense of the true nature of the VD problem in America, and the extent of the educational, research, and control needs that are remaining unaddressed by either CDC or NIAID.

I, therefore, think I can be of most service to you by focusing on aspects of the issues thus far not adequately covered—or wholly omitted—thereby encouraging a more complete picture of VD in America to emerge.

VD is not just a "dose of clap" or a "touch of syph" any longer, but rather a complex of many highly infectious diseases that happen to be sexually transmissible and that affect over 8½ million Americans each year.

At least five of these diseases are significant public health threats, not just in the sense that they are highly prevalent, but also—and primarily—in that they are directly responsible for the death and/or lifelong disability of an estimated 100,000 babies and young women of childbearing age, annually.

Two of these five serious diseases are caused by viral agents and are incurable. A third, and perhaps the one with which you're most familiar—gonorrhea—has already begun to elude our therapeutic grip, and is rapidly moving toward incurability.

Senator BROOKE. Is that a new strain that will not react favorably to penicillin or any of the so-called wonder drugs?

Mr. KNOX. There is one more drug used; but as the drugs are used, it is building up an immunity. It has developed an immunity. There are strains that are totally incurable.

Senator BROOKE. Is the dosage much different, or the treatment period?

Mr. KNOX. No. It's the same, as long as the drug is available. Once the resistance factor begins, no amount of penicillin——

Senator BROOKE. The treatment is the same?

Mr. KNOX. Essentially. Outpatient therapy.

Assuming a commitment to solve our veneral disease problem, sheer commonsense would have it that we adopt and unswervingly support a balanced program of research, education, and control. Instead, what have we? An underfinanced case finding and control program that was operationalized 30 years ago, and which, in its present form and financial condition, has about as much of a chance to succeed as a termite trying to find a meal in a petrified forest.

Our VD research program, touted to be the best in the world, is actually little more than a token effort. Of the total NIH investment in biomedical research, the discretionary allocation for VD amounts to under two-tenths of 1 percent. At a time when we should be

encouraging investigators to focus on such problems as incurability, lack of adequate diagnostic tests, vaccine development, the present investment of $5 million to support an alleged "special emphasis" VD research program is a barrier rather than an invitation.

Each year NIH must turn away many applications for VD research support, not on the basis of lack of merit, but because of the paucity of funds. In addition to the NIH sum of $5 million, we, the voluntary sector, amass and distribute over $870,000 annually to support VD research. That's nearly 20 percent of the NIH VD research expenditure, all coming from private individuals, alarmed and concerned about VD to the extent of willingly donating their money to support research. And even this is not enough.

An education program—the most immediately beneficial element of a balanced approach—simply doesn't exist within the framework of CDC or any other agency of Government. What has developed, though—because commonsense mandated that it must—was a preemptive decision on the part of the voluntary sector to attempt, as best it could with miniscule community resources, to fill the VD educational void and not wait for the hoped-for day when someone, somewhere, would wake up to the need for VD education.

In over 40 metropolitan areas throughout this country, educators, concerned laymen, business leaders, private and public practitioners have coalesced around this glaring void, and with limited resources and no help from CDC, have given of themselves to further VD education and awareness. They are doing a credible job despite seemingly insurmountable odds. With adequate resources, they could be doing an exemplary job.

It has recently become within your purview to furnish these needed resources. It is most important that you begin to do so at this time.

The time has come—the time has long since come—for us to begin to perceive VD as the serious public threat that it is. And doing that, we must begin to seek solutions, real and permanent solutions. Unfortunately, there's no getting away from the fact that an expanded program requires additional money.

I've attempted to put myself in your place in developing a balanced recommendation for VD appropriations. Wishing to harmonize short-term objectives with long-term goals, I can only conclude that education, control, and research must be the three key elements of a total problem-solving program.

Education is perhaps the easiest to address because it is the most glaring void. We're currently doing nothing—we must do something. We must also consider the untapped capabilities of the 40 or more voluntary VD organizations currently in existence. To ignore them would be wasteful.

Since section 317 of the Public Health Service Act now permits the expenditure of Federal dollars by not-for-profit VD organizations to further VD educational objectives, I recommend utilizing that authority and appropriating $5 million in fiscal 1978. ASHA would be willing to serve in an advisory or consultative capacity to this committee or CDC to help assure the smooth and productive implementation of such a program.

With regard to the case-finding and control element, I recommend that you at least restore the level of program that existed in fiscal

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year 1975, which at that time amounted to $28 million. This would require that you appropriate at least $30 million for fiscal year 1978, due to inflation.

Finally, because the permanent solutions to the VD problem will ultimately be found in the laboratory, I urge you to prioritize and energize the research element in two ways.

First, I recommend that the status of VD research be elevated from a discretionary program to a line item with NIAID.

Second, I recommend that you mandate immediate doubling of the investment in VD biomedical research—to $10 million in fiscal year 1978. It's time we serve notice on the research community that we seriously intend to conquer VD and invite their active and sustained participation.

In closing, I'd like to call attention to an incongruity that has stymied the adoption of a serious and energetic attempt to eliminate VD. It's simply this: those who are at risk of acquiring VD are by and large under age 35 and have yet to achieve a position of personal and professional stature. Those who have achieved such stature, who occupy positions of leadership and influence, are over 35 and rarely perceive VD as a personal risk to their health.

I therefore ask you, our leaders, to reflect seriously on those 8½ million people who are at risk; students, laborers, aspiring professionals, and others—taxpayers and your constituents—and formulate funding patterns in their best interests, which ultimately are in the best interests of this Nation.

Senator BROOKE. I would like to ask you a question. Do you have any data as to the man-hours lost?

Mr. KNOX. Yes. That is available; I don't have it presently in hand.

Senator BROOKE. Could you supply that for the committee's records?

Mr. KNOX. I can.

Senator BROOKE. Sometimes, unfortunately, you have to attack these problems, in a big government, by making people realize the seriousness of the problems through the economics of their consequences.

I am convinced that, as with other diseases, there are a great number—I don't know what it is, but I would suspect it's rather large—of lost workdays, lost manpower hours as a result of venereal disease. I think we ought to get that in the record. If you would supply that, that would be helpful. By "manpower," I mean man- and womanpower, as well. Some data is also needed as to the increase in venereal disease over the last decade, which would be helpful to us.

No matter what they say, it is a disease with which we have got to come to grips. Rather than decreasing, it is my understanding it's increasing. As you mentioned just now, we even have a strain that is resistant to certain wonder drugs. As you pointed out, even if you find a new drug, it will not be available for a long period of time. So these are the kinds of evidence that I think we will need.

Do you know what the total of fiscal 1977 research dollars was for VD?

Mr. KNOX. $5 million.

Senator BROOKE. $5 million. You are suggesting how much?

Mr. KNOX. Doubling it; $10 million. I am suggesting two things, really. The special emphasis program has been that way since 1971. NIAID put nothing in research. At that time, they acquiesced to some congressional pressure to institute a program. It's been a discretionary, nonline item since 1971. It's increased by varying amounts from 3 percent to a maximum of 9 percent. It's beginning to level off.

I think we should take it seriously and double the investment for fiscal 1978.

Senator BROOKE. That is what we are hearing now.

Mr. KNOX. Right. And really take it out of the total discretionary purview of NIAID to either support or not support it, and fit it into the framework of other things and put the whole research community on notice that we really intend to conquer VD.

Senator BROOKE. As you say, it's important as far as money and it's also important that we actually accept the challenge.

Mr. KNOX. It's more of a policy than a matter of money. It's a damned-if-you-do, damned-if-you-don't situation that has developed, because the discretion varies with the researchers because of the lack of certainty in knowing whether the research will be there.

When Fleming developed penicillin, he wasn't looking for penicillin. Most of the knowledge in the world in this area—if someone is looking for one thing, he may be looking for something different but recognizes something that has potential value.

We have to look at VD and hope from that, scientific breakthroughs will occur. We are not far away—it would be wholly unconscionable, as being as close as we are to a vaccine for gonorrhea, to come into contact with a strain that we have created ourselves because of not taking advantage of the scientific knowledge out there.

It's going to be a shock, but the folks from Cerebral Palsy and other diseases—palsy is a condition they don't understand. There is an increasing suspicion that cerebral palsy is caused by a mechanism through sexual transmission—

Senator BROOKE. If it's a fact, we ought to know it.

Mr. KNOX. Yes. It's this kind of thing that I am trying to convey. We are not really dealing with clap anymore; not a touch of syphilis. We are dealing with a highly complex issue that has not had any significant attention for decades and decades. We are beginning to pay for that now, in respect to gonorrhea.

It's a matter of time before herpes takes a toll, before syphilis begins to learn how to cope with penicillin again.

Senator BROOKE. Thank you very much. Your testimony has been most helpful. I think you made your case well.

## SUBMITTED STATEMENTS

Without objection, we will include a statement in the record from the United Mine Workers. Also, we will include a statement in the record from the National Congress of Hispanic American Citizens. We will also include all other written statements regarding health problems.

[The statements follow:]

## STATEMENT OF DR. LORIN E. KERR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

I am Dr. Lorin E. Kerr, Director of the Department of Occupational Health, United Mine Workers of America. While I appreciate the opportunity to appear before the Subcommittee today, I do so with mixed feelings. One is bafflement. I ask myself what must be done to convince the Congress that occupational diseases and accidents are a serious problem, sapping our national energy and destroying the quality of our lives? Why, I ask myself, are people more worried about the air above our cities than the air in our factories and mines which is many, many more times polluted? Should we be more concerned about the health status of our older citizens with pre-existing medical conditions than we are with cutting someone down in the prime of his or her working career--which we are doing in many of our mines and factories today. Is a whooping crane or bald eagle more important than the health and reproductive capacity of working women and men, many of who are daily exposed to mutagenic, teratogenic and transplacental carcinogenic substances?

I personally do not feel that these are judgements which a nation such as ours should have to make. But the Congress, knowingly or not, is making them when it appropriates literally billions for environmental pollution control and only about $50 million for research on worker health and safety.

When I start to think about my testimony, I also get angry with myself. I know what the occupational health problems are--I have to deal with some of them every day. I must be doing something wrong. Why, I ask myself, can't I convince Congress that the problems are as bad as I know they are. And then I become resigned, and it is with this feeling of resignation I submit my testimony of last year to the Subcommittee for inclusion in this hearing record. Since nothing much has been done in terms of improving the National Institute for Occupational Safety and Health's ability to effectively deal with its responsibilities under the law, what I said a year ago is as applicable today as it was then.

When I wonder why I have failed to convince the Congress about the necessity of a greatly expanded NIOSH budget, it occurs to me that

perhaps we ought to stop talking about job hazards and working men and women. Except for the people affected--the inadvertent guinea pigs in our industrial society--these seem to be abstract terms to others. Let's talk about medical costs. This seems to be a subject which everyone seems to agree needs to be controlled. As a health professional who has devoted many years to the problem of providing medical services at a reasonable cost, I can assure you that the nation is never going to even begin to solve the problem unless more attention is paid to prevention of diseases. And prevention of diseases and accidents is what NIOSH is all about. Forget about the noble words of the Occupational Safety and Health Act--that working men and women are entitled to a healthy and safe job--and think of the problem in cold, economic terms. Protect their health, and the costs of medical care will go down. The costs of this protection will be quite reasonable when compared to the costs of treatment.

In terms of activities which will help prevent disease and disability, I would like to remind the Subcommittee that NIOSH produced 29 criteria docments during the past year. These documents set environmental limits for exposure to chemicals, dusts, and other contaminants in the workplace. While these documents do not yet have the force of law, they are nevertheless very helpful to both labor and management, better identifying current problems and planning future controls. NIOSH is beginning to take a commendable new tack in preparing these documents. The Institute will identify hazards by groups of similar substances--pesticides, for example--and by work practices. They will consider the interaction between substances and the combined effects they may have on the health of the worker, who in the real world is never exposed to just one substance at a time.

Another Institute product I would like to mention are the CURRENT INTELLIGENCE REPORTS. This rapid alert system has proved to be an effective way to inform health professionals in government, labor, industry, and universities about a new hazard or about new data on an old one. Since January 1975 when the first alert was issued on vinyl chloride, NIOSH has sent out 18 current intelligence reports. One of the most recent ones warned that cutting fluids used by some 780,000 workers in scores of

industries to reduce friction during metal machine operations contained significant amounts of cancer-causing substances, nitrosamines.

A third tangible product of NIOSH activities is THE REGISTRY OF TOXIC EFFECTS OF CHEMICAL SUBSTANCES. This annual list contains all the chemical substances with published information on toxic reactions in either animal or man. The current edition which lists some 22,000 substances is widely used by industry, labor and government authorities in their efforts to reduce chemical hazards in the workplace.

Other publications which both industry and labor have found most helpful are the employee work practices guides and the health and safety guides for small businesses. NIOSH has published some 25 different health and safety guides. They have been distributed to more than 750,000 small businesses such as bakeries, groceries, gasoline stations, auto repair shops, soft drink bottlers and canners, laundries and dry cleaning plants, and hotels and motels.

NIOSH does not just share its expertise on paper. It also responds to requests for technical assistance from employees, employers, as well as federal, state, and local agencies. The most popular form of technical assistance is the health hazard evaluation, of which over 100 were conducted last year. The Institute usually responds to requests for these evaluations within two to three weeks. However, industrial hygienists can be mobilized within 48 hours in emergencies such as the recent Texas incident in which workers were reported to have suffered severe nerve damage from exposure to the pesticide, leptophos. I can speak from first hand experience that this service is invaluable.

I single out the foregoing activities to make the point that, while NIOSH was established under the law as a research unit, its programs have real-world application. This is more than can be said for some of the other HEW health research activities. One of NIOSH's criteria documents does much more to protect worker health and prevent disease than all of the other materials combined that I've seen coming out of HEW recently. Any failure to fully fund the Institute means that the American workers will fail to get the full benefit of NIOSH's considerable expertise which to my mind is inexcusable.

As I have pointed out on a number of occasions, the Department of Health, Education, and Welfare, failing to recognize the importance of NIOSH over the years, has not been at all supportive of its budget requests. Accordingly, the United Mine Workers of America was pleasantly surprised when HEW supported NIOSH's FY 78 request for almost $63 million, an increase of $14 million over the current level. While this was short of the $171 million the Union recommended to you last year, it appeared that HEW was finally beginning to realize the importance of protecting the worker's health. We were not surprised when the Ford Administration cut the request back to a level below this year's level. What could be expected from an Administration which wanted to throw OSHA into the ocean.

The UMWA, however, was greatly surprised and disappointed when the Carter Administration failed to restore the cuts. It would seem that the new folks in town have failed to make the distinction of the political maneuvering of Presidents Nixon and Ford in the field of occupational health and safety and the legitimate needs of America's workers. It is up to Congress to correct this confusion.

Last year I pointed out to this Subcommittee the shortage of trained personnel in the field of occupational health and urged that the requested $10 million for this activity be restored. Congress, to its credit, did appropriate $4.5 million. This year again HEW requested $10 million, only to have the Ford Administration cut it all out and the Carter Administration restore only $3 million. This means that the Institute will have even less funds for manpower training in FY 78 than it currently has unless Congress does something about it.

The UMWA recommends that this cut be restored and the figure be increased to $15 million. The major share of this money would go toward the funding of 10 regional educational resource centers. These funds would be awarded under the grant mechanism to either single universities or agencies, or a consortium of educational institution or agencies. The distinctive feature of this proposal is the required cooperative programs of a medical school, a school of nursing, a school of public health or its equivalent, and a school of engineering or its equivalent. We feel that this represents a unique approach to both the short and long term professional

training as well as providing labor and management with a resource to deal with occupational safety and health problems. They ought to be fully funded. At the current level of funding, NIOSH would only be able to support the three centers planned for the current fiscal year and then at a reduced level. The requested $15 million would also allow a small increase in the Institute's special training grant program.

Last year we recommended $12 million for occupational disease and accident surveillance activities but only $2.5 million, the same amount as the previous year, was appropriated. One of the most common complaints about governmental activities is that there is no effective way to measure the progress of the various programs, and I can assure you that without an effective surveillance system this will be the case with both NIOSH and OSHA. I regard funding of this activity as a way of assuring that the taxpayers are getting their money's worth. The requested $15 million would allow the Institute to update the data base on its National Occupational Hazard Survey and begin to establish a truly effective program to assess the health status of the American working public.

Last year you were asked to appropriate $20 million for research grants, a sum necessary to develop more interest among teaching institutions in the field of occupational health and safety. The meager $3 million NIOSH received for this activity in FY 77 has been cut back in the current budget to $2 million so that in this activity as in others NIOSH is in even worse shape than last year. Again we request that the Congress appropriate $20 million for NIOSH research grants.

The next item on my list of NIOSH needs is that of an adequate research facility. At present, the main inhouse research activities are being conducted in four different locations in Cincinnati, Ohio. One has been threatened with condemnation! If the Subcommittee chose to visit Cincinnati, the members would soon find out that they would be spending more time in automobiles than in the labs. This is not an environment conducive to productive activities and should be corrected as soon as possible. We recommend that $75 million be earmarked for a new main research facility capable of housing 800 employees.

As the members of the Subcommittee are aware, HEW is currently in the process of conducting a site survey to determine the best location for the proposed facility. We recommend serious consideration be given to locating it in the two buildings already under construction in the Washington area. Located adjacent to the National Institutes for Health, these buildings were to house the Armed Forces Medical School, plans for which have been stopped by President Carter. There are a number of benefits of this proposal, one being a savings to the taxpayer of $75 million by not having to construct another new building. It would also allow more effective NIOSH operations as well as providing a quicker solution to the Institute's facility and recruitment problems.

A critism that has been voiced against NIOSH is that there has not been enough attention to safety problems. Considering the limited budget, I feel that the decision to focus on occupational health was proper. But it is certainly time now to do more in the safety area. Last year, we recommended a figure of $18 million. The Carter budget calls for $2.1 million, not nearly enough. The Congress should appropriate $18 million so that the Institute could get on with its program on the descriptive epidemology of accidents, motivational studies, and ergonomics.

A complaint we hear from industry is that either the technology does not exist to clean up the work environment or if it does it costs too much. I think that a lot of this talk is phoney, but there is one way to resolve the issue: appropriate the $25 million HEW requested in the area of control technology. If the government is to live up to its responsibilities under the Occupational Safety and Health Act in a timely manner, it must move to fill the gaps in control technology research done by industry so that the feasibility of engineering control is determined for each operation or process where harmful or potentially harmful exposures are occurring. This is especially important for small businesses which do not have the funds or expertise to conduct their own research and development program. The requested $25 million would allow NIOSH not only to begin to assess the state of the art in control technology but start a research and development for new control technology, especially in areas which would aid small businesses. The precedent for research and development has already been established in

other areas for environmental control. Why not do the same for the work environment?

I mentioned earlier NIOSH's Health Hazard Evaluations. As the situation now stands, the Institute can only respond to half of the requests it receives, and this service has not been widely promoted. Currently funded at $2.7 million and with 70 positions, the Institute is able to make only 100 HHE's a year. By funding this activity at $13 million and adding 100 new positions, NIOSH would have the capacity to conduct 500 HHE's a year, far short of the actual need but certainly a great improvement over the current level.

In spite of the fact that the Institute is now producing criteria documents at the rate of 24 a year, it still remains a matter of running faster and getting farther behind. This activity is currently funded at $30 million. We recommended that this figure be doubled.

I would also suggest that the Subcommittee make a specific recommendation about a printing budget for THE REGISTRY OF TOXIC EFFECTS OF CHEMICAL SUBSTANCES. Last year the Institute could only afford to print 2,000 copies of this important reference book. I would suggest that $300,000 be earmarked for this activity. This would allow the printing of 25,000 copies.

Up until now, I have been discussing broad NIOSH activities which I am sure have the support of the entire labor movement. I would also like to touch upon some specific needs of the UMWA. The first has to do with the increasing use of diesel-powered equipment in the mining industry. This equipment is being introduced before we know what the possible health consequences may be. We certainly do know that coal dust is dangerous and we also know many toxic substances have the potential for synergistic action. Our Union does not want to stand in the way of technological improvements, although I am not sure that the use of diesels represents improvement. However, we certainly feel that the possible health effects must be thoroughly investigated and not with our members as guinea pigs. We strongly recommend that $5 million be added to the NIOSH budget to expand NIOSH's limited research program in this activity.

We would also like to repeat our request of last year to appropriate $10 million for research on chronic pulmonary and other job-related diseases occurring among coal miners. I would also like to repeat our last year's request for $10 million for the treatment of black lung.

As we have said many times since 1969, NIOSH should be totally and completely responsible for the chest x-rays of the working miners. This will provide high quality comparable films which will for the first time assure the adequacy of the information essential for eliminating the chronic pulmonary diseases plaguing the coal mining industry for decades. The UMWA urges that NIOSH shall be totally responsible for taking 25 percent of the chest x-rays of the working coal miners each year; the x-rays to be taken on-shift and the operators to continue to pay these costs by reimbursing NIOSH. This will probably cost the operators less than they are currently paying and will result in a universally higher quality of x-rays. It is estimated that the initiation of this program will require the addition of $10 million to the NIOSH budget. There will also be the need for 25-28 positions for necessary personnel such as qualified physicians and technicians.

Again we come to the problem of the total number of positions. I said last year and I repeat again the current ceiling of 900 is unrealistic. A total increase of 250 positions would not be unrealistic. But I hasten to add that increasing the number of positions is not going to mean much unless something is done about the status of NIOSH within HEW. As the situation now stands, the Institute is losing, rather than gaining, industrial hygienists in the regional offices. This is due to a downgrading which is directly related to the Institute's location under the Center for Disease Control.

The UMWA has developed a strong and aggressive working relationship with NIOSH and its precedent, the Bureau of Occupational Safety and Health. Our experience during this period of time forces us to strongly recommend that NIOSH be removed from within the Center for Disease Control, where it never belonged, and placed as a separate agency within the Public Health Service reporting directly to the Assistant Secretary for Health. This

change would enable NIOSH to operate more effectively with related agencies such as OSHA, EPA, and ERDA. The Secretary of Health should be authorized to place an additional 20 positions in NIOSH in GS-16, 17 and 18 levels. The higher grades are necessary to attract and retain qualified occupational health professionals and reduce bureaucratic delays in promulgating regulations and performing other administrative tasks. It would also improve NIOSH capabilities for conducting research and providing technical assistance and manpower development designated by law.

I have used the word "unrealistic" a number of times in my testimony. Based on previous experience, it would be unrealistic of me to expect that NIOSH is going to end up with our recommended budget of $191.3 million for FY 78 (plus $75 million for the new research facility). However, I do have a suggestion as to how HEW may get a bigger yield out of its occupational health dollars. Just as the Department seems to be becoming more aware of the health problems of America's worker so are some of its other component agencies. The trouble is that, to use a current expression, everyone is doing their own thing. This yields nothing but a fragmentation of activities and dilution of effort. We strongly urge that your report language recommend that NIOSH, as the legally authorized agency in the field of occupational health, be given the responsibility for reviewing and coordinating any and all HEW research that relates to occupational safety and health. If NIOSH cannot immediately be given the funding levels we feel are necessary, we would hope that those funds that are available within the Department are spent in the most productive manner possible.

In conclusion, I am not going to repeat my last year's reiteration of the scope and magnitude of the occupational health and safety problems American workers still face every day. If anything the situation seems more bleak in light of our increasing knowledge. I would just request that the Subcommittee keep the following figures in mind when considering the NIOSH budget:

National Cancer Institute - $818 million (up 4 million from FY 77)

National Health and Lung Institute - $404 million (up 7 million from FY 77)

National Institute for Environmental Sciences - 58 million (up 9 million from FY 77)

EPA Research Activities - $261 million

NIOSH - $49 million (down 2 million from FY 77)

In making these comparisons, I do not mean to imply, for example, we should not be spending $818 for cancer research. I would suggest, however, that a great imbalance exists and for this year at least it is up to Congress to correct it.

STATEMENT OF MANUEL D. FIERRO, PRESIDENT, NATIONAL CONGRESS OF HISPANIC AMERICAN CITIZENS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, MY NAME IS MANUEL D. FIERRO. I AM PRESIDENT OF THE NATIONAL CONGRESS OF HISPANIC AMERICAN CITIZENS (EL CONGRESO), A NATIONAL NON-PARTISAN CITIZENS' LOBBY FOR THE SPANISH-SPEAKING.

ON BEHALF OF OUR 25 MEMBER NATIONAL BOARD OF TRUSTEES AND THE 120 PARTICIPATING NATIONAL, STATE AND LOCAL SPANISH-SPEAKING ORGANIZATIONS, I WANT TO THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU REGARDING THE PENDING APPROPRIATIONS FOR THE CORPORATION FOR PUBLIC BROADCASTING, FOR THE FISCAL YEAR 1980. AT THIS TIME, I WOULD LIKE TO ADDRESS MYSELF TO THE VARIOUS REASONS WHY EL CONGRESO HAS SERIOUS CONCERNS AND RESERVATIONS REGARDING CPB AND THE PENDING APPROPRIATIONS.

AS I HAVE TESTIFIED TIME AND TIME AGAIN, THE CORPORATION FOR PUBLIC BROADCASTING HAS CONSISTENTLY INDICATED ITS LACK OF SENSITIVITY AND INTEREST IN HISPANIC ISSUES AND CONCERNS IN ALL AREAS INCLUDING PROGRAMMING, MINORITY TRAINING, EMPLOYMENT, AND GRANTD.

ON FEBRUARY 8 AND 9, 1977, MR. HENRY LOOMIS, PRESIDENT OF THE CORPORATION FOR PUBLIC BROADCASTING PRESENTED TESTIMONY BEFORE THE HOUSE AND SENATE SUBCOMMITTEES ON LABOR, HEALTH AND EDUCATION AND WELFARE, REGARDING APPROPRIATIONS FOR THE FISCAL YEAR 1980. AT THAT TIME, MR. LOOMIS STATED THAT CPB IS THE "PRINCIPAL SOURCE OF NEW AND INNOVATIVE PROGRAMS FOR PUBLIC BROADCASTING," YET OUR RESEARCH HAS SHOWN THAT 58% OF THE CPB MONIES GO TO LOCAK PBS STATIONS IN TERMS OF COMMUNITY SERVICE GRANTS FOR USE AT THE DISCRETION OF THE LOCAL STATIONS. MUCH OF THIS MONEY IS USED TO PURCHASE NATIONAL PROGRAMS OF INTEREST TO SPECIALIZED "WHITE UPPER MIDDLE INCOME PERSONS," RATHER THAN LOCALIZED MINORITY INTERESTS WHO MIGHT PREFER PROGRAMMING OF CULTURAL, LANGUAGE AND SOCIAL ISSUES OF LOCAL CONCERN.

ALTHOUGH THE ANNUAL BUDGET FOR FISCAL 1976 FOR CPB WAS $94,689,936, A TOTAL OF $453,436 WAS USED FOR HISPANIC PROGRAMMING. THIS PALTRY AMOUNT CAN ONLY BE CONSIDERED AN INDICATION OF THEIR LACK OF INTEREST IN THE NEEDS AND CONCERNS OF A LARGE GROUP OF AMERICANS OF SPANISH

DESCENT WHO HAVE CONSISTENTLY FOUND VERY LITTLE IN TERMS OF PROGRAMMING, WHICH TOUCHES THEIR DAILY LIVES AND DEPICTS THEIR CULTURE IN A TRUE FASHION. IN TERMS OF NUMBERS, THEIR AMOUNT REPRESENTS A TOTAL OF 4.49% OF THE PROGRAMMING BUDGET.

ALTHOUGH THE CPB FISCAL 1976 BUDGET PROVIDES FOR A PBS STATION IN SAN JUAN, PUERTO PICO, THERE ARE NO INDICATIONS OF SPONSORSHIP FOR LATINO PROGRAMMING FOR THIS YEAR. LET ME ALSO POINT OUT THAT THE ONLY TRUE SOURCE OF PROGRAMMING FOR THE LATINO COMMUNITY HAS NOT COME FROM CPB, BUT FROM THE UNITED STATES OFFICE OF EDUCATION'S EMERGENCY SCHOOL AID ACT WHICH TO DATE HAS PROVIDED SOME $14,000,000 FOR BILINGUAL PROGRAMMING FOR TELEVISION FOR THE PAST FOUR YEARS. THESE PROGRAMS ARE THAN GIVEN TO THE CPB STATION PROGRAM COOPERATIVE AT NO COST TO THE STATIONS.

IN THE AREA OF EMPLOYMENT THERE ARE PRESENTLY FIVE SPANISH-SPEAKING EMPLOYEES AT CPB, ONE OF WHOM WILL BE LEAVING SHORTLY BECAUSE HIS JOB LINE HAS BEEN ELIMINATED. THE SUBJECT OF CPB'S POOR MINORITY AND EMPLOYMENT RECORD HAS BEEN BROUGHT UP AS AN AREA OF CONCERN BY A MEMBER OF THE SENATE SUBCOMMITTEE ON APPROPRIATIONS. I SINCERELY FEEL THAT CPB SHOULD BE REQUESTED TO IMPROVE THEIR MINORITY HIRING PRACTICES PRIOR TO ANY FURTHER APPROPRIATIONS BEING APPROVED BY CONGRESS. THIS ACTION SHOULD ALSO BE TAKEN IN LIEU OF THE FACT THAT THE EMPLOYMENT PRACTICES BY THE PUBLIC TELEVISION STATIONS EQUALS IF NOT SURPASSES THE INDIFFERENCE TOWARDS THE HIRING OF MINORITIES IN THEIR AREAS. IN A STUDY MADE BY THE CITIZEN'S COMMUNICATIONS CENTER OF THE 1976 ANNUAL EMPLOYMENT REPORTS FILED BY THE PUBLIC BROADCASTING LICENSEES WITH THE FCC, IT WAS FOUND THAT OF THE 147 OF THE 154 U.S. PUBLIC TELEVISION LICENSEES THAT FILED THEIR EMPLOYMENT REPORT WITH THE FCC FOR 1976, THIRTY-THREE REPORTED NO MINORITY EMPLOYEES IN A FULL TIME CAPACITY. WITH REGARDS TO HIRING MINORITIES TO EQUAL THE PERCENTAGE OF MINORITIES LIVING IN THE AREA SERVICED, 69% OR 102 OF THE 147 BROADCAST LICENSEES HAVE LOWER MINORITY EMPLOYMENT PERCENTAGES THAN THE AMOUNT OF MINORITIES IN THE SERVICE AREA. ASSUMING THESE STATISTICS ARE CORRECT, YOU CAN BE QUITE CERTAIN THAT THE NUMBER OF HISPANICS HIRED AT THESE STATIONS ARE FEWER, IF THEY ARE HIRED AT ALL.

IN THE AREA OF PROGRAMMING, CPB HAS FUNDED REALIDADES WHICH IS IN ITS LAST YEAR. REALIDADES IS THE ONLY HISPANIC NATIONAL PROGRAM BEING AIRED AND WAS RECENTLY GIVEN AN AIR TIME OF 11 P.M. ON MONDAYS, COMMENCING

IN MAY. AS YOU CAN IMAGINE, THIS AIR TIME IS UNACCEPTABLE TO THE HISPANIC COMMUNITY THAT CANNOT STAY UP THAT LATE IN ORDER TO VIEW THE ONLY PROGRAM WHICH HAS BEEN PRODUCED BY ONE OF THEIR OWN AND FOR THEIR BENEFIT, EDUCATION AND ENTERTAINMENT, AS WELL AS THE NATIONAL AUDIENCE. WE CONSIDER THE SCHEDULING OF THIS PROGRAM AT THAT HOUR A PERSONAL AFFRONT TO OUR DESIRES AND AN ADDITIONAL INDICATION OF HOW WE ARE CONSISTENTLY BEING TREATED AS SECOND CLASS CITIZENS. THE RESCHEDULING OF THIS PROGRAM COULD PROVIDE A HIGHER VIEWING RATE WHICH WOULD INCLUDE CHILDREN THAT ARE NORMALLY IN BED BY 11 P.M.

IN THE AREA OF FUTURE HISPANIC PROGRAMMING, CPB HAS NOT MADE ANY COMMITMENT TOWARDS ANY OF THE PENDING HISPANIC PROGRAMMING PROPOSALS WHICH WERE SUBMITTED AS EARLY AS AUGUST 1976. CONSIDERING THAT THIS IS THE LAST YEAR FOR REALIDADES, A STRONG EFFORT SHOULD BE MADE BY CPB TO INSURE THAT THERE WILL BE MORE HISPANIC PROGRAMMING IN THE FUTURE, OR TO AT LEAST QUICKLY RESPOND TO THE PROPOSALS WHICH HAVE ALREADY BEEN SUBMITTED.

FOR THE JUST MENTIONED REASONS, AND MANY MORE WHICH I COULD CITE IF I HAD THE TIME, WE RESPECTFULLY REQUEST FROM THIS COMMITTEE TO ASSIST US BY ASSERTING YOURSELVES TO REQUEST FROM CPB THAT THEY BE MORE RESPONSIVE TO THE HISPANIC COMMUNITIES AND ITS NEEDS AND REQUEST FROM THEM THE FOLLOWING:

A) THAT CPB PRESENT A PLAN TO THIS COMMITTEE WITH A PROJECTED TIME TABLE IN WHICH THEY WILL HIRE MORE HISPANICS TO THEIR STAFF.

B) THAT CPB GIVE THIS COMMITTEE AN ASSURANCE THAT A SINCERE EFFORT WILL BE MADE TO INSURE THAT SEVERAL HISPANIC PILOT PROPOSALS WILL BE FUNDED, THUS INSURING HISPANIC PROGRAMMING FOR THE IMMEDIATE FUTURE.

C) A PLAN WHICH WILL ENCOURAGE THE PUBLIC TELEVISION STATIONS THROUGHOUT THE COUNTRY TO COMPLY WITH THE EQUAL EMPLOYMENT STANDARDS SET UP BY THE GOVERNMENT, WITH AN EMPHASIS ON HISPANIC HIRING WHICH IS PRACTICALLY NON-EXISTENT, ESPECIALLY IN AREAS WITH HIGH CONCENTRATION OF HISPANICS.

D) ASSISTANCE IN THE ACQUISITION OF A SUITABLE AIR TIME FOR REALIDADES' LAST SEASON.

E) A PLAN INSURING THAT LATINO PROGRAMS CAN SURVIVE THE SPC PROCESS.

I SINCERELY HOPE THAT THIS COMMITTEE WILL AID US IN OUR REQUEST FOR THE ABOVE CONSIDERATIONS.

THANK YOU.

STATEMENT OF WILLIAM J. CALDWELL, ASSISTANT DIRECTOR, AMERICANISM AND CHILDREN AND YOUTH DIVISION, THE AMERICAN LEGION

The American Legion appreciates the opportunity to express its views on the bills pending before this subcommittee which would provide grant funding authorizations for communicable disease control.

The Children & Youth Division of The American Legion has been vitally concerned with the high incidence and, hopefully, the eventual eradication of venereal diseases which have become a most difficult problem to control among our nation's children and youth. Since 1958, this organization has repeatedly submitted testimony before both branches of Congress supporting measures that have sought to provide more effective control programs and more adequate federal funding for the widest possible protection of our nation's young people.

The latest venereal disease trend data from the U.S. Public Health Service, Center for Disease Control indicates that in calendar year 1976, there were 1,001,994 reported cases of gonorrhea, an increase of only 0.2 percent from the number reported in 1975. Since 1962, reported cases of gonorrhea have increased annually by at least 10 percent. During the last six months of 1976, such cases actually declined by 1.7 percent compared to the same time period of the previous year. During the first 10 weeks of 1977, provisional data shows a decline of 4.2 percent in reported cases compared to the same period of the previous year. Primary and secondary syphilis cases reported were 23,731 down 7.2 percent compared with the previous calendar year. This trend carried into the first 2 months of 1977 and provisional data shows that reported cases declined an additional 14.0 percent as compared to the same period of the preceding year. Cases of early latent (less than 1 year's duration) syphilis declined by 6.2 percent in 1976 compared to 1975. During the first 2 months of 1977, provisional data shows that such cases continued to decline by 13.1 percent. Even with a general decline in both gonorrhea and syphilis, some geographic areas are experiencing increases.

Over 10 years ago, the Surgeon General of the United States announced a plan to achieve the eradication of syphilis in this country. Although the timetable for this effort may have been altered by cut-backs in venereal disease control programs, The American Legion is convinced if sufficient funds are provided for this activity that the goal is certainly attainable.

Failure of some states and localities to participate in certain communicable disease control programs seriously limits the effectiveness of neighboring states or localities to control the infectious spread of these diseases. None of the communicable diseases can be permanently eliminated in other areas. The American Legion feels that specific grants should be made to states in order to insure that all states utilize funds for venereal disease control and prevention as planned.

One finds no comfort in examining the incidence of infection among the 15 to 30 year old age group, that group in which people are most sexually active. This is partly due to fear, myths and misinformation about these diseases, all of which contribute to the reservoir of infection. Research leading to effective vaccines holds the key to the eventual elimination of the sexually transmitted diseases. Efforts must be brought to bear to decrease the incidence of gonorrhea and increase public awareness of the seriousness of this problem. The matter of eradicating syphilis and the control of gonorrhea is so serious that we cannot rely upon state and local governments to complete this job. This is a national problem requiring federal assistance. Without adequate federal financing, it seems impossible to achieve this goal primarily because of inflationary costs of necessary supplies and anticipated increases in staff

compensation. If appropriations are cut or remain static and do not at least reflect current inflation rates, we will be further behind in achieving our goal to control and eradicate venereal diseases.

We strongly urge this subcommittee to take favorable action on those proposals intended to greatly strengthen venereal disease prevention and control. We appreciate the opportunity for The American Legion to express its view on this serious health problem.

Attached to this statement is Resolution No. 462 (Venereal Disease Control) adopted at the 58th National Convention of The American Legion at Seattle, Washington. This Resolution reflects the current policy of our organization with respect to this subject.

FIFTY-EIGHTH ANNUAL NATIONAL CONVENTION OF THE AMERICAN LEGION
SEATTLE, WASHINGTON, AUGUST 24, 25, 26, 1976

RESOLUTION: No. 462

COMMITTEE: Children & Youth

SUBJECT: Venereal Disease Control

WHEREAS, Venereal disease is out of control in the United States, it is the number one communicable disease and the number two killer among communicable diseases, and

WHEREAS, Syphilis and gonorrhea are diseases which constitute a threat to all the people of our nation, and

WHEREAS, Neither of them can be eliminated permanently from any area without eliminating them from neighboring areas and from all areas of social interchange, and

WHEREAS, The cost of maintaining the victims of syphilitic insanity in tax-supported institutions is approximately $44 million per year, another $5 million is spent for aid to the syphilitic blind, expenditures that can be eliminated with the eradication of syphilis alone; now, therefore be it

RESOLVED, By The American Legion in National Convention assembled in Seattle, Washington, August 24, 25, 26, 1976, That it again urges the President of the United States, the Secretary of Health, Education, and Welfare, the Under-Secretary for Health and Scientific Affairs, and the Members of the United States Congress to recognize that venereal disease control is rapidly deteriorating and that immediate and emergency measures must be taken to restore fiscal and manpower resources adequate to complete the eradication of syphilis and to effect the control of gonorrhea.

## STATEMENT OF DR. ALAN R. DIMICK, PRESIDENT, AMERICAN BURN ASSOCIATION

It is a pleasure for me, as incoming President of the American Burn Association, to submit this testimony supporting the expansion of the Burn Injury Demonstration Program in Fiscal Year 1978. The membership of the Association has appreciated the interest and support which the Senate Labor/HEW Appropriations Subcommittee has shown in the area of burn care. We particularly want to recognize that your chairman, Senator Warren Magnuson, has long supported our concerns. The first Congressional initiative to improve service delivery in burn care came out of the Senate Commerce Committee, which he also chairs, when it developed the Fire Prevention and Control Act in 1974.

We hope that the Chairman and the entire committee will continue their support of the momentum which has developed in the past few years in both the private and public sectors, to reduce the impact of burn injury in the United States. With this momentum, the number of specialized facilities, according to one authoritative source, has increased from 78 to 163 in just six years.

This proliferation of facilities is not the sole answer to the problem, however. While it has increased our physical capacity to treat burn patients, it has exacerbated some problems and highlighted others. When, for example, the Health Services Administration submitted in September, 1976 the report "Burn Care", in response to your committee's request, they noted that 11 of the nation's 60 largest burn facilities were reportedly unable to recruit medical directors.

And there are other questions receiving increased attention:

- Is the proper mix of patients being referred to these facilities?
- Are minor to moderate burns being properly treated in non-specialized facilities?
- Is care being provided to all burn victims in the most cost-effective manner?
- What are the implications of reimbursement mechanism shortfalls for the long-range financial viability of burn care, particularly in specialized facilities?

- What is the impact of burn injury and burn treatment on the ultimate readjustment of burn victims?
- How can all the resources needed to care for burn victims from the instant they are injured, best be organized, and with what leadership?
- Finally, is there a pattern in the answers to these questions which suggests a need for ongoing federal support, to particular regions, for particular aspects of care, or for particular functions such as the training of physicians and other members of the burn care team?

These questions are quite different from the many clinical issues in burn care. Research on the latter has been supported by the National Institute of General Medical Sciences for almost ten years. They are health delivery system questions, which can best be approached in comprehensive demonstration projects at the regional level. Indeed, we anticipate that the new program's focus will enable improved dissemination of the research findings supported by NIGMS, and will increase the number of facilities competent to pursue such research. It is quite fitting that this program has been assigned to the Division of Emergency Medical Services within HEW, which has begun in the past few years to develop a systematic approach to meeting the nation's overall need in emergency medical care.

It is also quite fitting that this program is authorized for three years. Burn injury is both an emergency and a long-range problem for its victims, and the effectiveness of burn treatment can only be addressed in studies that can follow the recovery process of severe burn victims over a period of years.

The EMS Office is already moving quickly to prepare for contracting out the regional studies in burn care which are envisioned under this program, and which recently received initial funds in the supplemental 1977 appropriation. It is important that this year's appropriation, for the second of the three years authorized, be large enough to support the continuation and expansion of these contracts, in enough regions of the country to enable a thorough study of the problem.

In closing, I would like to tell you that recently in Los Angeles, (March 30-April 2) over 1,000 people representing all disciplines concerned with burn care met at the Ninth Annual Meeting of the American Burn Associa-

tion. At that meeting, the largest ever held on the burn injury problem, there was a consensus among burn care providers that region-wide efforts are needed to strengthen our approach to burn care. We look to this committee for support in our efforts to design and implement such approaches throughout the country.

Respectfully submitted,

Alan R. Dimick (PD)

Alan R. Dimick, M.D., President
American Burn Association
(as of 4/1/77)

## STATEMENT OF THE AMERICAN NURSES' ASSOCIATION

The American Nurses' Association appreciates the opportunity to present its views on the proposed health budget for fiscal 1978.

This is a period of transition during which many health programs will be extended for one year to enable the new Administration to do its own review and analysis and come up with its own recommendations. We are in agreement with this procedure but believe that in this interim, funding should be provided at levels which allow for inflation and also permit the programs to remain viable.

Cost containment is an objective of the Carter Administration and certainly one with which we heartily agree. However, we do not believe the proposed Carter budget is equitable in its recommendations for cuts of the previous year's appropriations levels. Health is especially hard hit. Admittedly, the time which the new Administration had to review the Ford budget and come up with new figures was extremely limited, but we believe that some adjustments in the health area are imperative.

We are particularly distressed by the excessive reductions in funds for support of nursing education. Nearly all of the reduction in support for health professions education was taken from nursing ($100 million). Cuts of this magnitude would seriously disrupt nursing programs and plans of students who enrolled in the understandable belief that commitments for student aid under the Nurse Training Act would be fulfilled.

We will speak later to the specifics of appropriations for nursing education.

### ADAMHA

The Carter budget requests $974 million for ADAMHA in fiscal 1978. This figure reflects an increase of one million above the current level. This means that training, service, and research programs will only be able to operate at their current levels. At a time when the needs of society cry out for enlarging the national pool of professionals for the delivery of expanded mental health, alcoholism, and drug abuse services

with an augmented use of preventive strategies deriving from sound research, we question how a budget that simply maintains the "status-quo" is justified?

NIMH Training

Restoring clinical training for professionals in the mental health, alcohol and drug areas to the current program levels means that there will be no new awards for institutional training support, and no new pre-doctoral fellowships. In our psychiatric nurse population, this will discourage many nurses from enrolling in graduate programs which would further prepare them as expert practitioners in psychiatric nursing. There is a conservative projected need for 50,000 graduate prepared nurses (Masters and Doctorates) in the next ten years to teach and administer quality mental health care. The numbers are even greater when one includes services for the prevention and treatment of drug abuse and alcoholism. Psychiatric nurses have made and continue to make substantial contributions in these areas where they function as teachers, supervisors, and administrators, as well as therapists.

We recommend a minimum of $110 million for the training of mental health professionals and for increases for the training of drug abuse personnel, and for personnel to work in alcoholism programs. We urge, too, that this subcommittee include its intent to maintain and not to cut the number of nursing students being supported (at no fewer than in FY'76).

NIMH Research

In the ADAMHA Forward Plan FY 1978-82, research is listed as the highest priority. Each Institute within ADAMHA has recommended continued and new funding for extramural research centers, expanded intramural research, and expanded research training. The current budget recommendations continue research funding at current levels. Within the nursing profession, many nurses are indicating a keen interest in research activities at the graduate and the post-doctoral levels, and want to participate in the extramural research programs so that they can devise better ways to deliver quality nursing services. It is imperative to the profession

and the mental health community, that these nurses are financially encouraged in their pursuits so that their professional contribution can be enhanced. Research is essential to continued improvement in treatment and care. We desperately need to make much greater and more rapid progress in the areas of mental health, drug abuse, and alcoholism. Many of society's problems are directly related to mental illness.

There have been recent research breakthroughs in the areas of depression, schizophrenia, opiate receptors in the brain, and alcoholism linking the disease to an hereditary predisposition. Such research studies and other similar studies need increased funding to continue. Hopefully, even more dramatic findings will be forthcoming. Study results are integrated into training curricula and services strategy. Only in this way will mental illness, and drug and alcohol addictions become more treatable and finally curable.

We recommend a minimum of $120 million for mental health research.

Community Mental Health Centers

Community mental health centers have had a substantial impact in making quality mental health care more widely accessible. However, although a total of 670 community mental health centers have been established since the start of the program in 1963, there continues to be a shortage of quality community-based mental health services in many areas of the country. We believe it is imperative that this innovative mode of mental health service delivery be allowed to flourish by increasing the number of CMHC operating centers. Only in this way will the original intent of the 1963 legislation of 1500 centers be realized.

We recommend $305.5 million for community mental health centers with an adequate amount earmarked for new starts.

Rape Prevention and Control

The National Center for the Prevention and Control of Rape is authorized to carry out and support research, services and education. We are very pleased to see this Center operational and are deeply concerned

over the absence of a budget request for 1978. We had hoped for increased support so that services of the Center could be expanded to include the training of personnel to work with rape victims, their families, and offenders. It is indeed premature to cut off or to lose identity of these program funds just as the Center is beginning to focus national attention on the problem of rape and to formulate effective strategies to combat it. The incidence of rape crimes in our society is rising and will continue to increase if adequate support is withheld from programs designed to control it.

We recommend a significant increase for rape prevention and control. These funds need to be earmarked and not mixed in with other operating programs.

Home Health

In the presence of rising hospital and other health care costs, home health care offers a cost-effective alternative. The development of adequate home health care programs could prevent or postpone the institutionalization of as many as 2.5 million elderly people alone. Not only would millions of dollars be saved, but the value of people moving toward greater self-reliance and increased independence would warrant increasing home health care services on humanitarian grounds alone.

Home health services provide both an economical and a desirable way of meeting many of the health care needs of society, both preventive and curative. They can also provide clients with a wide range of professional services which are not easily secured through the physician alone.

Nurses comprise the largest number of health care professionals providing home care services. Care provided in the home by qualified professionals constitutes some of the best, most innovative and client-centered health care available today. Home care can be used in conjunction with hospitalization to allow for early discharge and continuity of care or can be initiated independently without prior hospitalization.

The home setting promotes increased health-education, high levels of client participation, family involvement, and meaningful professional-client relationships. Non-elective admissions to hospitals plus other forms of expensive institutionalization are greatly decreased. More professional expertise must be recruited for this endeavor and more home care services must be made available to the entire population. The current proposed budget of $3 million is not adequate to accomplish this.

We recommend a significant increase for home health services in the next fiscal year.

Maternal and Child Health

The Administration proposal for FY'78 generally allows the same funding as FY'77 without allowing for inflation and resultant increased costs. This, in effect, means a reduction.

The programs of Title V of the Social Security Act operate under the Bureau of Community Health Services. The Bureau is responsible for grants to state health departments for the purpose of expanding services or developing methods to improve services for maternal and child care. Money is also available for technical assistance and consultive services from the Bureau and the HEW Regional Offices. However, with the downgrading of regional positions and the cutbacks in the Bureau staff and travel monies, there is a lack of qualified professionals to meet the needs. We question the ability of the states to maintain high level services without supporting assistance and consultation. We urge the return of the maternal-child health specialist in each Regional Office and the addition of Bureau staff to assure their expertise is available to states.

Furthermore, the research and training funding remains at the FY'77 level. We feel this is shortsighted. Research projects are aimed at developing new knowledge relating to maternal and child care and new systems to deliver the care. Where are the professionals needed to do the training and research? The trend in recent years has been to focus on

training to provide services. We are now at a juncture where we must balance the number of providers with the number of leaders as teachers, administrators, and consultants. We recommend the authorized sum of $30 million be budgeted for FY'78 for research and training with part of the money to be earmarked for nursing, and $320 million for grants-to-states. We urge restriction on the use of these training funds so that they cannot be directed to other uses.

Migrant Health

Since 1962 when the Migrant Health Act was passed, health care services have been provided to farm workers and their dependents either as migrant workers or seasonal workers who reside in the farming area. Amendments to the act in 1972 expanded the program to include year-round clinics with full time staff as well as seasonal clinics coordinated with community resources.

Migrant workers have great need for assistance to meet their health care needs. Their infant mortality rate is 25% higher than the national average and their mortality rate for tuberculosis and other infectious diseases two and one-half times the national rate. Hospitalization for accidents is 50% higher.

The plight of the migrant worker will be intensified this year because of crop damage caused by the severe cold of the East and the drought in the West. The migrant worker and his family will have more difficulty providing food and shelter, and even more difficulty in meeting their health care needs. Therefore, we recommend the budget be increased significantly. We see the addition as a firm commitment to deliver services to meet the critical unmet health care needs of migrants.

National Health Service Corps

Since the 1971 establishment of the National Health Service Corps, the number of geographic areas lacking adequate resources of health care personnel and services has been notably reduced. The program assists critical health manpower shortage areas to establish clinics that will

eventually become community owned and operated and to find the necessary health care providers who hopefully will choose to remain as community residents.

Nurse practitioners have always been eligible for recruitment since establishment of the Corps. However, nurses have not received National Health Service Corps scholarships until this year when, as noted earlier, 40 were awarded to nurses enabling them to receive their education with a promise to serve in shortage areas. Payback is a minimum of 2 years. There is strong evidence that nurses are more willing than physicians to practice in underserved areas and, once there, tend to remain longer. In a survey conducted by the National Student Nurses Association, over 50% of the baccalaureate nursing students stated they would accept a NHSC scholarship with the service requirements that are attached.

With the establishment of community clinics, such as those provided under NHSC, rural residents have access to primary care that emphasizes health maintenance, health promotion, and continuity of care. However, other health manpower shortage areas exist. Urban areas also have groups of low income medically indigent residents. These residents are often denied care by lack of money and lack of transportation to distant facilities.

We recommend the 1978 budget request be increased from $37.5 million to $45 million so that an adequate number of health personnel can be assigned to communities which reflect the spectrum of underserved areas rather than just a segment.

## NURSING EDUCATION

The Carter budget proposal states flatly that "there is no overall shortage of professional nurses." This oversimplification is greatly misleading and we ask what studies were used to come to that conclusion?

Legislation enacted in the 94th Congress and legislation being seriously considered this session puts special emphasis on the use of more professional nurses in expanded roles. At the same time, there is

significant evidence detailed in a recent National League for Nursing survey that the expansion trend in the supply of nurses has now stabilized at a virtual zero rate and it is predicted to stay at this rate for the next few years. Especially alarming is the serious continuing shortage of the advanced degree prepared nurses who will fulfill the roles called for in present and proposed legislation. The revised budget for FY'78 would delete all funding for support of this area of nurse education.

The abrupt removal of the majority of federal support for nursing education would have drastic effects upon institutions, faculty, students and patient care. There is a direct relationship between the quality of care and the quality of nursing education. Disrupting the educational preparation system just prior to the anticipated enactment of national health insurance could seriously affect the manpower supply that will be required.

Although $17 million was added to the Ford Request, the revised Carter budget proposes a reduction of $100 million from the amount appropriated for nursing education and nursing research in fiscal 1977. This amount alone represents over one-half of the total budget reduction requested for the entire Health Resources Administration. It is hoped that this subcommittee will seriously consider the following requests and give its continued support to the congressional intent expressed in passage of the Nurse Training Act by restoring aqequate funding for nursing schools and students.

Capitation

As with the previous Administration, and the last two fiscal year requests, again no funding is requested for this item. An adequate supply of nurses continues to be cited as justification even though P.L. 94-63 clearly states that receipt of capitation monies is not necessarily contingent upon increased enrollment. These funds are critical to some schools in providing faculty and facilities essential for maintaining quality programs, and to provide curricula improvement and continuation

of other administrative aspects of education programs. The accreditation status of many schools will be negatively affected through loss of faculty, support services and fewer curricula offerings. In addition, the student-faculty ratio will be increased.

The appropriation for FY'77 represented a $4 million reduction of funds from the previous year. For fiscal year 1978, the authorization is $55 million and we are recommending that $50 million be appropriated to maintain this program.

Special Projects

With increasing emphasis being placed on opportunities for disadvantaged students, expanded roles, maldistribution of resources and continuing education, the Special Projects program takes on added importance to nurse education and the delivery of improved health care.

Innovative projects of statewide, regional and national significance can be funded to address the above-mentioned situations. However, the revised budget request proposes a decrease of $9 million from last year's $15 million appropriation. This threatens the continuation of ongoing projects and allows for no new ones. We recommend that the full authorization of $15 million be appropriated which is needed just to fund approved applications.

Advanced Nurse Training

As is stated above, and stressed in our appropriations request last year, this is the area of nursing education for which funding remains most urgently needed, and for which we request the continued support of this subcommittee. The funding increase granted in FY'77 allowed collegiate schools of nursing to begin to address the problem of serious shortages of nurses prepared for leadership positions. Complexities of patient care need direction by nurses at advanced levels of quality care -- primary care, acute care and long-term care. It seems highly inconsistent for the Administration to request no funding for this program when they have repeatedly testified, and did so again this year, that there is a definite need for the nurse with advanced training.

Nursing teachers, administrators, supervisors, clinical specialists and researchers are among those whose positions generally require additional educational preparation. Schools have already contacted us saying that without federal support they would have to discontinue their advanced training programs or cut them back significantly. Many state boards of nursing have set a mandatory cut-off date a few years hence that will require faculty at all levels of nursing to have a master's degree. Career mobility should be available for nursing faculty. At present, only about 20% of nurses have baccalaureate or higher degrees, and the need projected for 1980 is for at least 440,000 nurses with advanced preparation.

Demands for continued improvements in the health care delivery system and also new opportunities for nurses in education, administration and "expanded role" careers require that increasing numbers of registered nurses continue their education beyond their initial training. This is the only source of funding for graduate programs in nursing and should have the highest priority. We recommend and request that $17 million be provided for this program.

Nurse Practitioner

In response to a growing demand, nurse practitioner grants were established in 1975 under P.L. 94-63 to foster the development of programs to prepare nurses to practice in the primary care role. Congress particularly emphasized the need for geriatric nurse practitioners for care of the elderly, a group whose lack of adequate health care has been graphically reported in the press in recent months. Additionally, during the 94th Congress and again in the present session, Congress has emphasized the use of nurse practitioners in rural underserved areas and has supported the concept in already enacted and proposed legislation.

A conservatiye estimate of nurses prepared to practice in the expanded role is about 7,000. Although some of these are prepared in such specialty practice as geriatrics, school health, Ob-Gyn and pediatrics,

there are more than 2,500 nurses prepared as family nurse practitioners. These nurse practitioners are able to provide a broad range of services to all age groups.

The median age of nurses graduating from nurse practitioner programs is 30 years; therefore, many of these individuals have a good practice base behind them. Most nurse practitioner graduates choose settings where maldistribution of health care services exists. Experience to date also shows that they tend to reside longer in these communities.

Evidence shows there are a number of nurse practitioners functioning as the sole primary health care provider in some clinics. Some areas where these clinics are located are Kentucky, Tennessee, Idaho, Montana, Vermont, New Mexico and Washington. Some examples follow:

- With the help of an initial federal grant of $27,000, Carolyn Whitaker set up a family nurse service clinic in Red Boiling Springs, Tennessee, in 1972. Many individuals of the community had been without any type of health care for 15 years. In the first year of operation, Ms. Whitaker saw over 2,000 patients and had 812 families registered with the clinic.

- In July 1971, Wilma Nicholson took over the operation of the SOS Health Center in Seeley Lake, Montana. The people of the Seeley Lake area had petitioned the state to send in an individual who could act as a para-medical person between themselves and their physicians who were located 60 to 120 miles away. Among her numerous duties, Ms. Nicholson is responsible for seeing to the health needs of one high school and three elementary schools. She operates the ambulance service. Once a month she runs a growth and development clinic for children and once a year she conducts a multiphasic screening program.

- Two nurse practitioners provide primary care for the logging community of Darrington, Washington, some 80 miles north of Seattle. With the assistance of a receptionist-clerk, they operate an out-patient clinic providing day-to-day care for the town's 1,100 residents and

people in the surrounding area. The nearest physician is 30 miles away over winding mountain roads.

Nurse faculty preparation, project staff and related costs for this program are also eligible for funding. And beginning in fiscal 1978, as mandated by the new Health Professions Act, nurse practitioner student stipends will also be funded from this program.

The fiscal 1977 appropriation was $9 million. HEW estimates that this amount will fund 61 grants of which 18 are continuing. The program was launched in fiscal 1976 with an appropriation of $3 million. We are recommending an appropriation of $16 million in fiscal 1978 to continue the impetus of the program and to help meet the rapidly expanding demand for nurses with this kind of advanced preparation.

Loans

Funding for the nursing loan program is being entirely deleted in the revised budget for FY 1978. The appropriation for FY 1977 was $22.5 million and it is estimated that approximately 28,125 students could be assisted. In recent years, the requests for loans was double and triple the amount actually appropriated.

In justifying the deletion of these funds, the Administration suggests that nurses are eligible for BEOG funds, and we must again point out this program remains tremendously oversubscribed. Adding nursing students to this competition would severely lessen their chances of receiving any support. Additionally, the nursing loan program provided for cancellation and deferment of payment when a student chooses to work in a designated shortage area for a specified period of time. Nurses have a special need for support during their training because of the clinical requirements which do not allow them opportunity to work part-time.

A recent evaluation of economic trends in this country by a weekly news magazine showed costs for tuition in private institutions to have increased a startling 105% in ten years. This trend in tuition increases is not diminishing. With decreasing loan monies available to the health

professions, evidence is also surfacing that only those students from affluent families will be entering these programs.

We strongly urge continuation of the nursing loan program and recommend an appropriation level of $24 million for FY 1978.

Repayment

No funding is requested for this program which repays a portion of a nursing education loan when the individual agrees to practice in a designated shortage area. The budget justification states that these needs can be met through the National Health Service Corps scholarship program. However, we must remind this subcommittee that only 40 slots have been designated for nurses in the NHSC scholarship program for 1978.

Although current figures showing the number of nurses taking advantage of the loan repayment program appear low, it must be pointed out that shortage areas for nurses were not designated until June, 1976. More conclusive figures should be available after the present academic year.

In a survey conducted by the National Student Nurses' Association last year, students were asked if they would be willing to practice in shortage areas and an average of 40% from all three basic education programs replied that they would.

We recommend an appropriation of $3 million for loan repayment which is the same level as FY 1977.

Scholarships

We support the Administration's request of $9 million to assist those students having exceptional financial needs. This support is essential in helping the disadvantaged to enter and remain in nursing education programs at every level. The $9 million should assist approximately 9,000 students.

Traineeships

This program provides financial assistance to nursing students who are undertaking a study of advanced preparation leading to positions

such as teachers, researchers, clinicians, and supervisors. Funding of this program takes equal priority with the Advanced Nurse Training section.

The necessity for traineeships, as with student loans, is based on the economy, higher costs of tuition, and the urgent need to expedite getting practitioners into the field. Evidence shows that more and more of these students are single heads of families or contribute necessary income to the family. Without the availability of traineeships, there is an increasing trend to part-time academic attendance which means that it takes two to three times the normal period to complete a program. In addition, some schools do not enroll part-time students.

Withdrawing support of the traineeships would have a serious effect on the enrollment of those nurses who want to go on for advanced degrees and whose leadership services are so urgently needed. Also, beginning in 1978 stipends will be funded from this section as mandated by the new Health Professions Act.

Support to approximately 3,000 trainees was available with the FY'77 appropriation of $13 million. We recommend a minimum of $18 million for the program in FY 1978.

Construction Grants

Although construction assistance has been authorized for each of the three fiscal years of P.L. 94-63, no funding has been requested and none appropriated. We feel that some attention should be given to this funding at this time.

There is documented need for construction assistance to nursing schools across the country. Schools in the states of Washington, South Carolina, Colorado, Michigan, Kansas, to mention a few, are in desperate need. Some need new facilities; others need renovations. Out of desperation, some schools have even applied for Local Public Works funding but, of course, to no avail.

Considering that a total of $60 million has been authorized over the three fiscal years, we believe need has been demonstrated and our request for $10 million for FY 1978 to be reasonable and legitimate.

Nursing Research

We appreciate the subcommittee's support and recognition of this nursing component in last year's line item appropriation. Response to the increased funding has been enthusuastic and strong as anticipated.

Although other components of the federal government have supported research and research training in special fields of considerable importance to nursing, the major focus for nursing research is centered in the Division of Nursing. This focus, which has centered recently on psychosocial and clinical management aspects of patient care, is not duplicated elsewhere within the federal structure. We would call this subcommittee's attention to a recent article in Nursing Research, January-February 1977, entitled "An Overview of Nursing Research in the United States." It presents a 100 year history of nursing research and is an excellent source of contributions which nursing research has made historically.

From its modest beginnings in 1955, nursing research funding has slowly grown to its present level of $5 million for research grants and contracts, and $1 million for fellowships. We feel that this focus of nursing has been shown to be invaluable in its application to direct patient care and are puzzled by the Administration's request for no funding for this program.

Research Projects

The number of research grant applications in process has more than doubled. Approximately 35 grants, both new and continuing, will be supported with the $5 million appropriated in FY 1977. These grants will cover such areas as psychological support of children undergoing surgery, cardiac rehabilitation, and the alleviation of pain and stress associated with illness. Under one regional research development grant, nurse clinicians studied not only the critically ill patient in a coronary care unit but his family in this health crisis situation. Patient

comfort and recovery were so improved when the spouse's need for support and communication were met that nursing practice on the unit was changed to provide the flexibility and staff time for this support.

We urge and recommend an increase of $2 million to $7 million for research projects to continue the impetus of this vital program.

Research Fellowships

This program makes awards to predoctoral and postdoctoral nurse candidates for specific research training. Authority for the Fellowship program comes under the National Research Service Awards Act (P.L. 93-348). This legislation is being extended, and specific language to include nursing fellowships is included in the bill.

Approximately 140 awards will be made possible with the FY'77 appropriation of $1 million. These nurses will combine nursing research with teaching and/or clinical practice.

Due to the large number of requests for fellowship applications which has exceeded estimates, we recommend an increase to $2 million for this program. Unless that occurs, new students cannot be added next school year.

Regional Offices

Again we would call this subcommittee's attention to the problems we have pointed out over the past two years -- they remain unchanged. Specifically, regional offices have moved health professionals from programs for which they were hired and assigned them to totally different responsibilities. Nurse consultants, as well as others, are being downgraded with a change in function. We maintain that program expertise is absolutely necessary to deal with individual programs and request support from the committee in assuring that this will occur.

Direct Operations and Staffing

Problems also exist at the direct operations level. Positions, travel funds, contract monies, etc., are now appropriated in a lump sum

under the direct control of the agency director rather than, as in the past, at the Division or program level. The result is that staff responsible for project and contract consultation are not always expert in that field, and those who have program responsibility are often not consulted about contracts which may duplicate or overlap with already funded activities resulting in waste and ineffective use of federal funds.

We believe that the accountability factor is in question in the funding of these programs and that accurate reports have become increasingly difficult to obtain. We respectfully submit that these problems be investigated and that this appropriation bill specify direct operating costs at the operating level (examples: Division of Nursing, MCH programs, NIMH, Rape Center, etc.).

# STATEMENT OF THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

Capitation Funding for Colleges of Veterinary Medicine in FY 1978

The Council of Deans of the Association of American Veterinary Medical Colleges appreciates this opportunity to comment on the continuing need for federal financial support of veterinary medical educational institutions.

There are now 21 schools and colleges of veterinary medicine with the 22nd college expected to enroll its first class of students next fall. These colleges are supported primarily by the 21 states in which they are located, yet they are national resources which provide educational opportunities for students, and veterinary manpower, for all the states. The federal capitation grant program has been most beneficial to residents of those states without veterinary colleges, because of the increased opportunities for education offered the students of those states.

In 1970, there were 18 colleges of veterinary medicine with a total enrollment of 5,006 students. In academic year 1976-77, the 21 colleges had a total enrollment of 6,571. This increase of 31 percent in 6 years should be attributed at least in part to the federal support provided through capitation and construction grants. The enclosed table shows the geographic distribution of the entering class of veterinary medical students in the 1976-77 academic year. It indicates that the colleges still give major preference to students from the states in which the school is located; however, students from every state in the nation are being admitted.

The President's budget for FY 1978 provides nothing for capitation grants for colleges of veterinary medicine. This is a serious error. While capitation grants have amounted to less than 10 percent of the cost of students' education, they have encouraged increased enrollment and acceptance of students from states that don't have colleges of veterinary medicine.

P.L. 94-484 in title III Section 301 (42 USC 293a) clearly indicates the intent to encourage regional programs in health professions education. The colleges of veterinary medicine are making progress in this direction and in offering greater opportunities for students from the states without veterinary medical colleges.

Veterinary medical education is basically as expensive as medical education, but options for funding it are much more limited. Veterinary medical teaching hospitals can rarely be self-supporting, and no third party payment system exists to assure payment for patient care and a means of supporting a house staff. Public funds are the major source of support of veterinary medical colleges.

Failure to provide for federal sharing through capitation grants would discourage progress which has been made in the past 6 years in offering greater opportunities for veterinary medical education. P.L. 94-484 authorizes capitation grants of $1450 per student. At this level the federal government would support about 10 percent of the cost of education for veterinary medical students. This is the minimum level of federal

support which will continue to assure acceptance of students on a regional basis. Without this assistance state legislatures may be tempted to restrict enrollment in these expensive programs to residents of the state supporting the program. There is a strong probability that several state legislatures would order reductions in enrollment to compensate for the loss of federal financial support.

This would be a major step backward and a loss of opportunities for many students who have no other hope for a veterinary medical education.

We encourage your consideration of appropriating at a level that would provide the full authorized funding for capitation grants of $1450 per student and by doing so provide the maximum possible educational opportunities for veterinary medical students. The appropriation of $10,000,000 would provide approximately $1450 per student for the anticipated enrollment in the year ending September 30, 1978.

## STATEMENT OF LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Leo J. Gehrig, M.D., Senior Vice President of the American Hospital Association. Our Association represents some 6,500 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 24,000 personal members. We welcome the opportunity to present our views on HEW health program appropriations for Fiscal Year 1978.

In reviewing the federal health budget for Fiscal Year 1978, we have identified a number of specific program activities in order to focus our comments on priority concerns. In each of these areas, we would like to call your attention to significant program needs and accomplishments and our recommendations for FY 1978 funding levels. The items we will cover are in the order in which they appear in the "Justification of Appropriation Estimates - Fiscal Year 1978" prepared by the Department of HEW.

COMMUNITY HEALTH CENTERS

The Administration's budget request increases the Community Health Centers Program funding for Fiscal Year 1978 by $14 million above the previous year's level. This increase would support a total of 512 projects--90 more than were funded in Fiscal Year 1977--and would increase the capacity for delivery of services for approximately one million additional persons. At this level, the Community Health Centers Program would serve about 10 percent of the estimated 44 million people residing in some 8,000 medically underserved areas.

We applaud the Administration's support of the Community Health Centers Program to expand health services delivery capacity in medically underserved areas.

Recommendation: that $229.1 million be appropriated for the Community Health Centers Program as has been requested by the Administration.

HOME HEALTH SERVICES

Under the authority of Section 602 of P.L.94-63--the Health Revenue Sharing Act of 1975 --the Health Services Administration in FY 1976 funded some 56 demonstration grants to public and private nonprofit home health agencies to establish or expand home health agencies. Priority is given to areas of the country in which high percentages of the populations are elderly, medically indigent or both, and which do not already have services or in which access to such services is inadequate.

Home health services are often a medically desirable and cost efficient means of service delivery. However, almost 800 U.S. counties, with an estimated total population of 12 million, are without Medicare certified home health agencies, thus denying eligible beneficiaries access to such care. The Administration's budget would provide home health services only to about 15,000 people.

The Administration's budget request of $3 million would support 40 projects in FY 1978, 20 new and 20 expansion projects, providing such needed elements as the development of home health agency staff competence, and technical assistance to both new and expanded programs.

In anticipation that this program will be continued, we believe it merits expansion. We recommend that funds also be made available for training to upgrade the skills of both professional and paraprofessional personnel involved in the provision of home health services.

Recommendation: that $6 million be appropriated for Home Health Services in Fiscal Year 1978 and of this amount, $2 million, or one half the Fiscal Year 1977 authorized level, be earmarked for training.

MATERNAL AND CHILD HEALTH

The Administration's budget for Fiscal Year 1978 would finance the Maternal and Child Health Program at $345 million, the same level at which it was funded during Fiscal Year 1977. The Administration proposes to implement new emphasis on Maternal and Child Health Programs through grants to states to develop a comprehensive child health system in each of the 57 states and jurisdictions by 1982.

We would observe, however, that results of Departmental efforts to improve availability and accessibility of services ought to be reflected in increased workload statistics. The Department's justification document depicts no such increased services. The justification speaks of increased emphasis on family planning, prenatal care, perinatal care, child health care, and adolescent health, particularly teenage pregnancy.

HEW's operational objectives for 1978 through 1982 include plans to: (1) develop family planning services in counties that currently are without such services; (2) increase by 50 percent the number of women receiving care in the first trimester of pregnancy in 20 areas per year; (3) increase the number of two year olds immunized by 10 percent per year with a goal of 90 percent by 1982; (4) implement genetic disease services in all states and jurisdictions by 1982; (5) implement 50 model systems per year to increase early

identification of hearing loss; and (6) increase the number of high school students receiving preventive health services in 20 areas per year.

In view of the fact that the Fiscal Year 1978 budget for the Maternal and Child Health Program is the same as the budget for Fiscal Year 1977, it would appear that the Department must delay progress on these worthy objectives.

Recommendation: that $353 million be appropriated for the Maternal and Child Health Program in Fiscal Year 1978. This amount would enable HEW to provide the increased emphasis to this program that it promises.

MIGRANT HEALTH SERVICES

Mr. Chairman, the federal Migrant Health Services Program is an important and greatly needed federal activity. The number of migrant and seasonal farm workers and their families is estimated to be approximately 3 million. While nearly one-half million persons are expected to receive ambulatory health care services under this program in Fiscal Year 1978 through some 998,000 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 meet 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 needed hospitalization of beneficiaries.

Despite the great need for this program, the Administration is not asking for increased support of this program in Fiscal Year 1978. The appropriation request for $30 million is to be used to continue the existing 125 migrant health projects, including 33 new Primary Health Care Centers established in Fiscal Year 1977, and reflects a decrease in hospital services. Migrant projects last year were forced to ration arbitrarily utilization of hospital services under the hospital demonstration project for purely budgetary reasons when it became apparent that the demand for services would exceed the projections upon which contracts for hospital services were based.

Recommendation: that an appropriation of at least $35 million be made for the Migrant Health Program for Fiscal Year 1978 and that of this amount at least $3.5 million be earmarked for the Hospitalization Program.

NATIONAL HEALTH SERVICE CORPS

One of the most successful federal initiatives to assist in the resolution of the geographical maldistribution of physicians and other health professionals is the direct provision of health services in manpower shortage areas by the National Health Service Corps (NHSC). The Congress gave additional support to the Corps through provisions in the Health Professions Educational Assistance (HPEA) Act of 1976, authorizing substantial increases in funding for NHSC scholarships and expanding shortage area criteria. Such shortage areas now may include urban or rural areas determined to have a health manpower shortage, or a population group considered to have a health manpower shortage, or a public or private, nonprofit medical facility (including hospitals) or other public facility having a health manpower shortage.

In Fiscal Year 1977, HEW statistics indicate that 421 of the 710 approved NHSC sites are staffed, approximately 90 more sites than were staffed in the previous fiscal year. While such an increase is impressive, it should be remembered that the 710 approved sites represent less than half the total number of designated health manpower shortage areas.

In authorizing HEW to waive the requirement that a community contribute to salary costs of Corps personnel and to make loans to a community to help it set up a practice for a Corps member, the HPEA Act lends even further support to one of the Corps' basic goals: the building of independent health care practices which will be continued beyond the period of obligation incurred by Corps members. We understand that the proportion of Corps members who decided to remain in their service areas beyond the period of obligation in Fiscal Year 1977 is estimated to be 43 percent, compared with 30 percent and 38 percent in Fiscal Years 1975 and 1976, respectively.

The Administration's budget request of $37.6 million will enable the Corps to provide health services in some 453 communities with approximately 975 members. This amount is almost $10 million below the level of funding authorized for the Corps by the HPEA Act and will not permit support to 322 communities with approved applications.

Recommendation: that $42 million be appropriated for operation of the National Health Service Corps for Fiscal Year 1978.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSROs)

Progress is being made by HEW in implementing the PSRO program. We are pleased to note the increased financial support proposed by the Administration for this program in Fiscal Year 1978, which should make possible full implementation of PSRO hospital review

and bring uniformity and consistency to the current varying state and federal hospital utilization review program requirements.

Recommendation: that the Administration's request for an appropriation of $72.2 million for the PSRO program be supported.

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 the first to agree that much better emergency services need to be developed, and we vigorously supported enactment of the Emergency Medical Services Systems Act in 1973 and passage of the Emergency Medical Services Amendments of 1976 (P.L.94-573) last year.

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. Primary program emphasis is being placed on clinical systems designed for five categories of critically ill or injured patients: (1) trauma, including burns and spinal cord injury; (2) acute cardiac; (3) high risk infant; (4) poison; and (5) patients with behavioral problems, including psychiatric, alcohol abuse, and drug overdose. An evaluation of recent EMS impact data from several regionalized EMS systems using the five critical patient categories demonstrated that morbidity and mortality are reduced when patients are treated immediately and appropriately. Selected data showed:

- A 15 percent decrease in the vehicular accident death rate in one rural Illinois area after its facilities were reorganized.
- About 400,000 acute heart attack victims die nationally each year prior to receiving definitive hospital care. A sophisticated demonstration prehospital life-support system established in Nassau County, New York, resulted in a five-fold decrease in the prehospital death rate of heart attack victims. Similarly, in a rural setting near Charlottesville, Virginia, the death rate from acute heart attacks decreased 26 percent for all persons under the age of 70 subsequent to the development of an EMS prehospital care system.
- Serious spinal cord injury, traditionally viewed as a hopeless condition, is now being successfully treated in Illinois by rapid evacuation to a specialty care center in Chicago in less than four hours. Sixty-two percent of the victims returned to active employment within six months, at an estimated savings of some $3 million in health care costs.
- For all other emergency and critical conditions, planned and cared for on an EMS systems basis, results have shown significant savings in lives and decreases in suffering.

The nation's hospitals have played a major role in the provision of emergency medical services. Meeting the emergency medical needs of a community or region continues to require coordinated planning, often crossing political boundaries; adequately designed, equipped and staffed transportation and treatment resources; effective communication systems; and well trained emergency personnel at all levels. It is important to recog-

nize, however, that provision of emergency medical services must be tailored to the resources available and to the needs of a variety of settings across the country.

The Department has developed a plan for 300 EMS systems to be established in the United States. According to the Administration's budget, 252 such systems will have received support under this program by the end of Fiscal Year 1978. In view of the need to continue expansion of these systems and to maintain the systems already in place, we believe continued federal financial support is essential.

In 1975, there were more than 73 million emergency outpatient visits reported by over 7,000 hospitals. Of these visits, 68.9 million (94 percent) took place in emergency departments of community hospitals. Based on a comparison with 1973 statistics, this figure shows an average increase of 4 million emergency outpatient visits annually. It is a significant index of the continually increasing demand placed on hospitals for emergency services to outpatients.

Every hospital cannot and should not support a fully equipped emergency department with the variety of specialists necessary to cope with every conceivable emergency. Modern transportation, telecommunications systems, and the training of emergency care physicians and paramedical personnel have opened up a variety of options, however. We now have the technological sophistication to provide rural areas with immediate and referral services for life-threatening emergencies similar to the services provided in large urban areas. The challenge, whether in a rural or an urban setting, is to concentrate a sufficient volume of services of specific kinds into single systems so that staff and equipment can be assembled to provide prompt and adequate care in life-threatening situations. Communication and transportation are vital links in an effective EMS, and hospitals are centrally involved in such programs.

The Administration proposes $33.6 million for the support of the Emergency Medical Services Program in Fiscal Year 1978. This amount includes no financing for research under Section 1207 of the Public Health Service Act or for the Burn Injury Program (Section 1221 of the Act). Further, in excess of 100 EMS systems which have received feasibility and planning grants and which are qualified for initial operations grants are not projected to receive funding in FY 1978.

Recommendation: that an appropriation of $48.3 million be made for this program. This amount exceeds the Administration's request by $14.7 million and would provide initial operations grants for an additional 15 regional EMS systems ($6.9 million); a continuation of the EMS

research effort at the Fiscal Year 1976 and 1977 levels ($4.0 million); and phase-in of the Burn Injury Program by financing it at approximately one-half the authorized level ($3.8 million). It appears that the Fiscal Year 1977 Supplemental Appropriations bill will include funds for the latter program; therefore, it is certainly appropriate that the program be financed at an increased level in Fiscal Year 1978, particularly in view of the fact that the '77 amount represents a maximum of one-half year financing.

CENTER FOR DISEASE CONTROL - PREVENTIVE HEALTH SERVICES

Disease Control - Health Education

In reviewing the proposed budget for this program for Fiscal Year 1978, we were pleased to note that the Administration proposes to increase its financing to $7.1 million, or $2.5 million over the Fiscal Year 1977 level. We were distressed, however, to see that the proposed plan for the expenditure of these funds makes no mention of support for implementation of the National Consumer Health Information and Health Promotion Act of 1976, P.L.94-317. Section 1701(b) of the Act authorizes $10 million for this program in Fiscal Year 1978.

The Act requires the HEW Secretary to formulate national goals with respect to health information and health promotion, preventive health services, and education in the use of health care, as well as a strategy to achieve these goals. Further, the Secretary is required to report: (1) to the President and Congress by June 23, 1978 and annually thereafter on the activities carried out under this Act; (2) the Department's assessment of manpower resources needed to carry out programs relating to national goals established under the Act; and (3) the results of the study he is required to conduct of health education and preventive health services coverage within public and private health insurance programs.

In order to accomplish the purposes of the Act, HEW is authorized to support, by grant or contract, research initiatives and new and innovative demonstration and training programs in health information and health promotion, preventive health services, and education in the appropriate use of health care. Grants to states and other public and nonprofit private entities are authorized to assist them in meeting the costs of demonstrating and evaluating programs which provide information on costs and quality of health care and/or information about health insurance policies and prepaid health plans.

We are persuaded that such research, demonstration and training projects are essential to the development of valid determinations concerning the effectiveness and efficiency of alternative health education methods, programming and resources. Such determinations are vital to the development of national goals and policies in these areas.

Failure to fund this program would be inconsistent with governmental concern in recent years about improving personal health through health education and avoiding the costs of treating illness.

Recommendation: that an appropriation of $17.1 million be made for Health Education in Fiscal Year 1978, including $10 million for implementation of P.L.94-317.

COMMUNITY MENTAL HEALTH CENTERS

This Association continues to support efforts to expand the Community Mental Health Centers (CMHCs) program. We believe it is a valuable alternative to institutional care for many individuals suffering from certain kinds of mental illness. Our House of Delegates has adopted a formal resolution acknowledging that CMHCs are "greatly contributing to the care of patients and the health of all Americans." With adequate funding, the provisions of the Community Mental Centers Amendments of 1975 could give important impetus to achieving the goal of a national network of comprehensive mental health centers serving all areas of the country.

The expansion of state and local participation in the CMHC program has demonstrated the value and the viability of a comprehensive and integrated community approach to service delivery. It also points up the willingness of state and local governmental entities to initiate services when they are reasonably certain that federal support will be available. In the very recent past, state mental hospital populations have decreased significantly, and many of these patients are now receiving treatment in community settings. Unfortunately, however, many communities do not have available comprehensive, community-based mental health services to meet adequately the mental health needs of these patients and others in the general population.

We understand that as of July 1976, the National Institute of Mental Health estimates that some 860 designated catchment areas in the United States have received no federal funds to establish comprehensive, community mental health centers. An estimated 110 of these areas do not have any of the four direct mental health services (inpatient, outpatient, partial hospitalization, and emergency services) required by the original

Community Mental Health Centers Act. The need is identified and the product is proven, and yet the Administration's budget proposal includes no funding to support new CMHC projects.

Operating experience of CMHCs demonstrates the need for continued federal funding. It is estimated that 20 percent of the income of CMHCs is derived from third party payments, including Medicare and Medicaid. Income from direct patient fees, fund raising, and other sources account for about 14 percent; federal funding contributes 34 percent; and the remaining one-third is supplied by state and local governments. In light of these realities, the Administration's proposal to fund community mental health programs in the aggregate at $233 million is an inadequate assurance that the gains of the past will not be eroded.

Recommendations: that an appropriation of $269.3 million be made for the Community Mental Health Centers Program for Fiscal Year 1978 as follows:

Planning Grants - an appropriation of $1 million should be made for new Planning Grants for Fiscal Year 1978. Assuming an average grant size of $50 thousand, this level of funding would permit 20 additional projects to conduct the crucial first step of planning for viable community treatment programs. The Administration's budget would finance no planning grants.

Operations Grants - an appropriation of $176.6 million should be made for operations grants, which would include $18.4 million for new starts in Fiscal Year 1978. The Administration proposes to finance no new starts in Fiscal Year 1978; the amount we recommend would continue this aspect of the program at the Fiscal Year 1977 level. Based on the Fiscal Year 1977 average grant of $600 thousand (down from $1 million in Fiscal Year 1976), this amount would fund 30 new projects.

Consultation and Education Grants - an appropriation of $11.5 million should be made for consultation and education grants. This amount includes $3.3 million above the Administration's continuation funding level and would be adequate to support approximately 42 new consultation and education grants. The services authorized to be provided under such grants are a fundamental component of successful community-based mental health ser-

vices programs. Because such services are not easily identifiable as services to individual patients, third party reimbursement is difficult to obtain.

Conversion Grants - an appropriation of $20 million should be made for conversion grants, which would include $8.6 million to support approximately 33 new conversion grants. This category of grants is important for centers desiring the capability to deliver the more comprehensive scope of services envisioned by Congress in enacting the 1975 amendments. The Administration's request would finance only continuation of existing conversion grants. Financing at the level we recommend would permit the awarding of new and continuation conversion grants at the Fiscal Year 1977 level.

Financial Distress Grants - an appropriation of $8.1 million should be made for financial distress grants. Approximately 16 new awards could be made to assist centers to continue operations. The Administration's proposal would only continue existing grants of this kind.

Continuation Funding - We endorse the Administration's request for $52.1 million to continue the funding of staffing $38.2 million) and Child Mental Health services ($13.9 million) pursuant to previous legislation.

NATIONAL CENTER FOR HEALTH STATISTICS

The Administration's budget indicates that a major focus of the National Center for Health Statistics during Fiscal Year 1978 will be the rapid development and implementation of the Cooperative Health Statistics System. The purposes of this activity are to: (1) assist state and local governmental and nongovernmental groups involved in matters relating to health in the design and implementation of a cooperative system for producing comparable and uniform health information at the national, state and local levels; (2) coordinate the activities of federal agencies with respect to the design and implementation of such a system; (3) undertake and support by contract, research and development, demonstration and evaluation of such a system; (4) provide the federal share of the data collection costs under such a system; and (5) review statistical activities of HEW to assure that they are consistent with such a system.

We strongly support the Administration's proposed increased funding of $6 million for this valuable program and the stated intention that in Fiscal Year 1978 special emphasis will be placed on (1) the development in several states of total health information systems to demonstrate the importance and usefulness of health care utilization data; (2) the expansion of research and demonstration projects regarding methods of data use; and (3) the continuation of research on data collection methods for hospital care, long-term care, and ambulatory care data. While we also support the emphasis on bringing states with manpower developmental contracts up to a full level of implementation, there is serious concern that such an effort would unnecessarily drain resources from other areas of emphasis.

Recommendation: that an appropriation should be made at least at the level of the Administration's request for $34.8 million for the National Center for Health Statistics for Fiscal Year 1978. In addition, we would also urge the Committee to include language in its report on this appropriation which would specify that the funds appropriated for the National Center include at least $14.2 million for the cooperative Health Statistics System, so that funding would be specifically earmarked to encourage this important program and special emphasis be placed on developing systems which will demonstrate the importance and usefulness of health care utilization data.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

The federal expenditure for health services research in 1975 was approximately $75 million. The National Center accounted for about half of this total sum. To a large extent, the $35 million expended by agencies other than the National Center was used to support projects related to specific government programs. As a result, much of the research funded by other agencies in 1975 addressed relatively narrow questions. This continues to be the case. The National Center, by contrast, is the only agency for which research priorities are not necessarily defined by the immediate information needs of an operating program.

The Center's program is determined by the need for general information to inform health policymakers, define delivery problems, and identify alternative approaches to organizing, producing, distributing, and financing health services.

As an example, the American Hospital Association and the National Center this past December jointly sponsored a Symposium on the American Hospital in the 1980's in an

effort to anticipate and define public policy issues of the future. Initiatives of this kind afford an opportunity for governmental and nongovernmental providers and researchers to share and discuss research findings and assess needs for future research efforts.

The Administration has proposed a $300 thousand increase in the financing of the National Center for Fiscal Year 1978. This increase will not even finance the salary increases of the program support staff; hence, a decrease in research projects is being proposed rather than an increase.

Recommendation: that an appropriation of at least $33 million should be made for the National Center for Health Services Research. This amount would be equal to, not greater, than the amount available in Fiscal Year 1976.

HEALTH PLANNING

The American Hospital Association has had continuing interest in the successful implementation of Public Law 93-641. The cornerstone of this areawide planning effort is the maturation and successful functioning of the designated Health Systems Agencies (HSAs). During our testimony on this program last year, we pointed out that the $61.5 million being requested by the Administration for Fiscal Year 1977 was inadequate and recommended $90 million as a more reasonable transitional funding level. We were delighted with the demonstraton of support for this program by the Appropriations Committees and the resulting appropriation of $97 million by Congress.

The Administration is now proposing Fiscal Year 1978 financing of these local planning agencies at the Fiscal Year 1977 level, i.e., $97 million. Considering that the $97 million level in Fiscal Year 1977 was an amount that would permit the development of HSAs, including the recruitment and hiring of qualified staff, it is clearly evident that the identical amount in Fiscal Year 1978 would not permit continuation of the orderly development of this program but, in fact, be a step backward.

Public Law 93-641 authorizes that fully designated HSAs be funded at the greater of $175 thousand or $.50 per capita, with additional funding made available through matching grants up to $.25 per capita. Approximately 11 HSAs will become fully designated and eligible for full funding in Fiscal Year 1977, and the remaining 202 HSAs (including Section 1536 waiver states) should achieve this status in Fiscal Year 1978.

Although the Fiscal Year 1978 authorization for this program is $125 million, that amount should not be needed before Fiscal Year 1979. An appropriation of $118 million will finance the local planning agency program at the maximum authorized level for the last three quarters of the fiscal year, and allow for recruitment and filing of authorized HSA staff positions during the first fiscal quarter as the remaining conditional HSAs achieve full designation.

Recommendation: that the Fiscal Year 1978 appropriations for Health Systems Agency funding under Section 1516 of P.L.93-641 should be $118 million.

The State Health Planning and Development Agencies (SHPDAs) have final approval/disapproval authority under the Social Security Act for Capital Expenditure Review and for state certificate of need reviews. SHPDAs make findings with respect to proposed new institutional health services, review all institutional health services being offered in a state at least every five years, and make findings on the appropriateness of those services. Under designation agreements, the state agencies also assist Statewide Health Coordinating Councils through the payment of operating expenses and provision of staff support. Despite the fact that 42 state agencies will be performing a full range of functions by the end of Fiscal Year 1977 and be ready for full designation, and that all 56 state agencies will be ready for full designation agreements in Fiscal Year 1978, the Administration proposes no change in the aggregate funding level of this program. In other words, the Administration envisions an increase in SHPDA responsibility and range of functions to be performed without a concomitant increase in financial support. The Administration's justification for this program for both Fiscal Years 1977 and 1978 reflects an average staff size of 18 per state agency. This contrasts significantly with the earlier departmental estimates that an average staff size of approximately 28 and attendant financing of $30 million would be required. It is our understanding that estimated budgets for SHPDAs for Fiscal Year 1978 are about $27 million.

Recommendation: that the Fiscal Year 1978 appropriation for state agencies under Section 1525 of P.L.93-641 should be $27 million in recognition of the increased responsibility related to the final designation of all SHPDAs and the budgeted requirements of such agencies.

The Administration's budget proposes $8.5 million for other Title XV activities, including $6.5 million for planning methods development and technical assistance and $2 million for Section 1526 rate review demonstrations. An appropriation of $2.5 million, or $4 million less than the Administration has requested for planning methods development and technical assistance is adequate and would enable the Department to concentrate its efforts on development of a plan for targeting the use of such funds on those projects which have the greatest potential for a useful impact on the areawide and state health planning and resources development process.

Recommendation: that $2.5 million should be appropriated for planning methods development and technical assistance. We support an appropriation of $2 million for Section 1526 rate review demonstrations.

HEALTH FACILITIES CONSTRUCTION

Title XVI of the Public Health Service Act, added by P.L.93-641, continued on a substantially modified basis the federal effort for health facilities modernization and construction initiated in 1946 under the Hill-Burton program. Emphasis in this authority is placed on the modernization of existing health facilities and the modernization and construction of ambulatory care facilities. Priority is provided for projects which give assistance to urban and rural areas that are underserved and in which services are provided to financially disadvantaged groups. Public institutions are earmarked to receive at least 22 percent of appropriated funds to upgrade their facilities to eliminate or prevent imminent safety hazards, or to avoid noncompliance with state or voluntary licensure and accreditation standards.

Mr. Chairman, we testified before this Committee one year ago that, based on HEW estimates using 1974 data, the most pressing construction need includes the modernization of 128,000 general hospital beds and the construction of some 1,700 outpatient facilities and the modernization of another 1,500 existing outpatient facilities. Each of these categories of projects represents facility modernization and/or construction priorities as expressed in Title XVI. No funds were appropriated under the original Title VI authority for the Hill-Burton program in Fiscal Years 1974 or 1975, and this authority was replaced in 1975 with the Title XVI authority in P.L.93-641. Despite the appropriation of some $51 million in Fiscal Year 1976 for health facility construction grants under Title XVI, the Administration has yet to obligate any of the funds. Further, the Administration's budget request for Fiscal Year 1978 includes no funds for new grant or loan activities.

The specific needs we cited earlier in this statement were based on HEW 1974 data, the last year for which state plans data were collected. Since the Department has not received state medical facilities plans since that time, it is not aware of the extent to which these needs have been modified. Generally speaking, however, hospitals have found it increasingly difficult in recent years to obtain adequate construction financing at favorable terms and obsolescence of many needed facilities has continued.

We understand that HEW received some 136 applications amounting to $166 million (the federal share) this January from public hospitals alone, all seeking project grants from the approximately $11 million available to this category of applicants under the 22 percent set aside in the 1976 appropriation.

Recommendation: that $135 million be appropriated in Fiscal Year 1978 for Medical Facilities Construction, of which $29,700,000 (22 percent) would be available for project grants to public hospitals, and $105,300,000 for allocation to the states and other jurisdictions for modernization of health facilities and construction and modernization of ambulatory care facilities.

MEDICAL FACILITIES GUARANTEE AND LOAN FUND AND INTEREST SUBSIDIES

The Labor-HEW Appropriation Act for Fiscal Year 1977 (P.L.94-439) increased the cumulative total principal amount of loans to be guaranteed or directly made, which may be allotted among the states, under Titles VI and XVI of the Public Health Service Act from $1.5 billion to $1.75 billion. In enacting this increase, the Senate Report on the Act noted that without the increase many existing facilities in need of modernization, renovation, or expansion of such services as outpatient medical departments would not be able to secure the necessary financing to undertake such projects. HEW, however, has not approved any loans or loan guarantees, despite the language of the Senate Appropriations Committee's report on the Fiscal Year 1976 Labor-HEW appropriations bill:

> The Committee is concerned with the continuation of the loan and loan guarantee fund provided for the modernization of hospitals and new construction of ambulatory treatment facilities. The Secretary has assured the Committee that HEW has the requisite authority and funds for interest subsidy to make allocations to the States for the continuation of these programs in FY 1976. In view of the significant needs which exist for these activities, the Committee expects the Department to continue to make direct loans and loan guarantee commitments during this fiscal year at least at the levels previously allowed.

Mr. Chairman, we seek the Committee's assistance not only to persuade the Department to implement this program under the existing authority, but also to secure an increase

in the authorization for loans and loan guarantees. Implementation of this program and an increase in its authority are needed because obsolescence of needed facilities continues and repair and modernization construction costs are increasing exponentially. The criteria for assistance mandated by Title XVI will act to ensure that needed projects for: (1) rural communities and areas with limited financial resources; (2) facilities serving densely populated areas; (3) outpatient services for rural or urban poverty areas; and (4) correction of life safety code problems, will receive deserved priority.

Recommendation: that the cumulative total principal amount of loans to be guaranteed or directly made, which may be allotted among the states, under Titles VI and XVI of the Public Health Service Act should be increased from $1.75 billion to $2 billion in Fiscal Year 1978. Further, we recommend an appropriation for interest subsidies sufficient to meet the accruing obligations under Section 626 and 1620(b)(2) of the Public Health Service Act for Fiscal Year 1978.

HEALTH PROFESSIONS EDUCATION - NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS

Mr. Chairman, we have testified repeatedly before this Subcommittee in support of adequate funding for operation of the National Health Service Corps to ensure that the early successes demonstrated by the Corps be continued. As noted earlier in this statement, the numbers of designated and approved NHSC shortage areas far exceed the number of staffed sites. It has been our observation since the inception of the program in 1971 that the Corps' recruitment efforts have been severely hampered by the relatively low levels of funding for scholarships and overall program operation. In Fiscal Years 1976 and 1977, $22.5 million and $35 million were obligated for student scholarships. Congress, in enacting the HPEA Act of 1976, authorized more than twice as much for NHSC scholarships in Fiscal Year 1978 than was obligated in Fiscal Year 1977. We support the Congress' initiative and suggest that it will be a positive factor in enhancing the recruitment capacity of the Corps, and, more adequately, in meeting the needs of the medically underserved.

Recommendation: that $50 million be appropriated for National Health Service Corps scholarships for Fiscal Year 1978. This amount would allow the Department to award an additional 1,000 scholarships so that it might move more quickly to satisfy the need for an additional 3,275 NHSC members, as projected for the end of Fiscal Year 1978.

NURSING TRAINING

Institutional Assistance

Capitation Grants

The Administration's Fiscal Year 1978 budget request includes no funds for capitation grants to schools of nursing. It is suggested that support for most nursing programs is not necessary since the supply of nurses is adequate and nursing students have access to other forms of student financial assistance from the Office of Education.

Public Law 94-63, enacted July 1975, extended the Nurse Training Act through Fiscal Year 1978, and authorized $55 million for this purpose in Fiscal Year 1978. These funds are vital to the fiscal integrity of many schools of nursing. Capitation assistance has enabled many schools to increase enrollments, attract faculty, and improve curricula. Schools of nursing, like all other educational institutions, have fallen victim to inflationary pressures in our economy. The continued provision of quality nursing education would be seriously jeopardized if the Administration is permitted to terminate capitation assistance.

Further, one of the largest categories of nurse training programs, i.e., hospital-based programs, would find it necessary that the hospitals turn to patients and third party payers, including Medicare and Medicaid, to make up for revenues which would be lost if these payments were discontinued as is proposed. Forty million dollars were obligated for this program in Fiscal Year 1977, and almost 1,100 schools of nursing received assistance. As a minimum, that level of effort should be maintained in Fiscal Year 1978.

Recommendation: that $40 million be appropriated for capitation grants to schools of nursing.

ADVANCED NURSE TRAINING

One of the most serious problems in nursing continues to be the lack of graduate degree preparation of nursing school faculty. The advanced nurse training program authorized by P.L.94-63 can assist collegiate schools of nursing through the award of grants and contracts to plan, develop, operate and significantly expand or maintain programs for advanced training of professional nurses to be teachers, administrators, supervisors, or nursing specialists.

During Fiscal Year 1977, approximately 80 such projects were supported. The Administration's proposal would not fund this vital program for Fiscal Year 1978.

Recommendation: that $10 million be appropriated to finance the Advanced Nurse Training Program.

NURSE PRACTITIONERS

One of the justifications advanced by the Administration in support of its proposal to terminate nursing capitation grants is that the supply of nurses is adequate. For purposes of P.L.94-484--the Health Professions Educational Act of 1976--the Congress determined that there is no longer a shortage of physicians and surgeons in this country. National statistics citing adequate supplies of health care professionals provide little solace to citizens who reside in critical health manpower shortage areas, however.

The lack of adequate access to health care services experienced by millions of our citizens points up the need to continue our national attack on problems of maldistribution of health professionals. Nurse practitioners who provide primary care in ambulatory and community settings substantially extend the delivery of health services in rural and other underserved areas.

Data available so far suggest that nurse practitioner training programs of the calibre supported by P.L.94-63 are especially productive and that the majority of nurse practitioner training program graduates are working as practitioners. Some 20 states have amended their nurse practice acts to recognize the expanded role of the estimated 8,000 nurse practitioners. The nurse practitioner authorities contained in P.L.94-63 go far beyond the traditional focus of nurse practitioner training programs limited to the areas of pediatrics and obstetrics-gynecology. They emphasize training for particular problems of geriatric and nursing home patients, as well as train- to provide primary care in a variety of settings.

The Administration has requested that the activity be funded in Fiscal Year 1978 at the previous fiscal year's level of $9 million, which would continue support to about 45 programs.

Recommendation: that $15 million be appropriated to finance Nurse Practitioner Training Programs.

NURSE SPECIAL PROJECTS

Nursing special project grants provide funding for a variety of programs, including cooperative merger efforts between hospitals and academic institutions, increasing the recruitment of students in nursing from disadvantaged backgrounds, and preparing nurses for the provision of care in ambulatory and community settings. The Adminis-

tration requests $6 million for Fiscal Year 1978, a reduction of $9 million below the Fiscal Year 1977 program level.

Recommendation: that the appropriation of $15 million be retained for Nursing Special Projects Grants for Fiscal Year 1978--a continuation of the Fiscal Year 1977 level of effort.

STUDENT ASSISTANCE

Loans, Traineeships, and Fellowships

The Administration funded these programs during Fiscal Year 1977 at a combined level of $36.5 million. Approximately 28,000 students received nursing loans during Fiscal Year 1977. No funds, however, are requested for Fiscal Year 1978. Schools are expected to provide student loans from replenished loan funds on hand.

The loan referral and cancellation feature of the nursing student loan program was designed to encourage recipients to seek full-time employment in designated geographic shortage areas. Termination of the program would mean the loss of another device for ameliorating the nurse maldistribution problem.

The Administration's proposal also would eliminate support in Fiscal Year 1978 for nurse traineeships which were funded at $13 million during Fiscal Year 1977 and assisted some 3,300 trainees. Traineeships assist registered nurses undertaking advanced educational preparation for leadership positions as teachers, administrators, or nursing supervisors. Failure to provide funding for this program will mean a significant reduction in assistance available to registered nurses who wish to seek advanced training in nursing. This situation would further exacerbate the existing shortage of adequate personnel to fill leadership positions described earlier.

Nursing fellowships totalling $1 million were awarded to approximately 110 nurses during 1977 for specified research training for several purposes, including efforts to promote the availability and utilization of nurses with research training as faculty in schools of nursing. No funds are requested for this activity during Fiscal Year 1978.

The Administration's rationale for discontinuing the traineeship and fellowship programs is that there is an adequate supply of nurses. This reasoning ignores the purposes of such programs and the issue of the inadequate supply of nurse teachers, administrators, and researchers.

Recommendation: that a total of $36.5 million be appropriated for Nursing Student Loans, Traineeships, and Fellowships ($22.5 million, $13 million, and $1 million, respectively).

NURSING SCHOLARSHIPS

We concur with the Administration's proposal to fund nursing scholarships in Fiscal Year 1978 at $9 million, an increase of $2.5 million above the current level of obligation. These scholarships enable students with exceptional financial need to undertake courses of study at all degree levels of nursing education. The proposed level of funding will support 2,500 new awards in Fiscal Year 1978.

Recommendation: that the Administration's request for $9 million to finance the Nursing Student Scholarship Program should be supported.

PUBLIC HEALTH TRAINING

The Health Professions Educational Assistance Act of 1976--P.L.94-484--authorized $18.2 million for public health training in Fiscal Year 1978 to be accomplished through capitation grants to schools of public health, grants to other public or nonprofit private educational entities, and special project grants for public health and health administration.

This legislation recognizes the continuing need for appropriately trained managers in all segments of the health care system. The grants for graduate programs in health administration will help to meet this need. In addition, the special projects authorization will enable some 7,000 students to receive training in Fiscal Year 1978 in such high priority areas as preventive medicine and dentistry, environmental and occupational health, dietetics and nutrition, and health administration, planning and policy analysis. All of the public health training initiatives authorized in the recent legislation should receive the Administration's full and early commitment. In this regard, no funds have been included in HEW's budget to finance Public Health Traineeships and traineeships in other graduate programs in health administration (Sections 748 and 749 of P.L.94-484 respectively).

Recommendation: that an appropriation of $17.5 million be made for public health training in Fiscal Year 1978. This amount would provide $7 million for Public Health Traineeships and $2.5 million for Traineeships in other Graduate Programs in Health Administration under Section 748 and 749 of P.L.94-484. Further, it would allow $3 million for Grants to Graduate Programs in Health Administration and $5 million for Special Projects Grants to Public Health and Health Administration programs.

ALLIED HEALTH TRAINING

Allied health personnel support, complement, or supplement the professional functions of physicians, dentists, and other health professions in the delivery of health care to patients. They also assist environmental engineers and other personnel in environmental health control and preventive medicine activities.

Federal programs in allied health training have helped many students, who otherwise would have been financially unable to do so, to pursue active and necessary careers in the health field. The program as authorized by last year's health manpower legislation will help to assure the availability of qualified health professionals through credentialing and continuing education efforts. The program also would improve geographic distribution of allied health personnel through regional systems of coordination and management of allied health education and training.

The Administration's proposal would not finance traineeships for advanced training of allied health personnel or education assistance, including such assistance for disadvantaged individuals in allied health training, as authorized by Sections 797 and 798 of P.L.94-484 respectively. The Administration has requested an appropriation of $8 million for allied health training, $20 million below the Fiscal Year 1978 level and nearly $20 million below the authorized amount.

Recommendation: that $24 million be appropriated in Fiscal Year 1978 for Allied Health Training activities, including traineeships ($4 million) and assistance to disadvantaged individuals in allied health training ($1 million).

SPECIAL EDUCATION PROGRAMS

Family Medicine Residencies and Training

This program to support the development of family medicine faculty and family medicine training programs, including general dentistry, addresses the problems of both specialty and geographic maldistribution of physicians and dentists. The program has several goals, among them: (1) to increase the number of family medicine practitioners who will enter the health care delivery system at points where needs are greatest; (2) to make comprehensive personal health care available and accessible to medically underserved areas; and (3) to assure an increase in the proportion of family medicine training in community settings.

Recommendation: that the Administration's request to appropriate $45 million in Fiscal Year 1978 for Family Medicine Residencies and Training be endorsed.

PRIMARY CARE RESIDENCIES AND TRAINING

The Administration, in implementing the provisions of the health manpower legislation of 1976, hopes to confront directly the specialty maldistribution problem through the promotion of training of primary care physicians in general internal medicine and general pediatrics. The creation of additional primary care residencies providing opportunities in ambulatory primary care training will help assure continued improvement in the access to quality health care.

Recommendation: that the Administration's request to appropriate $15 million for Primary Care Residencies and Training be endorsed.

PHYSICIAN AND DENTAL EXTENDERS

Federal programs to train physician and dental extenders have been successful in impacting the shortage and maldistribution of health professionals. Physician assistants have increased the service delivery capacity of some primary care physicians' practices by as much as 40 to 70 percent. Recent research indicates that an increasingly high percentage of physician assistants are practicing in nonmetropolitan areas.

Dental extenders are trained to assume expanded functions under the supervision of dentists as members of dental care teams, thereby increasing the amount of services dentists are capable of providing and extending the mix of primary dental services available to the population.

Recommendation: that the Administration's request to appropriate $11 million in Fiscal Year 1978 for training of physician and dental extenders be supported.

AREA HEALTH EDUCATION CENTERS

In addition to the National Health Service Corps, the Area Health Education Program is directed at the problem of geographic maldistribution. Each center is engaged in training personnel, including medical residency training; assessing the health manpower needs of the region it serves; providing health care practitioners opportunities for continuing education; and other basic responsibilities. The Association favors the continued support of Area Health Education Centers. They are believed to have a positive impact on the training, placement, and effective utilization of health professionals in underserved areas.

Recommendation: that $15.5 million be appropriated for support of the Area Health Education Centers Program in Fiscal Year 1978, the same amount as has been requested by the Administration.

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT (P.L. 94-484), WHICH WAS ENACTED IN THE CLOSING MOMENTS OF THE 94TH CONGRESS, CONTAINED SEVERAL AUTHORIZATIONS DESIGNED TO INCREASE THE SUPPLY OF FAMILY PHYSICIANS. IN THIS STATEMENT, THE ACADEMY WILL SET FORTH ITS RECOMMENDATIONS REGARDING THREE OF THESE AUTHORIZATIONS.

(1) SECTION 786 OF P.L. 94-484 CONTAINS AUTHORIZATIONS IN THE AMOUNT OF $45 MILLION FOR FISCAL YEAR 1978 FOR THE PURPOSE OF MAKING GRANTS TO, OR ENTERING INTO CONTRACTS WITH, HOSPITALS, MEDICAL OR OSTEOPATHIC SCHOOLS OR PUBLIC OR PRIVATE NON-PROFIT ENTITIES. THESE GRANTS OR CONTRACTS ARE FOR THE PURPOSES OF OPERATING FAMILY PRACTICE TRAINING PROGRAMS, PROVIDING FINANCIAL ASSISTANCE TO INTERNS AND RESIDENTS INVOLVED IN SUCH PROGRAMS AND PROVIDING SUPPORT FOR TRAINING TEACHERS OF FAMILY MEDICINE. THIS SECTION ALSO PROVIDES THAT NOT LESS THAN 10% OF THE SUMS APPROPRIATED SHALL BE USED FOR SUPPORT OF THE GENERAL PRACTICE OF DENTISTRY.

THE CARTER ADMINISTRATION'S BUDGET REQUEST INCLUDES THE FULL $45 MILLION AUTHORIZED BY P.L. 94-484. IN MAKING ITS REQUEST THE ADMINISTRATION POINTED OUT THAT ITS PRIMARY GOALS FOR HEALTH PROFESSIONS IS TO REDRESS SPECIALTY AND GEOGRAPHIC MALDISTRIBUTION. IN TESTIMONY BY HEW SECRETARY CALIFANO BEFORE THE HOUSE SUBCOMMITTEE ON LABOR, HEALTH, EDUCATION AND WELFARE APPROPRIATIONS, HE STATED: "WE WANT TO INSURE PROPER GEOGRAPHIC DISTRIBUTION OF DOCTORS, NOT AN INCREASE IN ABSOLUTE NUMBERS, AND WE HOPE TO INCREASE THE SUPPLY OF CERTAIN SPECIALTIES SUCH AS PRACTITIONERS OF FAMILY MEDICINE." WE ARE IN WHOLEHEARTED CONCURRENCE WITH THE ADMINISTRATION'S BUDGET REQUEST OF $45 MILLION AND WOULD URGE THAT THIS AMOUNT BE APPROPRIATED BY THE CONGRESS.

CONTRARY TO THE OFTEN-HEARD COMPLAINT THAT FEDERAL FUNDS ARE WASTED ON NON-PRODUCTIVE PROJECTS, THE EFFECT WHICH FEDERAL SUPPORT FOR FAMILY PRACTICE HAS HAD ON INCREASING THE SUPPLY OF FAMILY PHYSICIANS IS BOTH OBVIOUS AND SATISFYING. ATTACHED TO THIS LETTER AS APPENDIX A ARE SEVERAL GRAPHS SHOWING THE GAINS WHICH HAVE BEEN MADE SINCE THE EARLY 1970'S IN INCREASING THE SUPPLY OF FAMILY PHYSICIANS. BETWEEN 1970 AND JULY OF 1976, THE NUMBER OF PHYSICIANS

IN FAMILY PRACTICE RESIDENCY PROGRAMS INCREASED FROM 290 TO 4,675--A GAIN OF OVER 1500%. FROM 1969 TO JULY OF 1976, THE NUMBER OF APPROVED RESIDENCY PROGRAMS INCREASED FROM 30 TO 288, AND NOW STANDS AT 310. OF COURSE, AN AMALGAMATION OF SEVERAL CONDITIONS--INCLUDING PUBLIC DEMAND, CREATION OF A SPECIALTY CERTIFYING BOARD AND IDEALISM AND THE COMMITMENT OF A NEW GENERATION OF MEDICAL STUDENTS--CREATED A CLIMATE UNDER WHICH IT WAS POSSIBLE FOR THIS PHENOMENAL GROWTH TO OCCUR. HOWEVER, THE FACT IS THAT WITHOUT THE FINANCIAL SUPPORT PROVIDED BY THE FEDERAL GOVERNMENT--BEGINNING IN 1972--MUCH OF THIS GROWTH WOULD NOT HAVE OCCURRED. WE BELIEVE THAT WITH THE APPROPRIATION OF THE $45 MILLION AUTHORIZED FOR THE CONTINUED SUPPORT OF THESE PROGRAMS, THE MOMENTUM WHICH THE FAMILY PRACTICE MOVEMENT HAS ACHIEVED WILL INCREASE AND GREATER PROGRESS WILL BE POSSIBLE.

ONE FURTHER POINT WHICH I WOULD LIKE TO MAKE IS THAT IN PREVIOUS TESTIMONY BEFORE BOTH THIS SUBCOMMITTEE AND OTHER COMMITTEES AND SUBCOMMITTEES OF THE CONGRESS, THE ACADEMY HAS TAKEN THE POSITION THAT BY INCREASING THE SUPPLY OF FAMILY PHYSICIANS, STEPS WILL HAVE BEEN TAKEN TO SOLVE BOTH SPECIALTY AND GEOGRAPHIC MALDISTRIBUTION OF PHYSICIANS. THIS LINE OF REASONING WAS PREDICATED ON THE BELIEF THAT FAMILY PHYSICIANS ARE MUCH MORE LIKELY TO PRACTICE IN RURAL AREAS AND OTHER AREAS OF NEED THAN ARE MORE LIMITED SPECIALISTS.

THIS CONTENTION IS BORNE OUT BY A SURVEY OF THE PRACTICE LOCATIONS OF FAMILY PRACTICE RESIDENCY GRADUATES IN 1975 AND 1976, WHICH IS ATTACHED TO THIS LETTER AS APPENDIX B. AS THIS MATERIAL INDICATES, THERE IS A REMARKABLE CORRELATION BETWEEN THE PERCENTAGE OF FAMILY PRACTICE GRADUATES ENTERING A SPECIFIC SIZE AREA AND THE PERCENTAGE OF THE TOTAL UNITED STATES POPULATION WHICH RESIDES IN AREAS OF THAT SIZE. FOR EXAMPLE, 17.1% OF THE U.S. POPULATION RESIDES IN NON-METROPOLITAN COUNTIES HAVING A POPULATION OF FEWER THAN 50,000 PEOPLE AND 20.8% OF THE 1976 GRADUATES OF FAMILY PRACTICE RESIDENCY PROGRAMS ESTABLISHED THEIR PRACTICES IN SUCH COUNTIES. ON THE OTHER HAND, 54.6% OF THE POPULATION RESIDES IN COUNTIES IN STANDARD METROPOLITAN STATISTICAL AREAS WITH POPULATIONS OF 500,000 AND ABOVE AND ONLY 41% OF THE 1975 FAMILY PRACTICE RESIDENCY GRADUATES ESTABLISHED THEIR PRACTICES IN SUCH COUNTIES, AS DID 40.7% OF THE 1976 GRADUATES. WE BELIEVE THESE FIGURES AND THE OTHERS CONTAINED IN APPENDIX B ARE ENCOURAGING AND DO SUPPORT THE POSITION THAT GRADUATES OF FAMILY PRACTICE RESIDENCY PROGRAMS

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WILL ESTABLISH THEIR PRACTICES IN RURAL AREAS, THEREBY HELPING TO SOLVE GEOGRAPHIC MALDISTRIBUTION.

(2) SECTION 780 OF P.L. 94-484 AUTHORIZES APPROPRIATIONS OF $10 MILLION FOR FISCAL 1980 FOR THE PURPOSE OF ASSISTING SCHOOLS OF MEDICINE AND OSTEOPATHY IN ESTABLISHING AND MAINTAINING ACADEMIC ADMINISTRATIVE UNITS TO PROVIDE INSTRUCTION IN FAMILY MEDICINE. TO BE ELIGIBLE FOR GRANTS UNDER THIS SECTION, THE FAMILY PRACTICE ADMINISTRATIVE UNIT MUST BE COMPARABLE IN FUNCTION AND FACULTY SIZE TO THE ADMINISTRATIVE UNITS FOR OTHER MAJOR CLINICAL DISCIPLINES AND MUST HAVE CONTROL OVER A THREE-YEAR FAMILY PRACTICE RESIDENCY PROGRAM WITH A CAPACITY TO ENROLL A TOTAL OF NO LESS THAN TWELVE INTERNS OR RESIDENTS PER YEAR.

SECTION 786 OF P.L. 94-484, WHICH WAS DISCUSSED ABOVE AND FOR WHICH THE ADMINISTRATION HAS REQUESTED AN APPROPRIATION OF $45 MILLION, DOES PROVIDE A POTENTIAL SOURCE OF FUNDS FOR THE SUPPORT OF FAMILY PRACTICE WITHIN MEDICAL SCHOOLS AS WELL AS AT THE RESIDENCY LEVEL. HOWEVER, THE MAJORITY OF THESE FUNDS WILL BE USED TO SUPPORT RESIDENCY TRAINING PROGRAMS. THOSE FUNDS AVAILABLE FOR THE SUPPORT OF FAMILY PRACTICE AT THE MEDICAL SCHOOL LEVEL WILL BE AVAILABLE WITHOUT REGARD TO THE REQUIREMENTS CONTAINED IN SECTION 780 RELATING TO ASSURANCES THAT THE FAMILY PRACTICE ADMINISTRATIVE UNIT BE COMPARABLE TO THE ADMINISTRATIVE UNITS FOR OTHER CLINICAL DISCIPLINES.

IT IS OUR RECOMMENDATION THAT FUNDS AUTHORIZED BY SECTION 780 BE APPROPRIATED IN ADDITION TO THE FUNDS APPROPRIATED PURSUANT TO SECTION 786. IT IS GENERALLY AGREED THAT ONE OF THE PRIMARY MEANS OF ASSURING THAT MEDICAL STUDENTS CHOOSE TO ENTER A FAMILY PRACTICE RESIDENCY IS TO INSURE THAT THEY ARE EXPOSED TO FAMILY PRACTICE AT THE MEDICAL SCHOOL LEVEL. PRIOR TO THE LAST FEW YEARS, ONE OF THE PRINCIPAL REASONS THAT STUDENTS WERE NOT CHOOSING TO PRACTICE FAMILY MEDICINE WAS BECAUSE THIS EXPOSURE WAS VIRTUALLY NIL. IT WOULD SEEM TO FOLLOW THAT THE STRONGER THE FAMILY PRACTICE ADMINISTRATIVE UNIT TO WHICH THE STUDENT IS EXPOSED, THE GREATER THE LIKELIHOOD THAT IT WILL AFFECT HIS CAREER DECISION. SINCE THOSE SCHOOLS RECEIVING FUNDS PURSUANT TO SECTION 780 WOULD HAVE TO INSURE THAT FAMILY PRACTICE IS ON A FOOTING WITH OTHER CLINICAL DISCIPLINES, WE BELIEVE IT IS IMPORTANT THAT SUCH FUNDS BE AVAILABLE.

It is our understanding that in the event Congress does appropriate the full $45 million authorized by Section 786, roughly $7 million will be available for family practice departments in medical schools. Accordingly, we are not requesting that the full authorization of $10 million contained in Section 780 be appropriated, but that $5 million be appropriated to supplement the $7 million provided through Section 786. In this way, medical schools would be encouraged to meet the more stringent requirements of Section 780 in order to have a potential source of funds in addition to the funds available through Section 786.

(3) Section 720 of P.L. 94-484 authorizes $40 million for fiscal year 1978 for the purpose of grants to assist in the construction of teaching facilities for the training of physicians, dentists, pharmacists, optometrists, podiatrists, veternarians and professional public health personnel. From the amount appropriated, at least 50% would be used for the construction of ambulatory primary care teaching facilities which includes facilities "dedicated for the training of students in the diagnosis and treatment of ambulatory patients and primarily in the specialties of family practice, general pediatrics, general internal medicine, general dentistry and pedodontics."

Although the Administration budget request did not include funds for the purposes contained in this section, we recommend that such funds be appropriated. Whether such funds were omitted by oversight or design, we do not know. However, we do believe that with the enactment of P.L. 94-484, the 94th Congress demonstrated a clear intent to correct specialty and geographic physician distribution problems through programs and policies designed to increase the supply of family physicians. We further believe that through its request for full funding for the support of family practice residency programs, the Administration has demonstrated similar intent.

Although it is true that the section relating to funds for the construction of ambulatory primary care teaching facilities does not affect family practice alone, we believe that the support which it would provide is an essential ingredient in the overall effort to provide increased numbers of family physicians.

THE RESIDENTS' TRAINING IN A FAMILY PRACTICE RESIDENCY PROGRAM REVOLVES AROUND THE MODEL FAMILY PRACTICE UNIT WHICH IS DESIGNED LIKE A PHYSICIAN'S OFFICE IN ORDER TO PROVIDE EXPERIENCE IN HEALTH MAINTENANCE AND CONTINUITY OF CARE. BECAUSE OF THE INNOVATIVE NATURE OF THIS TYPE OF RESIDENCY TRAINING, MANY HOSPITALS ESTABLISHING FAMILY PRACTICE RESIDENCY PROGRAMS HAVE NOT HAD THE REQUISITE FACILITIES. AS A RESULT, IT HAS BEEN NECESSARY TO RENNOVATE EXISTING FACILITIES OR CONSTRUCT NEW FACILITIES. THIS, OF COURSE, CAN BE EXTREMELY EXPENSIVE AND IN SOME INSTANCES, A DETERRENT TO THE ESTABLISHMENT OF FAMILY PRACTICE TRAINING PROGRAMS.

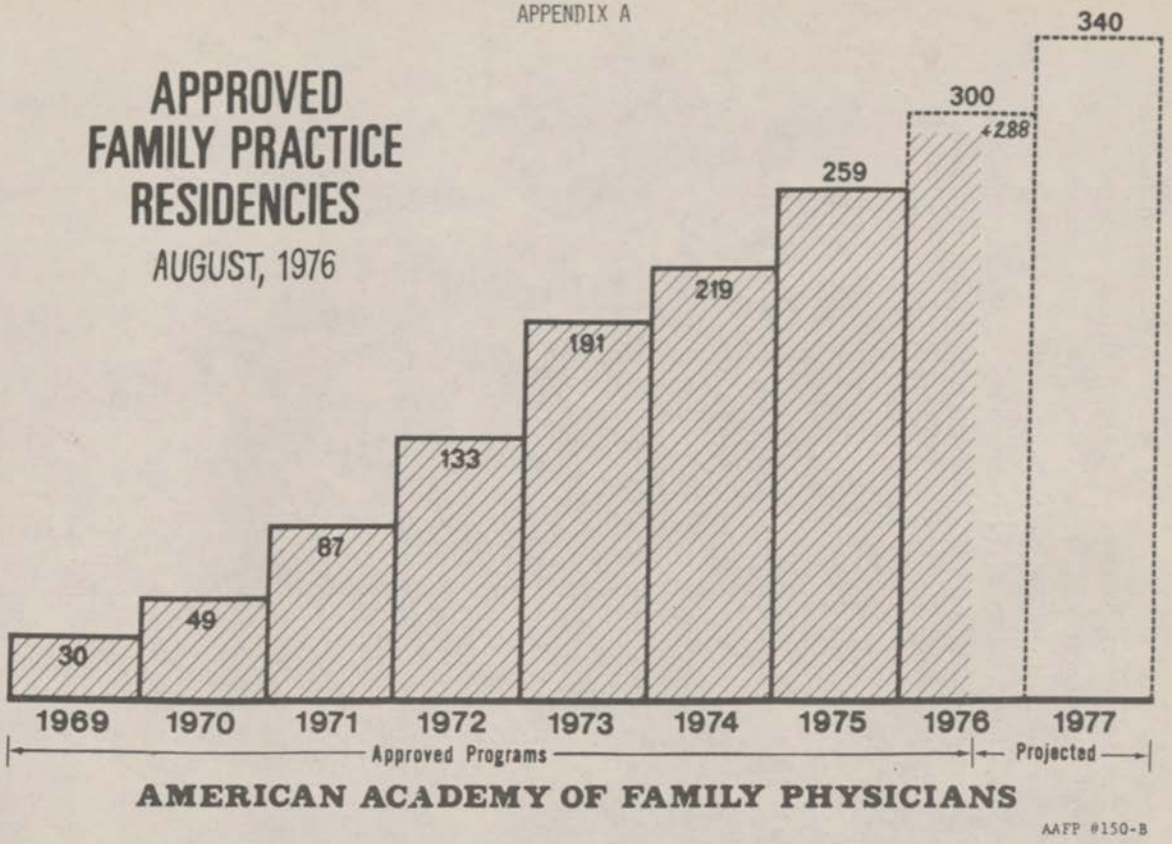
PAST AUTHORIZATIONS FOR THE SUPPORT OF FAMILY PRACTICE HAVE NOT INCLUDED FUNDS FOR CONSTRUCTION. WITH THE EXCEPTION OF THE AUTHORITIES PROVIDED IN SECTION 720 OF P.L. 94-484, NO SUCH AUTHORITIES EXIST IN THE CURRENT LEGISLATION. THEREFORE, WE STRONGLY URGE THE SUBCOMMITTEE TO APPROPRIATE FUNDS PURSUANT TO THE AUTHORITIES CONTAINED IN SECTION 720. AS WAS MENTIONED PREVIOUSLY, THIS TYPE OF SUPPORT IS AN INTEGRAL PART OF THE OVERALL EFFORT TO INCREASE THE SUPPLY OF FAMILY PHYSICIANS AND COMPLIMENTS THE OTHER AUTHORITIES CONTAINED IN P.L. 94-484 FOR THIS PURPOSE.

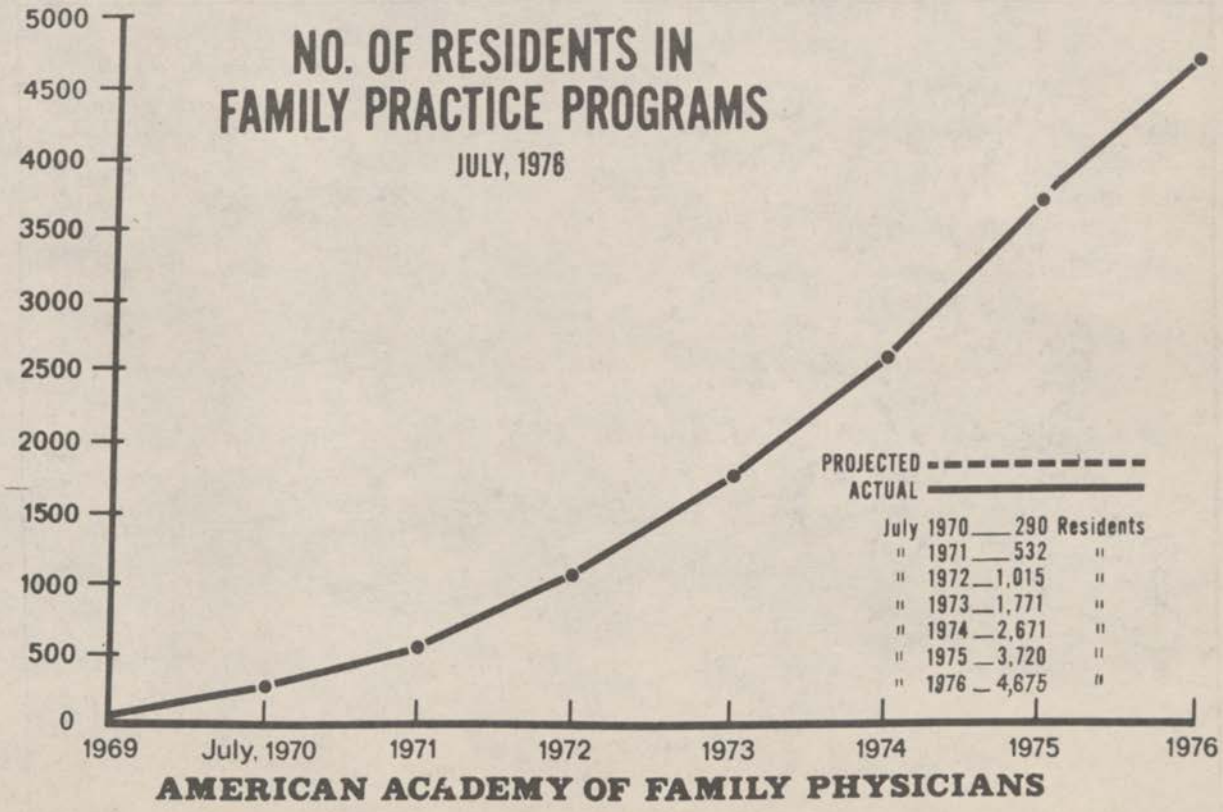
THE ACADEMY WOULD LIKE TO EXPRESS ITS APPRECIATION TO THE SUBCOMMITTEE FOR ALL OF THE SUPPORT WHICH IT HAS GIVEN TO THE FAMILY PRACTICE MOVEMENT IN THE PAST. THE PREVIOUSLY-MENTIONED TABLES IN APPENDIX A OFFER AMPLE EVIDENCE THAT THIS SUPPORT HAS PRODUCED RESULTS. ALTHOUGH SIGNIFICANT PROGRESS HAS BEEN MADE, MUCH REMAINS TO BE ACCOMPLISHED. CONTINUED FEDERAL SUPPORT FOR FAMILY PRACTICE DURING THIS CRITICAL STAGE OF ITS DEVELOPMENT AND WHILE ITS MOMENTUM IS STRONG WILL DO MUCH TO INSURE THAT FUTURE GENERATIONS OF AMERICANS ARE GUARANTEED THE BEST POSSIBLE MEDICAL CARE.

THIS IS NOT TO SAY THAT WE BELIEVE IT IS THE RESPONSIBILITY OF THE FEDERAL GOVERNMENT TO CONTINUE FUNDING FAMILY PRACTICE INDEFINITELY IN THE FUTURE. IN FACT, IT IS OUR HOPE AND OUR BELIEF THAT THE DAY IS RAPIDLY APPROACHING WHEN FAMILY PRACTICE WILL BE SUFFICIENTLY WELL-ESTABLISHED AND WILL HAVE DEVELOPED OTHER SOURCES OF INCOME SO THAT FEDERAL SUPPORT OF THE TYPE WHICH WE ARE REQUESTING WILL BE UNNECESSARY. TO THIS END, THE ACADEMY'S CONSTITUENT STATE CHAPTERS HAVE DILIGENTLY SOUGHT THE SUPPORT OF STATE LEGISLATURES AND SEVENTEEN STATES HAVE ADOPTED FAMILY

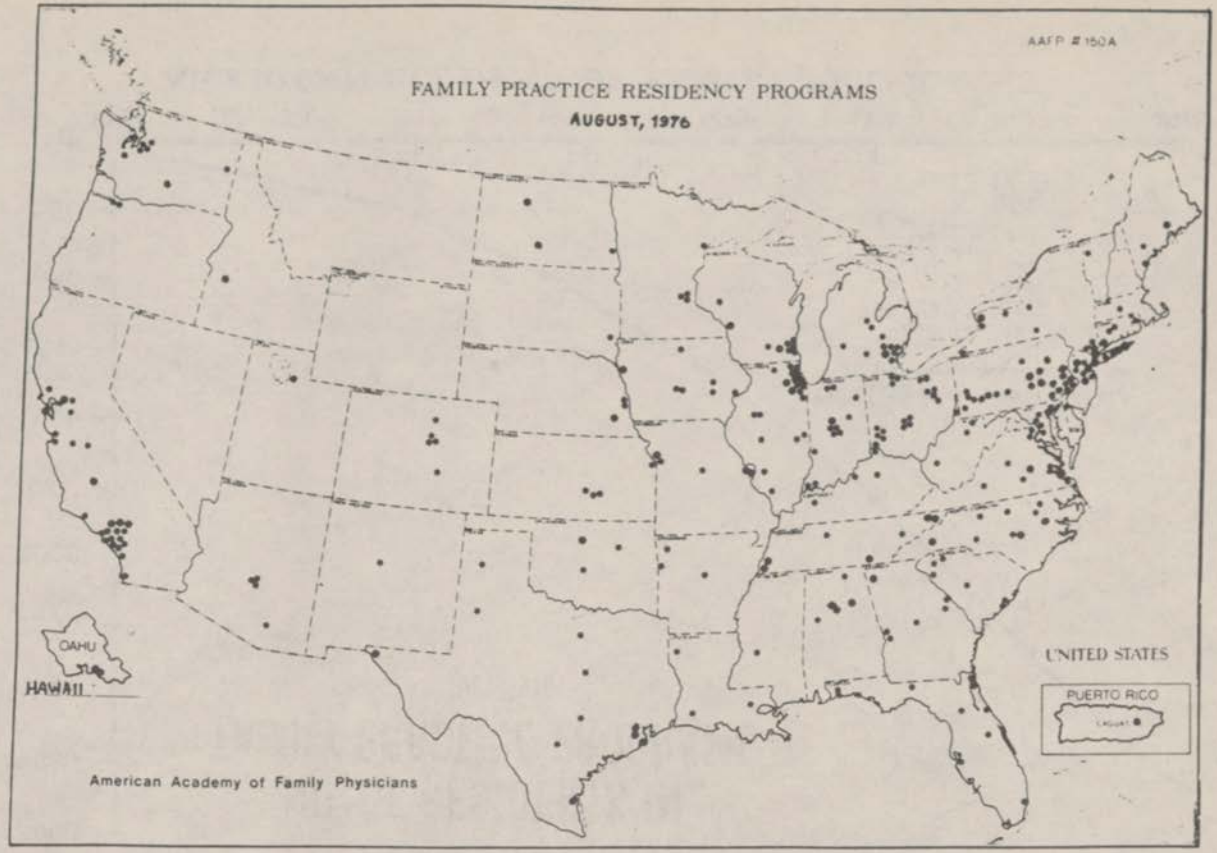
PRACTICE BILLS WITH ANOTHER TEN TO TWELVE STATES PROVIDING LINE-ITEM SUPPORT FOR FAMILY PRACTICE IN THEIR BUDGETS. NEVERTHELESS, THE FACT REMAINS THAT, AT THE CURRENT TIME, MANY PROGRAMS ARE DESPERATELY IN NEED OF THE FUNDS AUTHORIZED BY THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT AND WOULD NOT BE ABLE TO CONTINUE TO EXIST WITHOUT SUCH FUNDS. WE RESPECTFULLY REQUEST THAT THESE FUNDS BE APPROPRIATED.

# # #


APPROVED
FAMILY PRACTICE
RESIDENCIES
AUGUST, 1976
30
49
87
133
191
219
259
300
+288
340
1969
1970
1971
1972
1973
1974
1975
1976
1977
Approved Programs
Projected
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AAFP #150-B


NO. OF RESIDENTS IN
FAMILY PRACTICE PROGRAMS
JULY, 1976
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
1969
July, 1970
1971
1972
1973
1974
1975
1976
PROJECTED
ACTUAL
July 1970 ___ 290 Residents
" 1971 ___ 532 "
" 1972 _ 1,015 "
" 1973 _ 1,771 "
" 1974 _ 2,671 "
" 1975 _ 3,720 "
" 1976 _ 4,675 "
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AAFP #150-C

2985


AAFP # 150A
FAMILY PRACTICE RESIDENCY PROGRAMS
AUGUST, 1976
OAHU
HAWAII
UNITED STATES
PUERTO RICO
American Academy of Family Physicians

American Academy of Family Physicians

DIVISION OF EDUCATION

## Statistics Concerning Family Practice Graduate Medical Education

### Approved Residencies in Family Practice

| | |
|---|---|
| Community Hospital Residency Programs | 164 |
| University Based Residency Programs | 61 |
| University Affiliated Residency Programs | 49 |
| Armed Forces Residency Programs | 14 |
| | 288 |

### Residents in Training as of July 1, 1976

| | |
|---|---|
| First-Year Residents | 1,861 |
| Second-Year Residents | 1,577 |
| Third-Year Residents | 1,237 |
| | 4,675 |

# APPENDIX B

AMERICAN ACADEMY OF FAMILY PHYSICIANS

## SUMMARY OF DISTRIBUTION OF GRADUATING RESIDENTS (1975) BY COUNTY CLASSIFICATION

| | | |
|---|---|---|
| Total questionnaires distributed | | 562 |
| Total responses | | 516 (92%) |
| Total into practice or teaching | 423 = 82.0% | |
| Total into military | 72 = 14.0% | |
| Other (undecided, outside USA or unknown) | 21 = 4.0% | |

| Demographic County Classification | Number of FP Graduates locating within such areas | Percentage of FP Graduates locating within such areas | Percentage of US Population within such areas |
|---|---|---|---|
| 1 | 16 | 3.8% | 2.2% |
| 2 | 29 | 6.9% | 7.2% |
| 3 | 52 | 12.3% | 7.7% |
| 4 | 45 | 10.6% | 7.7% |
| 5 | 3 | .7% | 2.0% |
| 6 | 104 | 24.6% | 18.6% |
| 7 | 44 | 10.3% | 13.2% |
| 8 | 108 | 25.5% | 30.0% |
| 9 | 22 | 5.2% | 11.4% |
| TOTAL | 423 | 100.0% | 100.0% |

### DEMOGRAPHIC COUNTY CLASSIFICATION

1 - Non-metropolitan Counties with 0 to 9,999 Inhabitants
2 - Non-metropolitan Counties with 10,000 to 24,999 Inhabitants
3 - Non-metropolitan Counties with 25,000 to 49,999 Inhabitants
4 - Non-metropolitan Counties with 50,000 or more Inhabitants
5 - Counties Considered Potential SMSA's
6 - Counties in SMSA's with 50,000 to 499,999 Inhabitants
7 - Counties in SMSA's with 500,000 to 999,999 Inhabitants
8 - Counties in SMSA's with 1,000,000 to 4,999,999 Inhabitants
9 - Counties in SMSA's with 5,000,000 or more Inhabitants

Note: The county classification schema used in this compilation was that from 1973, while the resident location information is 1975 data. Since some counties may have changed their classification code between 1973 and 1975, the final analysis of data will need to use 1975 county classification codes matched with 1975 resident location. This will be available in the final data analysis form.

RG:sf
11-17-75

American Academy of Family Physicians

SUMMARY OF DISTRIBUTION OF GRADUATING RESIDENTS (1976)
BY COUNTY CLASSIFICATION

| | | |
|---|---|---|
| Total questionnaires distributed | | 821 |
| Total responses | | 775 (94%) |
| Total into practice or teaching | 658 = 84.9% | |
| Total into military | 44 = 5.7% | |
| Other (undecided, outside USA or unknown) | 73 = 9.4% | |

| Demographic County Classification | Number of FP Graduates locating within such areas | Percentage of FP Graduates locating within such areas | Cumulative Percentage of total Graduates | Percentage of US Population within such areas |
|---|---|---|---|---|
| 1 | 19 | 2.7% | 2.7% | 2.2% |
| 2 | 53 | 7.5% | 10.2% | 7.2% |
| 3 | 74 | 10.6% | 20.8% | 7.7% |
| 4 | 66 | 9.4% | 30.2% | 7.7% |
| 5 | 16 | 2.3% | 32.5% | 2.0% |
| 6 | 188 | 26.8% | 59.3% | 18.6% |
| 7 | 93 | 13.2% | 72.5% | 13.2% |
| 8 | 154 | 21.9% | 94.4% | 30.0% |
| 9 | 39 | 5.6% | 100.0% | 11.4% |
| TOTAL | 702 | 100.0% | | 100.0% |

DEMOGRAPHIC COUNTY CLASSIFICATION*

1 - Non-metropolitan Counties with 0 to 9,999 Inhabitants
2 - Non-metropolitan Counties with 10,000 to 24,999 Inhabitants
3 - Non-metropolitan Counties with 25,000 to 49,999 Inhabitants
4 - Non-metropolitan Counties with 50,000 or more Inhabitants
5 - Counties Considered Potential SMSA's
6 - Counties in SMSA's with 50,000 to 499,999 Inhabitants
7 - Counties in SMSA's with 500,000 to 999,999 Inhabitants
8 - Counties in SMSA's with 1,000,000 to 4,999,999 Inhabitants
9 - Counties in SMSA's with 5,000,000 or more Inhabitants

SMSA (Standard Metropolitan Statistical Area)

* Taken from Table K, page 32 of the Physician Distribution and Medical Licensure in the U.S., 1974, published by the American Medical Association

DJO:sf
11-3-76

## STATEMENT OF MICHAEL F. DOODY, PRESIDENT, AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

This statement is presented by Michael F. Doody, President of the American Osteopathic Hospital Association, 930 Busse Highway, Park Ridge, Illinois 60068.

The AOHA maintains its Headquarters in Illinois, with an office in Washington, D.C., and represents the 204 osteopathic hospitals which are located in 28 states. These institutions serve as the primary institutional care facilities for those patients (individual consumers) who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in the country.

Osteopathic physicians represent a second school of medicine. The osteopathic profession is a politically and philosophically separate and administratively independent school of medical practice. Osteopathic physicians represent slightly over 4 percent of all the physicians in this country, but they also represent in excess of 17 percent of all general parctitioners.

The 204 osteopathic hospitals represent more than 23,000 inpatient beds and employ approximately 62,000 people. In 1976 osteopathic hospitals had more than $1 billion in total expenses while providing health care services for more than 825,000 inpatient admissions and 3.1 million outpatient visits.

Osteopathic institutions and physicians are interested in the delivery of quality health care and for the most part are providers who concentrate in the areas of general practice and family medicine. Approximately 85 percent of all practicing osteopathic physicians are engaged in the delivery of primary care. Osteopathic hospitals are cost conscious institutions whose primary objective is the delivery of quality health care.

Osteopathic hospitals represent an important community health resource. Many of our hospitals are located in rural or semi-rural areas and provide a very necessary community health service. In some instances the osteopathic hosptial is the only hospital present within the community.

### INTRODUCTION

The Fiscal Year 1978 Budget is before this Subcommittee in two forms--the one presented by former President Ford, and the suggested revisions submitted by President Carter. In addition to these budgetary figures, both budgets carry with them legislative proposals which require action on the part of other committees of Congress. The American Osteopathic Hospital Association has presented testimony on the Ford proposals in the past, and will present comments and testimony on the legislative proposals of President Carter after they are submitted to the appropriate committees. It is not our purpose here to comment on the legislative proposals in any detail, but in our discussion of the dollar figures which we believe are important, some cognizance of these proposals will be taken.

This Association fully realizes the importance of the budgetary process and the care that must be exercised in allocating limited financial resources among the many important programs. This is especially important at a time when this country's economic resources are being taxed at an unprecedented level. It is also important to understand, however, that hospitals are also the victims of inflation--they are not the cause of it.

GENERAL COMMENTS

This Association strongly supports President Carter's decision to drop the Ford Administration's Medicare and block grant proposals. In testimony presented last year, we presented numerous arguments in opposition to these concepts which would have, among other things, required Medicare recipients to pay more of their own hospital expenses for short-term care. While we agree that this proposal would have cut Medicare costs, President Carter's approach would freeze premiums for supplemental medical insurance under Medicare at $7.20 a month through September 1978 and the difference would be made up with federal payments from general revenue. It is our belief that this is a far more equitable approach and would not place undue burdens on the nation's elderly.

LIMITS ON INCREASES IN HOSPITAL REIMBURSEMENTS

Included in President Carter's budget revisions is a reduction in outlays of some $830 million for the Medicare and Medicaid programs. These savings would be realized through the implementation of a program, subject to Congressional approval, which would set limits on increases in hospital revenues received from government, insurances companies, and individuals. The general proposal, which has yet to be reduced to legislative language, would set a 9% ceiling on any hospital's revenues in FY78 over FY77. It is intented to result in outlay savings of $695 million for Medicare, $134 million for Medicaid, and $1.6 billion for insurers and other payors in Fiscal Year 1978.

On many occasions, the Carter administration has indicated that the 9 percent (plus a 1 percent factor for exceptions) figure is not set in concrete. Yet the intent seems to be clear--to cut back on Medicare and Medicaid expenditures at the expense of hospitals. It is difficult for us to comment specifically on a program not yet set in a specific legislative proposal.

However, the American Osteopathic Hospital Association is unalterably opposed to arbitrary and unreasonable controls. A number of proposals have been offered in the past which impose a percentage limitation on the reimbursement of hospital costs. Such alternatives are by their very nature arbitrary and result in inequitable consequences. The inefficient institution is rewarded, and the efficient, cost-conscious institution is penalized. The reward system is reversed, incentives for economy are lost, and oftentimes it is the patient who suffers.

Osteopathic hospitals have taken action to contain costs. Our hospitals have taken a variety of cost-cutting steps such as mergers, shared services, the development of ambulatory care programs, cost containment reviews and many other internal management programs.

In addition there are a number of governmental and voluntary controls in existence such as the accreditation procedures, reimbursement controls, certification of need for facilities and services, that are all directed at this same issue.

The amounts hospitals must pay to meet operating expenses has risen steadily over the past several years. The major components of the rising costs include such things as energy, food, premiums for malpractice insurance and labor costs. The hospital market basket is becoming increasingly more expensive. And that market basket is a considerably higher priced market basket than the Consumer Price Index (CPI) market basket. Hospitals buy an extraordinary amount of utilities and petroleum-related or petroleum-base products. At the same time hospitals are not producing a uniform product such as the steel industry or the meat packing or other industries produce. The hospital product, a patient day of quality health care, is an extremely complex item to produce and it is a product that is constantly changing and improving. Government reglations, program requirements, and accreditation programs all aimed at improving quality also have significant financial implications. Improvements in care--for example intensive care units, ambulatory and emergency services and other innovative procedures, the declining length of hospital stays and treatment with more complex diagnoses--have all contributed to the change and improvement of the product, but have also contributed to increased per unit costs. Finally, a highly trained, very specialized labor force requires considerably higher rates of compensation.

There is a need to devise new financial mechanisms that will encourage efficient management of our resources and contain rising costs without, at the same time, impairing the capacity of the health care system to meet our patients' needs. The hospital industry has provided several recommendations and suggestions for bold and innovative prospective financing systems which move away from reasonable cost reimbursement but which take into account hospitals' full financial requirements. We urge consideration of these proposals and stand ready to work with the committees of the Congress in the effort to devise a workable yet equitable financing system. It is vital, however, to stress that such a solution should be a health program--not a budget program.

President Carter's proposal is partially based on the principle of prospective reimbursement. This is the principle which sets a hospital's annual budget in advance and reimbursements are based on this dollar figure. However, the Carter plan also proposes to set a maximum limit on increases in hospital reimbursements for a given year. It is this concept which concerns this Association, and it is this concept which we will address in our testimony on the legislative proposal when it is submitted by the Administration. It is our purpose here to indicate that the ultimate enactment of this proposal could significantly affect the estimate the Administration has made in the amount of savings that may be achieved through the Medicare and Medicaid programs by enactment of this proposal.

HEALTH MANPOWER AND HEALTH PROFESSIONS ASSISTANCE

When former President Ford submitted his FY78 budget, he proposed major cuts in spending programs under the new Health Professions Education and Assistance Act (P.L. 94-484). President Carter's budget revisions did not reinstate many of these proposed reductions. This Association believes that it is vital that Congress act to assure the continued viability of health professional training institutions. President Carter has proposed that capitation levels be reduced from the figures authorized in P.L. 94-484 which will result in funding levels severely lower than Congress intended. It is our belief that capitation grants should be fully funded and we sincerely urge that the Congress appropriate funds equal to the full authorization levels.

An area of vital concern to the nation and to this Association is family practice/primary care. The osteopathic physician is oriented toward general or family practice and osteopathic hospitals are best equipped to provide primary care services. In an age when the medical profession tends to be over specialized, the osteopathic profession has maintained that the vast majority of Americans are most in need of primary care. The Congress has realized this need and many proposals have been made in this regard. P.L. 94-484 contains a provision for extending the program of grants for training in family medicine and specifically authorizes the support for internship training in osteopathic medicine as an educational modality that produces primary care physicians.

We strongly recommend full funding for this program as well as full funding for other special projects in P.L. 94-484 which have as their objectives the training and support of primary care physicians and institutions.

CONCLUSION

Every American has the right to receive high quality health care from the physician and hospital of his or her choice. The delivery of high quality care is the major priority of osteopathic hospitals and it is their desire and aim to provide the primary care needed by the people of this nation. The Congress, the President, and the American people have become increasingly cognizant of the importance of the areas in the total health care delivery system. It is therefore vital that funding for these areas be adequate and that sufficient funds also be made available to ensure sound health planning across the country. There is no substitute for good planning, particularly in health care delivery, and there is no substitute for delivering the kind of health care Americans want and need.

# STATEMENT OF THE UNIVERSITY ASSOCIATION FOR EMERGENCY MEDICAL SERVICES

## RECOMMENDATIONS

## FY '78 APPROPRIATIONS

PUBLIC HEALTH SERVICE ACT

| | |
|---|---|
| TITLE VII-Section 789 - Emergency Medical Services Training | $10,000,000 |
| TITLE XII-Section 1205 - Research | $ 4,500,000 |
| TITLE XII-Section 1221 - National Burn Injury Program | $ 4,000,000 |

THE UNIVERSITY ASSOCIATION FOR EMERGENCY MEDICAL SERVICES

The University Association for Emergency Medical Services (UA/EMS) is vitally concerned that the organization and implementation of effective emergency medical services proceeds in as orderly a manner as is possible and as swiftly as practicable. We are particularly concerned with research, data collection and the training of physicians and other professionals in the field of emergency medical services.

The Association has as its primary objective improving the quality and delivery of care to the acutely ill and injured through educational programs centered in teaching hospitals. The name, constitution and bylaws of UA/EMS were approved at the charter meeting in Denver, Colorado, in November of 1970. Current membership is over 400.

The objectives of UA/EMS are clearly laid down in its constitution which, in essence, states that improvements in the quality and delivery of emergency medical care shall be pursued by: collecting and disseminating information regarding EMS problems; providing an annual forum to discuss these problems; aiding and encouraging the university physician in his participation in the field of EMS; developing guidelines and consulting in matters of emergency department staffing, administration, design and performance; recommending appropriate changes in EMS legislation at the local, regional and national levels; and, encouraging academic recognition for work in this field by teaching physicians.

The problem of organizing an effective system of emergency medical services continues to be a major area of concern to all health care professionals.

EMERGENCY MEDICAL SERVICES RESEARCH APPROPRIATIONS

Mr. Chairman, EMS research continues to be a pressing need. Although the general characteristics and components of EMS systems are well delineated, the varied demands of our complex society require that research be targeted in several key areas.

For example, we need to know more about the design of treatment protocols and methods of measuring results in the management of emergency conditions. Furthermore, it is important to evaluate the effectiveness of new devices, diagnostic measures, and treatment methods. And these are but a few of the areas in which research is needed. A good start has been made, but the impetus will be lost without continued funding of ongoing research commitments.

Fluctuating research levels create a situation which hinders total research productivity. Sound scientific research is incompatible with on-again, off-again financial support.

A corollary of both research and planning efforts is the accumulation, interpretation and accessibility of reliable data concerning the field of emergency medical services.

We need to know more about the persons who use EMS systems, the providers of those services, and the outcome of the services provided. It is essential that we have information about the morbidity and mortality of patients who enter the system. At this time, we are still guessing and estimating about such critically important matters as:

- total number of physicians, nurses, and allied health personnel involved in EMS
- types of facilities and equipment that are available to emergency patients
- profile of the educational backgrounds and on-the-job training that are represented by the persons providing emergency care.

Certainly no single organization in the private sector -- and perhaps, no consortium of such organizations -- can be expected to undertake such an awesome task without the financial support of the federal government.

Based on these pressing needs, we respectfully urge that a minimum of $4,500,000 be allocated to support of Section 1205 of Title VII of the Public Health Service Act for fiscal year 1978.

84-877 (Pt. 4) O - 77 - 32

TRAINING IN EMERGENCY MEDICAL SERVICES

Another area of deep concern to UA/EMS is the development and implementation of effective training programs for the persons who provide emergency medical services.

The Emergency Medical Services Amendments of 1976 amended Title VII of the Public Health Service Act, which deals with health manpower, by adding Section 789 - 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. . . ." Some $6,600,000 in awards were made for the training of emergency medical technicians, emergency medical dispatchers, emergency department nurses and for continuing education and training of physicians.

Under the 1974 authorization, there were over 192 applications requesting more than $25,600,000 for training purposes. Only 76 of these applications received funding, yet they provided training opportunities for over 36,000 health care personnel. Current indications are that the requests for funding under Section 789 will double this year.

Of major interest to UA/EMS is the need to develop emergency medicine residency training programs. It has been estimated that a dramatic increase in the number of residency programs will be needed by 1980 in order to meet projected emergency physician manpower needs by the year 2000. Today there are 35 such residencies. These programs will not only be the major source for practicing emergency physicians, but are also the reservoir from which will be drawn the educators of tomorrow's emergency physicians.

Another area of training that must be considered is the need to upgrade and update the skills in emergency medicine of the physician who has moved to this specialty in mid-career. Our best guesses are that virtually all of the estimated 15,000 emergency physicians now practicing have received little, if any, formalized training in emergency medicine. On-the-job training and continuing education programs are second best catch-up measures. Many more residency programs are needed since existing programs are finding as many as 100 applicants for every opening. There can be little doubt that without governmental assistance the projected physician needs in emergency medicine cannot be met.

In order to meet the continuing need for program development in this vital health manpower area, we recommend that $10,000,000 be appropriated for fiscal year 1978.

NATIONAL BURN INJURY PROGRAM

The Emergency Medical Services Amendments of 1976 add Section 1221 of Title XII of the Public Health Service Act - National Burn Injury Program. UA/EMS recommends that $4,000,000 be appropriated for FY '78 for this program. The Burn Task Force Report of HEW dated September 15, 1976 to the Senate Committee on Appropriations recommended $5,000,000. We believe that the $4,000,000 level will fulfill the needed demonstration burn injury programs.

In summary, Mr. Chairman, the University Association for Emergency Medical Services urges favorable consideration of legislative action that will provide for continuing support of research programs in emergency medical services, development of reliable and accessible data concerning EMS, and the organization of much-needed training programs for emergency physicians as well as continuance of training of allied health personnel. Should additional information be required, please be assured that our Association stands ready to serve in any way we can.

## STATEMENT BY AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

RECOMMENDATIONS

FY '78 APPROPRIATIONS

PUBLIC HEALTH SERVICE ACT

| | | |
|---|---|---|
| TITLE VII-Section 789 | - Emergency Medical Services Training | $10,000,000 |
| TITLE VII- | - Operating Funds for Administration of Section 789 | $ 250,000 |
| TITLE XII-Section 1202,1203,1204 | - Planning, Establishment, Expansion and Improvement Programs | $37,125,000 |
| TITLE XII-Section 1205 | - Research | $ 4,500,000 |
| TITLE XII-Section 1221 | - National Burn Injury Program | $ 4,000,000 |

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS BACKGROUND

The American College of Emergency Physicians (ACEP) was formed in 1968 by a group of physicians responding to the growing public demand for improved emergency medical care. ACEP has grown rapidly and now has over 8,000 members whose primary interest is the delivery of emergency medical care.

The primary goal of the College is the attainment of appropriate physician education in emergency medicine and the adequate provision of quality emergency medical services to the American public.

NEED FOR EMERGENCY MEDICAL SERVICES

Mr. Chairman, the facts demonstrating the need for emergency medical services have been highlighted in previous hearings and in the media. Such facts include:

- accidental injury is the leading cause of death among persons 1 to 44 years old.
- cardiovascular disease accounted for about 1,100,000 deaths in the U.S. in 1972 - of these, approximately 600,000 were sudden deaths.
- over 700,000 medical and surgical emergencies which terminate in death occur annually in the U.S.

We could go on with additional statistics, but believe the benefits of improved emergency medical services can best be stated by emergency physicians whose experience has indicated that there have been reductions in coronary deaths, increased neonatal survival rates, decreases in deaths from automobile accidents, and so forth - DUE TO IMPROVED EMERGENCY MEDICAL SERVICES.

## EMERGENCY MEDICAL SERVICES AMENDMENTS OF 1976

In October 1976, P.L. 94-573 (The Emergency Medical Services Amendments of 1976) was enacted by Congress and signed by the President. These amendments authorized continuation of Emergency Medical Services (EMS) systems for three years. The legislation also authorizes a National Burn Injury program. Furthermore, as issued in a joint statement, Congress called for the Administration to provide adequate positions and operating funds to the administrative unit responsible for carrying out the legislation.

## EMERGENCY MEDICAL SERVICES APPROPRIATIONS

The American College of Emergency Physicians was very active in the development and passage of P.L. 94-573. We observed the deliberations of the House and Senate in the establishment of the program and believe that they are realistic. Our purpose in speaking today is to request that Congress provide an appropriation so the EMS program may continue its progress in improving emergency medical care.

## EMERGENCY MEDICAL SERVICES TRAINING

Section 789 of P.L. 94-573 authorizes funds for the training and education of emergency medical personnel. The significance of training and education for emergency physicians cannot be overstated. The emergency physician is the catalytic agent for the development of the emergency medical services system. The well-trained, qualified emergency physician is the responsible professional in EMS systems for the supervision and quality of training for all EMS personnel. Without adequate numbers of well-trained emergency physicians, the EMS system will deteriorate over time and the hope of past EMS support will be lost. With adequate numbers of these physicians in place, the hope of the EMS Act can be realized. The federal money will have served as the catalyst and there will be the personnel and the systems in place that can be maintained long after federal support has ended. That does not detract from the accomplishments made to date, but most emergency department nurses and emergency paramedic personnel will admit that, without strong and continued team leadership, the chance for long-term systems gains in emergency medicine are slight.

By asking for full funding of $10,000,000 in Section 789, ACEP is asking the federal government to provide only a small percentage of the total dollars needed. The estimates are that by the year 2000 this country will need 180-200 programs each graduating three fully-trained emergency medicine residents per year. Estimates are that $250,000 is the minimum amount of money needed to establish a residency in an existing facility where most of the teaching personnel are already in place. In addition, $40,000 is needed to support each resident for each year of his three-year training. With 28 approved residencies already in existence and a goal for establishing 10 new residencies this year, the conservative estimate of support for 1978 is between $15,000,000 and $17,000,000. Full funding of Section 789 will only provide $3,000,000 of that support. ACEP feels that this is the minimum needed to serve as a catalyst for emergency physician residency training. The remaining $7,000,000 will go for the training of emergency department nurses and emergency paramedic personnel needed to make the EMS system a viable patient care system.

GRANT APPROPRIATIONS FOR PLANNING, IMPLEMENTATION, EXPANSION AND IMPROVEMENT

It has been estimated that in FY '78, grant applications will come from 200 EMS regions and will total in excess of $70,000,000. We recommend that $37,125,000 be appropriated. This will provide support for EMS regions currently in the implementation phase, and will permit continuity of the implementation of these programs.

NATIONAL BURN INJURY PROGRAM

A total of $5,000,000 was authorized for the National Burn Injury Program for FY 1978. These funds will be used primarily for demonstration burn injury programs. We recommend that $4,000,000 be appropriated for FY '78 in this program. This recommendation corresponds to the professional recommendations of the Burn Task Force Report to the Senate Appropriations Committee by the Secretary of DHEW on September 15, 1976.

EMERGENCY MEDICAL SERVICES RESEARCH

We recommend a FY '78 appropriation of $4,500,000 authorized under Section 1205 of the legislation. These funds will be utilized for current

research projects, as well as for increasing demands for applied and basic research in the field of emergency medicine. Current and potential research projects include: studies on the means to determine the efficacy of EMS systems; clinical research in emergency and criticial medical and surgical care problems; research in methods and management of data systems; and, research targeted to the establishment of realistic and achievable measures of quality.

## STAFF POSITIONS AND OPERATIONAL FUNDS

Our experience indicates that the Division of Medicine, Bureau of Health Manpower, Health Resources Administration Central Office is in dire need of permanent staff positions and operating funds for travel, documentation, and other financial support to implement the training provisions of Section 789 of Title VII. The Central Office has struggled to cooperate with all of the interests involved in emergency medicine with too few staff people and with insufficient financial support. We recommend that the Subcommittee report direct that $250,000 be allocated for staff positions for more adequate functioning and management.

Mr. Chairman, thank you for the opportunity to submit testimony. We hope we have been of assistance to you during your deliberations.

STATEMENT OF DOROTHY HALL, RN, MS, DIRECTOR, DEPARTMENT OF NURSING, NORTHEASTERN OKLAHOMA A & M COLLEGE

It is intended that this statement will provide information which will encourage the members of the Appropriations Committee of the United States Senate to make a favorable determination in the matter of funding for construction of schools of nursing.

If funding is provided for, in at least, Fy 78, the moratorium will be lifted on the processing and review of applications which have been on file in the Division of Nursing of DHEW since October, 1975.

Among these applications is one, which is the second application, submitted by Northeastern Oklahoma A & M College of Miami, requesting financial assistance for construction funds for a school of nursing.

The first application submitted on March 17, 1975 requested $600,000.00 to be used with $200,000.00 of state matching money, to construct a building for a new associate degree nursing program.

On July 1, 1975 notification was received from the regional office of DHEW that the National Advisory Council on Nurse Training, at its June 1-6 meeting, recommended that the application not be approved, and the recommendation was sustained by the Department. The letter of notification stated that the Council in making its recommendation noted that;

1. The application did not include a statewide plan for nursing.
2. The space requested was excessive and unjustified.
3. The questionable attrition rate (in excess of 50%) was greater than the national average.

A second application for $428,400.00 was submitted on October 28, 1975. This application provided for expansion of the existing facility. A letter of explanation relating to the previously identified concerns of the Council i.e., lack of a state plan for nursing, excessive space request and questionable attrition rate, accompanied the application.

The letter explained that the review comments made by the Oklahoma Health Planning Commission were based on the State Nursing Education Plan as developed by the State Board of Nurse Registration and Nursing Education and adopted in the State's Comprehensive Health Plan by the Commission.

The letter also explained that the space request in the second proposal was reduced, as information relating to the method for computing the space request

had been acquired prior to preparation of the second proposal.

The projected enrollment for five (5) years following construction was originally based on a fifty (50) percent attrition rate due to the absence of a track record upon which to base a more definite figure. In reality, the school of nursing attrition rate to date has been at thirty (30) percent. The rate used in the second application was forty (40) percent, a figure obtained from the National League for Nursing Research Division.

On April 1, 1976 notification was received from the Division of Nursing of DHEW that the Council deferred action on the second application pending a site visit, for the purpose of obtaining additional information. On July 7, 1976 a site visit was conducted by DHEW staff.

On July 29, 1976 additional and revised materials, as requested by the site visitors were submitted to the regional office of DHEW. The application request was changed to $551,325.00.

On August 31, 1976 notification was received from the Division of Nursing of DHEW that a moratorium had been placed on the further processing and review of all nursing school construction grant applications. The notification further stated that the application would not be reviewed by the National Advisory Council on Nurse Training in September as previously planned. It was explained that the Division of Nursing had accepted construction grant applications throughout most of the fiscal year 1976 despite the absence of an appropriation, because several million dollars remained available from prior year funds. The moratorium was declared when these funds became obligated and when there were no funds for the program made available in the, then, pending fiscal year 1977 appropriation's bill. If the moratorium is lifted by August, 1977, an opportunity will be provided for updating the application.

The availability of previous funding opportunities were premature to the needs of the associate degree nursing program at Northeastern Oklahoma A & M College.

In the early 1960's the college, urged by its service community attempted to initiate an associate degree nursing program. Lack of availability of clinical facilities for teaching nursing as well as lack of prepared nursing faculty prevented this effort from materializing. However, a practical nursing program, the only one to be developed within the state's system of higher education, was begun in 1963.

It was during this period that extensive construction was carried out on the campus. Included in the construction was a technology building within which was designed a unit (2,832 s.f.) to house the practical nursing program. The size of the unit was based on a projected enrollment of fourteen (14) to twenty-eight (28) students. As the need for a program that would prepare students to become registered nurses became more acute, and as previous limiting factors changed, the college finally began an associate degree nursing program in 1973. The program was assigned to the unit previously designed for fourteen (14) to twenty-eight (28) practical nursing students.

Throughout the state, as most colleges initiated nursing programs, space was somehow made available and an area was renovated and refurbished to meet the needs of the program. However, at Northeastern Oklahoma A & M College it has not been feasible to relocate the unit in nursing, or to provide additional space due, in part, to the limitations imposed on administration by the nature of the building's construction and due in part to the increase in enrollment which has been maintained at a relatively stable level.

It is acknowledged that federal assistance for construction of nursing education facilities has been available since 1964. Due to the stage of development of its nursing education programs however, Oklahoma was not as ready as many other states to seek such assistance until recently. Since 1970 Oklahoma has received federal assistance for construction of four (4) schools of nursing. Two (2) schools, one (1) private and one (1) public are located in university settings in metropolitan areas. The other two (2) one (1) private and one (1) public are located in junior college settings. Only one (1) of these, the private school is located in a rural area of Oklahoma.

Since its inception in 1973, the nursing education program has, in spite of the limited physical facilities, moved rapidly to develop a quality opportunity for students to learn the practice of nursing. Accreditation by the National League for Nursing was granted in 1976.

Two classes have graduated a total of forty-five students. Ninety-three (93) percent of the graduates have attained licensure as registered nurses. It is anticipated that thirty-two (32) students will graduate in May, 1977. Approximately forty (40) first year students will progress to the second year level for the Fall Semester of 1977. From a group of more than two hundred (200)

applicants, forty-eight (48) first year students will be admitted for the Fall Semester. At least sixty (60) of the applicants have already been on the campus for a year taking general education courses hopeful of being admitted as nursing students.

The school is faced with a serious dilemma. The options are limited. If funding is not provided, the program certainly can not be expanded to allow for increased enrollment. It is doubtful that with the current rate of enrollment, that the program housed in crowded inadequate facilities, can long maintain its quality of instruction. The needs of the service community will not be met by reducing enrollment, nor will it be met by producing a graduate of questionable quality.

Support of the program by the administrators of health care facilities from a wide area of Northeastern Oklahoma and adjacent states is appropriately documented. Many of these same administrators are dependent upon the product of this program for staffing the nursing services of their facilities.

This statement does not attempt to address the effect that the moratorium has had on health care services in this country. However, it would seem appropriate to state that in those areas which are currently underserved by registered nurses, and which have been anticipating construction funds with which to build a school of nursing, so as to develop a primary source of supply of registered nurse manpower, that such an area would be adversly effected, and that, that effect would impact directly upon the health care delivery system of the area.

In conclusion, it is recognized that the cost of extending the support for construction of schools of nursing, must be considered in relation to the expected benefits.

It is expected that by providing funds to construct a school of nursing at Northeastern Oklahoma A & M College, the following benefits will be derived:

1. The number of qualified registered nurses will be increased within the area, thereby effecting a more reasonable balance in the ratio of registered nurses to licensed practical nurses to auxillary workers in nursing.
2. The area's dependence on schools of nursing in other areas of Oklahoma and outside of Oklahoma, for preparation of its

major supply of nurse manpower, will be decreased.

3. An opportunity will be provided for an increased number of students, representative of the area's minority population, to enter nursing, thereby effecting a more equitable distribution of the area's minority population, within nursing.
4. An opportunity will be provided for licensed practical nurses who wish to become registered nurses, to expeditously do so, through the associate degree route.
5. Some graduates of the program, who might never have considered doing so, before achieving at the associate degree level, will be stimulated to pursue a higher degree in nursing, thereby contributing to the areas potential pool of nurses required for leadership roles.

It is expected that through these benefits, the profession of nursing will become more adequately equipped to contribute significantly to a quality health care delivery system within the rural area of Northeastern Oklahoma.

Finally, in 1970 in its publication "Costs of Nursing Education and a Case for its Greater Support" the National Commission for the Study of Nursing and Nursing Education made this salient remark:

"Nursing may well be the key to whether our entire system for health care remains viable and responsive to the requirements it faces. It is essential therefore, that the nation that makes those demands prove itself willing to support the efforts required to meet them".

Appreciation is expressed to the Members of the Committee for their attention to this matter and for providing the opportunity to enter this statement in its report.

## STATEMENT OF AMERICAN ASSOCIATION OF COLLEGES OF NURSING

The American Association of Colleges of Nursing is appreciative of this opportunity to address the issue of funding for nursing for FY 1978. Recognizing the critical need for improved health services and the major role which nurses have on the quality of health services provided to the people of this country, we are requesting a budget level of $173.5 million dollars for FY 1978. This increase of $14 million over the level of support for FY 1977 is viewed as modest given the current needs and directions in the health care delivery system. An itemized breakdown of requested budget support by program is attached.

Major priorities for funding are in Advanced Nurse Training, Traineeships and Research. Increased funding levels are requested for these programs as the results of these programs have the greatest impact on improvement of the quality of nursing services delivered to our society.

Advanced Nurse Training and Traineeships - Appropriations for Advanced Nurse Training were only recently made available and it is the only source of support for graduate education in nursing. New, expanded and revised programs at the graduate level have been made possible through this funding. Increased support is necessary in order to prepare more nurses at the graduate level with specialization in primary care, geriatrics, maternal/child health, community health and other clinical areas. Currently, only 3% of the entire registered nurse population has educational preparation at the masters level and less than 1% are prepared at the doctoral level. A significant increase in the number of nurses prepared at the graduate level is absolutely critical. Nurses with masters and doctoral preparation must be available in significant numbers to assume leadership positions in clinical practice, education and research.

Traineeship support is requested at the level of 18 million. This support is necessary to offset the educational costs of students pursuing graduate study. Without traineeship support most nurses would not be able to engage in full time study, thus significantly slowing the progress currently being made in preparing larger numbers of nurses at the graduate level.

Nursing Research - Three million is requested for nursing research fellowships and $7 million for nursing research projects, Support for doctoral and post-doctoral research fellowships is necessary in order to continue the development of new knowledge necessary to improve the quality of nursing practice. Findings from nursing research projects are having positive effects on the quality and types of services provided to patients. Research is being conducted on a multitude of health problems including cardiac care, compliance, behavioral problems, stress, cancer, and on the effectiveness of various nursing interventions on quality of care.

Capitation - A total of $50 million is requested for Capitation support. Capitation provides support to Schools of Nursing to assist in the total costs of nursing education. This support is of particular importance for baccalaureate programs as they represent the only 'feeder' programs for a pool of qualified candidates to pursue graduate study in nursing. Only 20% of the total current registered nurse population have educational preparation at the baccalaureate or graduate level in nursing. Preliminary data indicate that the average cost of baccalaureate preparation in nursing is $2,500 per student per year. Data are also revealing that quality and productivity in patient care services are increased through provision of care by nurses prepared at the baccalaureate or graduate level.

Most nursing programs in this country made commitments to expand or develop new program directions as a result of the recent appropriations for Capitation support. Withdrawal of this support would lead to instability and inefficiency in the management of nursing programs. Loss of this support would also seriously jeopardize the viability of many nursing programs and reduce the ability to make steady progress on improvement of quality of services through the preparation of nurses at the baccalaureate and graduate levels.

Data are available which indicate that the nurses prepared at the baccalaureate and graduate levels are the nurses seeking and maintaining employment in the inner city and rural areas where greater access to and equality of health care provisions are so desperately needed.

Special Projects - Funding for Special Projects is requested in the amount of $15 million. Support from the Special Projects Program is basically the only source of support to nursing schools for development of innovative approaches in nursing curricula and continuing education programs. Continued maximum support of this category of funding under the Nurse Training Act provisions is needed to stimulate and test the development of new approaches and higher quality in nursing education. It is also necessary for the development of local and regional programs in continuing education for nurses.

Student Financial Assistance - Funds for scholarships, loans, and loan repayment are needed to assist students in the costs of pursuing educational preparation in nursing. Current estimates indicate that over 30% of the students enrolled in public institutions and over 50% of the students enrolled in institutions which are independently financed require some form of financial assistance in order to pursue nursing on a full-time basis.

Nurse Practitioner Programs - A total of $16 million is requested to support nurse practitioner programs. Nurses are being prepared to provide primary care in a variety of settings through the nurse practitioner programs. During this transition phase in which primary care knowledges and skills are being incorporated into baccalaureate and graduate programs, it is necessary to provide supplemental learning experiences for the current nurse population to be prepared in primary care.

Construction - A modest request for $10 million in construction is supported. Many baccalaureate and graduate nursing programs are in desperate need of building facilities in order to more fully achieve their objectives and expand their programs.

NIMH Training - The present funding for NIMH means there will be no new awards for institutional training support and no new pre-doctoral fellowships thus discouraging many nurses from enrolling in graduate programs which would further prepare them as expert practitioners in psychiatric nursing. In the next ten years, 50,000 (and this is a conservative projection) graduate prepared nurses, both masters and doctorates, will be needed to teach and administer quality mental health care. If the services for the prevention and treatment of drug abuse and alcoholism are included, even more will be needed. Psychiatric nurses functioning as teachers, supervisors, administrators, and therapists make substantial contributions to the health of our country. A minimum of $110 million is needed for the training of mental health professionals, for increases for the training of drug abuse personnel, and for personnel to work in alcoholism programs.

NIMH Research - Research is given top priority in the Alcohol, Drug Abuse and Mental Health Administration Forward Plan FY 1978-82. However, the current budget recommendations only continue research funding at current levels. Within the nursing profession, many nurses are keenly interested in research activities at the graduate and post-doctoral levels and want to participate in the extramural research programs in order to develop better ways to deliver quality nursing services. These nurses need financial encouragement in their pursuits.

Research is the groundwork to continued improvement in treatment and care. Greater knowledge is urgently needed in the areas of mental health, drug abuse, and alcoholism. The recent breakthroughs in the areas of depression, schizophrenia, opiate receptors in the brain, and alcoholism linking the disease to an hereditary predisposition must be encouraged by increased funding rather than allowed to languish through lack of funding. Research findings integrated into training curricula and services strategy offer the hope of effectively treating, and finally curing, mental illness, as well as drug and alcohol addictions. We recommend a minimum of $120 million for mental health research.

Maternal and Child Health - The Administration proposal for FY 1978 for Maternal and Child Health which generally allows the same funding as FY 1977 is actually a reduction because it does not allow for inflation and resultant increased costs.

The research and training funding remains at the FY 1977 level, a self-defeating approach. Research projects aimed at developing new knowledge relating to

maternal and child care and new systems to deliver the care must be staffed by professionals. In recent years the focus has been on training to provide services. Now we must balance the number of providers with the number of leaders as teachers, administrators, and consultants. To accomplish this the authorized sum of $30 million should be budgeted for FY '78 for research and training with part of the money earmarked for nursing.

Under the Social Security Act the programs of Title V operate under the Bureau of Community Health Services which is responsible for grants to state health departments for the expansion of services or developments of methods to improve services for maternal and child care. Money has been available for technical assistance and consultive service from the Bureau and the HEW regional offices. However, with the downgrading of regional positions and the cutbacks in the Bureau staff and travel monies, there is a lack of qualified professionals to meet the needs. In order to maintain high level services, the states need supporting assistance and consultation. To do this, we recommend the return of the maternal/child health specialist in each regional office and the addition of bureau staff to assure that their expertise is available to states. The funding level of $320 million for grants-to-states is recommended.

Direct Operational Staffing - As direct operating funds have been allowed to be moved from the program operation level to the agency level, it has resulted in a downgrading and weakening of quality program guidance, a key function of the HEW role.

Specifically, regional offices have moved health professionals from programs for which they were hired and assigned them to completely different responsibilities. Nurse consultants and other health professionals are being downgraded with a change in function. At headquarters, positions, travel funds, contract monies, etc. are now appropriated in lump sum under the direct control of the agency director rather than, as in the past, at the division level. Thus, staff responsible for project and contract consultation are not available as needed, and those who have program responsibility are often not consulted on contracts--all of which leads to duplication, overlap, and ineffective use of federal funds.

It is our recommendation that these problems be investigated and that this appropriation bill specify direct operating costs at the operating level (e.g. Division of Nursing, MCH programs, and NIMH).

In summary, despite the need for more and better prepared nurses at the baccalaureate and graduate levels, support for nursing education has been at a minimal level during the past two administrations. Congressional support for nursing education has been steady. Nursing has demonstrated the capacity to provide high quality care and the ability to fill significant gaps in the health care delivery system. Nursing contributes significantly to the health of the nation, and we trust that your support for nursing will continue.

We will be glad to provide you with additional information or assistance. Please feel free to call on Dr. Mary Kelly Mullane, Executive Director of the American Association of Colleges of Nursing at 332-1917, 1918.

FEDERAL
NURSING BUDGET
(in millions)

| Nursing Training Act | Appropriated FY '77 | Authorized FY '78 | Carter Revision | AACN Recommendations |
|---|---|---|---|---|
| Capitation | $40 | $60 | $0 | $50 |
| Special Projects | 15 | 15 | 6 | 15 |
| Financial Distress | 0 | 5 | 0 | 2 |
| Advanced Nurse Training | 9 | 25 | 0 | 17 |
| Nurse Practitioner | 9 | 25 | 9 | 16 |
| Loans | 22.5 | 35 | 0 | 24 |
| Scholarships | 6.5 | formula | 9* | 8.5 |
| Traineeships | 13 | 25 | 0 | 18 |
| Loan Repayment | 3 | -- | 0 | 3 |
| Construction Grants | 0 | 20 | 0 | 10 |
| Construction Interest Subsidies | 0 | 1 | 0 | 0 |
| Total | $118 | $211 | $24 | $163.5 |
| Nursing Research | | | | |
| Research Projects | 5 | 0 | 0** | 7 |
| Research Fellowships | 1 | 0 | 0** | 3 |
| | $6 | $0 | $0 | $10 |

*For disadvantaged students only.
**Authorization levels are now 'open' as a result of committee hearings and action

| | Appropriated FY '77 | Authorized FY '78 | Carter Revision | AACN Recommendations |
|---|---|---|---|---|
| NIMH Training | $87 | | $87 | $110 |
| NIMH Research | 102 | open | 102 | 120 |
| Maternal and Child Health | 346 | 350 | 344 | 350 |

## STATEMENT OF NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

This statement is submitted on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 343 community mental health centers, most of which receive federal grants under the CMHC Act, and another 176 agencies which are developing CMHC programs or which have a direct interest in community mental health.

Since the FY 1971 Nixon budget, federally-funded community mental health centers have been an annual target for budget cuts, and the Nixon - Ford Administrations proposed phase-out budgets for CMHCs from FY 1971 through FY 1978. However, as a result of Congressional actions there have been funds for new starts in the CMHC program in every one of these budgets, with the exception of FY 1975 when authorizing legislation was not passed over Ford's veto in time for appropriations to be made. During these years of strong opposition from the Administration, the CMHC program was funded at minimal levels, and the most recent FY 1977 appropriation for new starts ($26.5 million) is in fact not sufficient for the number of applications already approved (38 applications requiring $32.3 million).

President Carter's proposed budget unfortunately continues this policy of phase-out of CMHC programs by including only sufficient funds for continuation of existing grants. There is not even funding in the Carter budget for continuation of existing programs which have received operational grants but which now require distress grants to continue operations. If no changes are made to this budget, existing services in the community will be reduced substantially. Most of the cuts will come in cost-effective services such as prevention, early intervention and outpatient care because alternative funding is hard to find for these programs.

This phase-out budget appears to undermine the work of the new Mental Health Commission which will review the CMHC program as part of its work and make recommendations regarding improvements in community care of the mentally ill. Under the proposed budget, cutbacks are inevitable and there will be a deterioration in the existing system of care even before the Commission decides on whether or not to recommend expanding such a system. This budget policy also appears to be in conflict with the Administration's support for a one-year extension of the program, which includes funding for new starts.

In fact, the need for new starts in FY 1978 is more urgent than in previous years because of the backlog of grants, approved but not funded to date due to there being no appropriation for new starts in FY 1975 and extremely low appropriations in FY 1976 and FY 1977. The following table shows the current situation regarding such grants:

| | # of applications | Funds Required to Award Grants |
|---|---|---|
| Planning | 40 | $ 2.1 million |
| New Operations | 38 | 32.3 |
| Consultation and Education | 56 | 5.0 |
| Conversion | 31 | 7.7 |
| Distress | 12 | 4.0 |

Below is a table showing the National Council of Community Mental Health Centers suggested funding for FY 1978, which would permit funding of outstanding applications as well as a very limited number of new applications, far less than the number expected during the coming 18 months. Following is a brief discussion of each recommendations.

($ in millions)

| | FY 1977 Appropriation | FY 1978 Budget Request | FY 1978 NCCMHC Proposal |
|---|---|---|---|
| Planning (Sec. 202) | $ 1.0 | $ 0 | $ 2.5 |
| New Operations (Sec. 203(a)) | 26.5 | 0 | 50.0 |
| Continuations: Operations/Staffing and Children (Sec. 203(a) and (e)) | 170.3* | 210.3* | 215.3* |

| | | | |
|---|---|---|---|
| Consultation and Education (Sec. 204) | 8.0 | 8.2* | 15.0 |
| Conversion (Sec. 205) | 20.0 | 9.4* | 24.0 |
| Financial Distress (Sec. 211) | 8.0 | 5.0* | 12.0 |
| Facilities (Sec. 221) | 0 | 0 | 5.0 |
| TOTAL | 232.8 | 233.0 | 323.8 |

*Enough for continuations only

New Operations Grants

The 38 communities which have prepared applications for new operations grants have been through a detailed, complicated process to assess community needs, involve community representatives and design a comprehensive service program utilizing all available services and resources in the community. In many instances this process takes years to complete, and even if funding is available in FY 1978 for these new programs these communities will have waited 18 months or more from the time they sent their applications to the regions to the time funding is provided. Under the new Carter budget, not only must they expect to wait at least another 12 months, but most will be forced to review, revise and resubmit their applications with updated data and a new survey of needs.

These 38 applicants could bring comprehensive mental health services within the reach of another 5.7 million Americans and could be expected to treat about 57,000 persons in their first year of operation, most of whom have no alternative source of treatment other than a remote state mental hospital.

In addition to funding these outstanding applications, the NCCMHC proposal includes $17.7 million for applications expected to be approved by the end of FY 1978. The 38 outstanding applications represent the results of two review cycles; and there are five more review cycles before the end of FY 1978. Thus, only a fraction of the applications approved over the next eighteen months could be funded with this $17.7 million (about 20 new centers to serve 3 million persons).

Consultation and Education

Consultation and education programs are the early intervention and prevention part of the CMHC programs and are a unique part of the federal program. Through C&E, the centers can impact directly on the future costs of mental illness by early detection of those in need of treatment and through educational programs to increase awareness of mental health problems and suggest good mental health practices both to the general population and to certain groups, such as parents or teachers.

After the eight-year operational grant has expired, categorical funding for prevention is generally only available through the federal program. While some centers charge agencies for C&E services such charges cannot cover the entire cost of the prevention program. Moreover, the federal grant has an incentive clause which encourages such collections and can thus increase the C&E budget of a CMHC substantially more than the amount of the federal grant alone.

At this date, 56 CMHCs have applied for C&E funding and had their applications approved, requiring $5 million. This is a modest investment, but one which can have enormous significance and impact on the mental health of the catchment areas concerned.

NCCMHC proposes that all of these 56 centers should be funded in FY 1978, and together with the continuation funds included in the Carter budget this will require $13.2 million. In addition, money should be available for C&E applications received over the next 18 months. Thus, NCCMHC recommends $15 million be appropriated, the full amount expected to be authorized.

Conversion Grants

Under the current law, CMHCs funded prior to FY 1976 must add additional services so as to meet the new standard set for CMHCs in the 1975 Amendments to the CMHC Act (Title III, PL 94-63). There is a deadline for compliance with

such standards, and all existing centers have been planning and initiating the newly required services over the last 18 months. Unless the federal start up funds which are made available through the conversion grant program continue to be appropriated, this entire process will be thrown into chaos. Some centers have obtained state and local assistance for services based upon the assumption of a federal conversion grant and will be grossly overextended if such a grant is not forthcoming.

These new services are also the basis of a comprehensive system of service delivery which CMHCs should provide. For instance, a specialized service for children and for the elderly, and where necessary for alcoholics and drug abusers too, ensures that no population group in the catchment area will be denied CMHC services. Screening of patients being considered for admission to state mental hospitals and follow-up care of all patients released into their community from institutions will enable the centers to greatly improve the currently uncoordinated system of community care.

As with the C&E grant, the conversion grant program requires only limited federal expenditure and has the effect of encouraging and increasing state and local contributions to the CMHC program, as well as third party reimbursements. Conversion grants provide the needed initial funding for start up of services, but the operation of such services is funded through other means. These short-term, generally one year, grants will pay off in greatly improved service delivery and significant changes in the continuity of patient care, and particularly care for those patients leaving institutions who need additional services and assistance to live productive lives in the community.

NCCMHC suggests a full appropriation of the amount authorized for conversion grants (which is expected to be between $22 and $24 million), so that these important services can be initiated and the existing centers will be able to meet the deadline in the legislation and thus not be forced to drop out of the federal system. Thus the drastic reduction in current services which would then result could be avoided.

Distress Grants

CMHCs funded through the 8-year operational grants are expected to continue their programs through alternative funding sources once these grants expire, with the exception of prevention programs funded through the C&E grant. However, under some circumstances CMHCs cannot continue to offer comprehensive services, or in some cases even very modest services, without continued federal aid. Factors which play a large role in whether the center can in fact become self-sufficient are: Medicaid coverage in the state (most CMHC patients have low incomes and cannot pay the full cost of services); number of patients with insurance coverage (some states require group plans to cover mh services, others do not, some populations particularly rural populations, have very low rate of insurance coverage); Medicare reimbursements (generally available in significant amounts only to centers operated by a hospital); state and local government funding (low in poverty areas).

If National Health Insurance coverage for mental health is to be built upon the system approach to care -- an approach which offers the opportunity to control costs and quality of care -- continued operation of the centers now in existence seems essential. The cost of reestablishing such services in the future will be excessive, and certainly far more than the cost of maintaining the current level of services through distress grants.

As of January 1, 1977, 79 centers have ended their eight year support and are eligible to apply for distress funding. A survey by NCCMHC of these centers shows that about half of them will require assistance to maintain the level of services they have previously provided their community. To fund these programs is estimated to require $12 million, an increase of $4 million over the FY 1977 appropriation, and $7 million over the Carter request.

To date, 12 applications have been approved but not funded (requiring $4 million) and a number of centers which received FY 1977 distress funding will require additional funding in FY 1978 ($5 million is required for this purpose, and has been requested in the Carter budget). Thus $3 million would be available for centers applying over the next 18 months.

The NCCMHC survey clearly shows that failing to fund a distress grant application has an immediate effect on services, with cutbacks reported generally in areas where alternative funding is hardest to find: preventive services, outpatient

care, outreach and satelite clinics which make services more accessible. The impact of the phase-out budget proposed by the administration would be significant, with thousands of individuals unable to receive services which were previously available in their community.

Planning

40 applications for planning new CMHC programs are already approved, requiring $2.1 million. NCCMHC proposes an appropriation of $2.5 million to fund these projects which are now designed and ready to be initiated, but does not propose additional planning dollars at this time, pending the Carter administration's review of the CMHC program.

Technical Assistance Funding

PL 94-63 Title III, the CMHC Act Amendments of 1975, authorize the National Institute of Mental Health to utilize up to 2% of appropriated funds for providing technical assistance to CMHCs. One of the intentions behind this provision was to give the existing centers the expertise they need to become efficient operations. Managerial skills and financial accounting systems are poor in a number of these programs, particularly the smaller centers. Unless changes can be made it is unlikely that such centers will be able to continue to operate comprehensive programs once federal funds terminate because of their inability to provide the data needed by third party payors.

In FY 1976 over $4 million could have been used for technical assistance, but only $375.000 was actually spent. In FY 1977, $4.5 million is available, but only about $1 million will be utilized.

Since technical assistance funding comes out of other appropriations it does necessarily result in reductions in other types of funding, and in practical terms this means less money to start new programs since continuation grants cannot be reduced. However, utilizing an additional $3 million for technical assistance could have an immediate and substantial impact on 500-600 existing centers, making a difference in many cases as to how much funding they can collect from various sources as well as assisting them in improving their services to meet the requirements of the new law. This same amount of money, if put into new grants, could provide initial funding to no more than 4 or 5 programs.

NCCMHC believes that at this time, with new requirements for all CMHCs and the increased necessity for these programs to rely on third party payments, the full amount authorized should be used for technical assistance in FY 1978. However, unless the Congress specifically directs the NIMH to utilize these funds it is clear that only a small fraction of the money will be spent and NCCMHC therefore urges the subcommittee to include reference to this issue in its report on the FY 1978 appropriations measure.

The NCCMHC budget proposals are suggested as a means to continue a modest growth in the CMHC program at approximately the same rate as in previous years. The number of new programs which could be initiated is in line with earlier years and is substantially below the number of applications which can be expected to be approved. NCCMHC C&E, conversion and distress funding proposals have been carefully calculated to meet the urgent need for these programs. Planning of new centers is proposed only for those communities already geared up to start such a process. This proposal for FY 1978 funding is designed to be reasonable and attainable, and reflects NCCMHC's recognition of budgetary problems. On the other hand, it also reflects a belief that by funding community mental health center programs the government can have an impact on accessibility and quality of care and on accountability and control of health care costs.

Several studies have documented overall savings in health care costs when mental health services are readily available and the new detailed requirements for federal CMHCs in PL 94-63 ensure accountability and set minimum standards for all programs.

NCCMHC therefore urges the subcommittee to appropriate $323.8 million for CMHCs in FY 1978, as suggested in the NCCMHC proposal on page 2.

NCCMHC is a member of the Coalition for Health Funding, and supports the Coalition's recommended appropriations for FY 1978. However, for CMHC programs the NCCMHC recommendation and the CHF recommendation are slightly different. NCCMHC recommends a total of $323.8 and CHF a total of $305.5. The difference results from differences for continuation awards, consultation and education, conversion, and facilities assistance. In the case of C&E and facility grant funding, the CHF recommendation is higher than the expected authorization, and in the case of conversion the CHF estimate was made on the assumption that no more than $20 million would be authorized whereas in fact between $22 and $24 million will be available.

## STATEMENT OF AGHE

The budget request of the Carter Administration for AoA programs for FY 1978 is favored over the recommendations in the Ford budget; however, it is evident that the Administration's budget request falls short of providing the funds needed to carry out the "declaration of objectives for older Americans" as set out in the Older American's Act of 1965. The inadequacy stems not only from a continuation of the relatively low level of past funding but also from the substantial increases in the cost of services which have occurred in recent years. Given the concerns all organizations in the field of aging as well as informed citizens have for the plight of many older Americans, we hope that Congress in its budget review and study of program needs will make upward adjustments in that budget in those cases where it is clear that the expsense of programs will meet the urgent unmet needs of older persons.

The reinstatement of funds for model projects under Title III is strongly endorsed. The use of funds in model projects serves not only to continue to reveal new and innovative ways to achieve program improvements but provides needed service as well.

As representatives of post secondary educational instructions, we strongly endorse the Administration's proposed higher level of funding for Title IV. The use of these funds for research and training is having a significant impact on programs and is attracting substantial additional resources from educational institutions, private foundations, and individuals to train professionals and paraprofessionals in the field of aging and to carry out both basic and applied research. Activity under Title IV has a four fold effect:

1. Increases public knowledge about the aging.
2. Increases members of qualified professionals, and paraprofessionals and others working in the field of aging.
3. Redirects educational and related resources into the field for training and research about aging.
4. Provides a continuing body of knowledge about aging today and the expectations for tomorrow.

The Older American's Act of 1965, as initially enacted, recognized that the declaration of older Americans, which are specified in Title I of the Act could be met only if significant attention were given to the utilization of

proven research and the training of special personnel to carry out the programs and activities specified in the Act. In the early ammendments to the Act the broad range of educational training and research needs were further delineated by specifying, for example, that comprehensive programs should include education for older citizens who need it; pre-retirement training and continuing education be made available to mature and older people; a national plan be developed for meeting the needs of trained personnel in the field of aging and for training persons to carry out such programs; and studies conducted, commissioned and published.

In the further ammendments to the Act, educational training and research needs have been given greater specificity. In the program areas under the Older American's Act (Title III, VI, VII, and IX) short term training is authorized for purposes of improving the administration of these specific programs. Thus it is evident that the intent of the greater specificity pertaining to short term training is to reserve under Title IV that training needed by professionals and paraprofessionals that will update their knowledge in the field of aging as it relates to their area of professional competence.

We affirm the importance of the precise wording of the Older American's Act as it relates to educational and training needs and strongly support adequate funding for short term training under each of the operating programs to more effectively administer the programs of the Act. The level of funding recommended by the Administration for FY 1978 is an improvement over the earlier recommendation of the Ford Administration, but it is hoped that adjustments will be made to increase these recommended amounts if the hearings and review by Congress indicate that such are warranted.

The expenditure for training under Title IV is 3 1/3% of the total outlays in the Older American's Act, for research, 1 1/2%, for gerontological educational centers less than 1%. Though relatively modest, these programs under the Older American Act stimulate the use of substantial additional funds from state and local government and from private sources that more than match the federal allocation. As such, Title IV programs represent a solid investment in manpower and knowledge to insure the long term effect of all programs for the aged.

## STATEMENT OF ASSOCIATION OF REHABILITATION FACILITIES

Dear Mr. Chairman:

This letter is to detail supportive information regarding appropriations for the Department of Health, Education and Welfare for Fiscal Year 1978. In particular these comments are rendered on behalf of the Association of Rehabilitation Facilities (ARF) regarding appropriations authorized under the "Rehabilitation Act Extension of 1976" (P.L. 94-230) which amends the basic authority the Rehabilitation Act of 1973" (P.L. 93-112). According to Section 11 of P.L. 94-230 entitled "Contingent Extension of Programs" there are specific authorized appropriations detailed for certain sections of the Act, and others which specify "such sums" authorizations. This contingent extension of rehabilitation programs will take effect "Unless the Congress, before April 15, 1977, has passed legislation which would have the effect of extending the authorization of each program and activity the authorization for which is extended through the fiscal year ending September 30, 1977".

Since it is apparent that no such new authorizing legislation is likely and that the contingent extension will be in force, we would like to offer our comments and suggestions at this time. ARF offers these comments as an organization representing more than 1,000 rehabilitation facilities which provides rehabilitation services to more than 300,000 individuals annually. Rehabilitation facilities and workshops are an essential partner with the state - Federal Rehabilitation Program providing rehabilitation services to more than 224,000 state VR clients in FY 1975 (20% of those served). In the same fiscal year some $137 million VR case service funds were expended in rehabilitation facilities and workshops (30% of case service funds expended).

Our comments relate to the dollar needs for appropriations for the three basic authorities contained in provision of the Rehabilitation Act which include:

- Title I - Vocational Rehabilitation Services (Basic State Grants and Innovation & Expansion Grants)
- Title II - Research and Training
- Title III - Special Federal Responsibilities (rehabilitation facility construction, vocational training services, and special projects including technical assistance and projects with industry)

In order to ensure a balanced program of rehabilitation we urge your committee to favorably consider the following recommendations:

### FISCAL YEAR 1978
### TITLE I APPROPRIATIONS

We are supportive of fully funding basic services under the authorized appropriations at the level of $760, and we encourage the maximal utilization of these funds to support rehabilitation case services for the severely disabled. It is our understanding that this level is consistent with the ability of the states to provide the 20% matching as specified under Section 110 of the Act. Although, this appropriation level is as authorized under the Rehabilitation Act, it should be recognized that due to the limitations of state matching monies that the current overall funding authority is sufficient only to maintain current service levels. The proposed level will not allow for additional expansion of services to those individuals requiring rehabilitation services. In addition we recommend the appropriation of $25 million for the Innovation and Expansion Program authorized under Section 120 of the Act; this level is consistent with the authorized appropriation level. We are strongly in favor of a maintenance of effort in this program since, it provides an exceptional mechanism for expanding services to the severely disabled through provision of a more favorable matching ratio.

### TITLE II APPROPRIATIONS

We would recommend that the sum of $35 million be appropriated for the training of rehabilitation personnel under Section 203. The authorized level per the contingent extension is $30 million plus "such additional sums as Congress may determine to be necessary". Because of the need to expand the training and education of those serving the severely disabled it is essential that this level of funding be appropriated. The need for the training and education of rehabilitation facility personnel is particularly acute, since many handicapped individuals served by the basic program can only be served and benefit from the comprehensive rehabilitation services afforded by rehabilitation facilities. It is further recommended that appropriations of no less than $5 million

be earmarked in a line item appropriation for the training of rehabilitation facility personnel. During the past ten years the average expenditure for the training of workshop and facility administrators and vocational evaluators within this training category has averaged $1.5 million per year. This is approximately 4% of overall training expenditures, while rehabilitation facilities are now serving one out of every five VR clients served by the program. The suggested earmark would assure a level of manpower training consistent with the level of service and importance of rehabilitation facilities to the state-Federal Rehabilitation Program.

## TITLE III APPROPRIATIONS

During the past five years there has been decremental funding of rehabilitation facility funding under various authorities of this title. The following recommended levels are consistent with the recommendations of H.E.W. in connection with the H.E.W. Sheltered Workshop Study and the Comprehensive Needs Study which detail the need for expanded and improved rehabilitation facilities services. The following recommendations are based upon actual need (see attached) survey substantiation of funding needs). Although developed for FY 1976, the needs levels are still valid since appropriations to meet these needs were not forthcoming during FY 1976 and 1977. Consistent with the current administrations strategy to stimulate the economy in part through public works and construction programs, the recommended levels in this currently authorized program would be supportive of the approach. Since the Title III construction program for rehabilitation facilities entails rather elaborate planning processes this ensures construction of only those facilities for which there is documented current need. The long-term value of such projects is certainly greater than the "quick start" projects currently being funded under Title I of the "Public Works Employment Act of 1976". The full funding of the following projects would provide immediate assistance to agencies providing essential and needed public services particulary to meet reconstruction and renovation standards mandated by law. Our recommendations for FY 1978 are as follows:

| PROGRAM | SECTION | RECOMMENDED APPROPRIATION LEVEL (in millions) |
|---|---|---|
| Construction | 301(b) | $60 |
| Initial Staffing | 301(c) | $15 |
| Project Planning | 301(d) | $ 3 |
| Vocational Training Services/Facility Improvement | 302(b)(c) | $28 |
| Special Projects | | |
| Projects With Industry | 304(d) | $ 5 |
| Technical Assistance | 304(e) | $ 2 |

The need for full funding of the proposed appropriations is even more critical in these categories, since during the FY 1976 Transition Quarter the Office of Human Development reprogrammed $5.2 million which would have been devoted to some of these programs.

In conclusion we would like to express our appreciation for your past efforts, and we would encourage further vigorous advocacy by your committee for appropriations affecting the handicapped citizens of this nation. It is our hope that the recommendation detailed in this letter will be carefully considered in your deliberations. Furthermore, it is our sincere hope that it will be recognized that a vigorous and viable rehabilitation facility program is essential to the overall Rehabilitation Program. If our Association can provide any further support or information we would be delighted to do so.

Very truly yours,

T. P. Hipkens

T.P. Hipkens
Director

by CSR

APPENDIX

ESTIMATES OF REHABILITATION FACILITY
CONSTRUCTION/FACILITY IMPROVEMENT
FUNDING REQUIREMENTS

I. Facilities Specialist Survey - In June 1975, ARF conducted a comprehensive survey of 53 general state VR agencies and 19 blind agencies; a total of 43 state agencies replied to this survey and indicated the following needs:

| | # Projects | $ Req. |
|---|---|---|
| CONSTRUCTION (new) | 102 | $ 44,431,000 |
| FACILITY IMPROVEMENT (renovation & expansion) | 224 | $ 16,950,845 |
| TOTAL | 326 | $ 61,381,845 |

These figures represent the construction or facility improvement needs of primarily vocational facilities and does not include medically or psychosocially oriented facilities. They represent actual projects which should be funded in the near term.

| | $ Req. |
|---|---|
| A. Medically Oriented Facilities | |
| CONSTRUCTION (new) | $ 33,032,000 |
| EXPANSION & RENOVATION | $ 10,156,000 |
| SUB-TOTAL (Med) | $ 43,188,000 |
| B. Vocationally Oriented Facilities | |
| CONSTRUCTION (new) | $ 27,649,000 |
| EXPANSION & RENOVATION | $ 68,188,000 |
| SUB-TOTAL (Voc) | $ 95,837,000 |
| TOTALS (Med. & Voc.) | $139,025,000 |

Since this represents a measurement of an estimate of no more than 10% of the some 3,000 medical and vocational rehabilitation facilities in the U.S., it represents a conservative estimate of need.

INTERNATIONAL ASSOCIATION
of
REHABILITATION FACILITIES

FACILITIES OPERATIONS
SURVEY
F.Y. 1976

SUMMARY

IARF conducted a survey of its institutional membership in March 1975. The purpose of this survey was to provide basic operational data to support requests for additional appropriations and legislation for rehabilitation facility operations. A total of 333 completed surveys were returned to the IARF office; this represents a 50% response rate from a potential return of 666 - IARF institutional members surveyed.

Of particular interest is financial information regarding the capital expenditures required by facilities during the coming fiscal year. The following is a summary of total capital needs of the responding facilities.

| Medical & Comprehensive Facilities (Med. Component) | $ Requirements |
|---|---|
| Capital expenditures over next year | $25,976,000 |
| Capital expenditures over next two years | |
| Expansion & Renovation | $12,501,000 |
| New Construction | 33,032,000 |
| Equipment & Materials | 10,156,000 |
| Total | $55,689,000 |

| Vocational, Psycho-Social & Comprehensive Facilities (Voc. Component) | $ Requirements |
|---|---|
| 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 |

These capital needs are reflective of the requirement for additional operating funds which cannot be met through traditional sources of fees, donations and local community funding. They represent the urgent requirement for upgrading, expansion and development of services to handicapped individuals.

With regard to utilization and client capacity, the following data was obtained from respondents:

| Medical & Comprehensive Facilities (Med. Component) | # Clients |
|---|---|
| Total client capacity | |
| Outpatient | 55,135 |
| Inpatient | 12,133 |
| Total Capacity | 67,268 |
| Total clients referred but waiting service | |
| Outpatient | 728 |
| Inpatient | 843 |
| Total Waiting Service | 1,571 |

The ratio of inpatient capacity to those awaiting service indicates the need for a 12% increase in service capacity.

| Vocational, Psycho-Social & Comprehensive (Voc. Component) | # Clients |
|---|---|
| Total client capacity | 52,291 |
| Total waiting service | 6,255 |

The ratio of total client capacity to those referred but awaiting service indicates the need for an overall 12% increase in service capacity. A total of 172,860 clients are serviced annually and on a nationwide basis. These facilities report an 85% 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 accomodate 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 Acut during F.Y. 1976.

| Medical & Comprehensive Facilities (Med. Component) | # Facility | % |
|---|---|---|
| Could utilize mortgage insurance | 7 | (10) |
| Could not utilize mortgage insurance | 62 | (90) |
| Totals | 69 | (100) |
| Total mortgage amount to be insured | $ 5,757,000 | |

| Vocational, Psycho-Social & Comprehensive (Voc. Component) | # Facility | % |
|---|---|---|
| Could utilize mortgage insurance | 103 | (41) |
| Could not utilize mortgage insurance | 146 | (59) |
| Totals | 249 | (100) |
| Total mortgage amount to be insured | $40,054,000 | |

Vocational facilities were asked about their utilization of the S.B.A. Handicapped Assistance Loan (HAL) Program during F.Y. 1975. The following is a summary:

Vocational Facilities Applying For S.B.A. Loans

| | # Applied | # Approved | Total $ Amount |
|---|---|---|---|
| Direct Loans | 19 | 8 | $ 754,000 |
| Immediate Participation Loans | 7 | 5 | 1,246,000 |
| Guaranteed Loans | 3 | 0 | - 0 - |
| Totals | 29 | 13 | $2,000,000 |

Some 11.4% of the 228 responding vocational facilities eligible to participate under this program made application to S.B.A.

Revised June 5, 1975

Association
of
Rehabilitation Facilities

SURVEY OF STATE FUNDING NEEDS
REHABILITATION FACILITIES
F.Y. 1976

IARF conducted a survey through the auspices of its Facilities Specialist Division in order to determine Federal Fund requirements for rehabilitation facilities. Facilities supervisors and specialists in each State Vocational Rehabilitation were contacted and requested to complete a survey inventory based upon estimates or projections for each of seven special project grant programs. These grant programs are authorized under "Title III - Special Federal Responsibilities" of the Rehabilitation Act of 1973 (P.L. 93-112). Respondents were requested to base requirement estimates upon the assumption that additional appropriations would be available to meet these needs and not upon current funding levels.

A total of fourty-three (43) State V.R. Agencies responded. Following are the total number of grants and annual dollar requirements in each project area. Please note that this represents a projected estimate of the funding requirements during F.Y. 1976 for 43 agencies of the 53 general and 19 blind agencies surveyed.

| | | # Grants | Annual $ Requirement |
|---|---|---|---|
| I. | Projects with Industry (Section 304(d) ) | 58 | $ 9,521,600 |
| II. | Projects for Vocational Training Services (Section 302(b) ) | 68 | $ 3,985,100 |
| III. | Project Development Grants (Section 301(d) ) | 115 | $ 3,985,100 |
| IV. | Construction Grants (Section 301(b) ) | 102 | $44,431,000 |
| V. | Initial Staffing Grants (Section 301(c) ) | 110 | $13,744,116 |
| VI. | Facility Improvement Grants (Section 302(c) ) | 224 | $16,950,845 |
| VII | Technical Assistance (Section 304(e) ) | 278 | $ 1,606,500 |
| | TOTALS | 955 | $97,451.161 |

The appended attachment is a summary of responses from each state returning a completed survey.

IARF DIVISION OF FACILITIES SPECIALISTS

SURVEY OF STATE NEEDS
ANNUAL SCHEDULE OF FEDERAL FUND REQUIREMENTS
REHABILITATION FACILITIES - F.Y. 1976

| State | Projects with Industry | | Proj. for Voc. Training Serv. | | Project Dev. Grants | | Construction Grants | | Initial Staffing Grants | | Facility Improv. Grants | | Technical Assistance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # Gr. | Annual $ Requirement | # Gr. | Annual Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement |
| N. Carolina (Blind | — | - 0 - | — | - 0 - | — | - 0 - | 2 | 1,890,000 | 2 | 159,000 | — | - 0 - | 4 | 3,200 |
| N. Dakota | — | - 0 - | — | - 0 - | 2 | 34,600 | 4 | 955,000 | 9 | 439,000 | 5 | 455,845 | 1 | 1,500 |
| Ohio | 5 | 500,000 | 6 | 900,000 | 2 | 60,000 | — | - 0 - | — | - 0 - | 2 | 180,000 | 15 | 7,500 |
| Oklahoma | — | - 0 - | — | - 0 - | 3 | 6,000 | 2 | 475,000 | 2 | 50,000 | 7 | 230,000 | 6 | 3,000 |
| Oregon | — | - 0 - | 2 | 500,000 | 3 | 100,000 | 3 | 500,000 | 4 | 400,000 | 10 | 500,000 | 5 | 2,000 |
| Pennsylvania | — | - 0 - | 5 | 1,000,000 | 10 | 500,000 | 3 | 1,000,000 | 5 | 400,000 | 10 | 800,000 | 10 | 4,000 |
| Puerto Rico | — | 1,000,000 | — | 1,000,000 | — | - 0 - | — | - 0 - | — | 2,400,000 | — | - 0 - | — | 500,000 |
| Rhode Isl. | — | - 0 - | — | - 0 - | 3 | 15,000 | 1 | 425,000 | 6 | 125,000 | 2 | 250,000 | 10 | 18,000 |
| S. Carolina | 1 | 100,000 | 3 | 300,000 | 4 | 200,000 | 1 | 2,000,000 | 3 | 225,000 | 1 | 100,000 | 4 | 20,000 |
| S. Dakota | — | - 0 - | — | - 0 - | — | - 0 - | 1 | 320,000 | — | - 0 - | — | - 0 - | 8 | 6,000 |
| Tennessee | — | - 0 - | — | 2,000 | — | 100,000 | — | 50,000 | — | - 0 - | — | 25,000 | — | 1,000 |
| Texas | 12 | 2,100,000 | 3 | 510,000 | 6 | 150,000 | 10 | 4,500,000 | 8 | 600,000 | 70 | 7,000,000 | 15 | 10,500 |
| Texas (Blind) | — | - 0 - | 1 | 120,000 | — | - 0 - | 2 | 175,000 | 3 | 75,000 | 1 | 10,000 | 10 | 5,000 |
| Utah | 1 | 50,000 | — | - 0 - | 1 | 80,000 | 4 | 1,000,000 | 2 | 50,000 | 12 | 1,000,000 | 6 | 6,000 |
| Virginia | 1 | 100,000 | 2 | 200,000 | 5 | 7,500 | 5 | 500,000 | 5 | 175,000 | 5 | - 0 - | 10 | 5,000 |
| Virginia (Blind) | — | - 0 - | 1 | 2,000 | 1 | 20,000 | — | - 0 - | — | - 0 - | 1 | 30,000 | — | - 0 - |
| Washington (Blind) | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - |
| W. Virginia | — | - 0 - | 4 | 300,000 | 6 | 48,000 | 6 | 1,000,000 | 8 | 600,000 | — | - 0 - | 12 | 800,000 |
| Wyoming | 1 | 50,000 | 1 | 50,000 | 2 | 100,000 | 1 | 200,000 | 1 | 50,000 | 1 | 100,000 | 4 | 3,000 |
| TOTAL | 58 | 7,212,000 | 68 | 9,521,600 | 115 | 3,985,100 | 102 | 44,431,000 | 110 | 13,744,116 | 224 | 16,950,845 | 278 | 1,606,500 |

ARF DIVISION OF FACILITIES SPECIALISTS

SURVEY OF STATE NEEDS
ANNUAL SCHEDULE OF FEDERAL FUND REQUIREMENTS
REHABILITATION FACILITIES - F.Y. 1976

| State | Projects with Industry | | Proj. for Voc. Training Serv. | | Project Dev. Grants | | Construction Grants | | Initial Staffing Grants | | Facility Improv. Grants | | Technical Assistance | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement | # Gr. | Annual $ Requirement |
| Alabama | — | - 0 - | 2 | - 0 - | 2 | 50,000 | 3 | 4,000,000 | 2 | 300,000 | 3 | 75,000 | 6 | 6,000 |
| Arizona | 5 | 100,000 | 3 | 300,000 | 2 | 50,000 | 10 | 1,000,000 | 10 | 1,000,000 | 5 | 250,000 | 10 | 10,000 |
| Arkansas | — | 30,000 | — | 300,000 | — | 25,000 | — | 1,000,000 | — | 30,000 | — | 100,000 | — | 5,000 |
| California | 6 | 500,000 | 8 | 1,000,000 | 15 | 75,000 | — | - 0 - | — | - 0 - | 6 | 600,000 | — | 20,000 |
| Connecticut | 1 | 80,000 | 1 | 120,000 | 2 | 100,000 | — | - 0 - | 2 | 100,000 | 4 | 120,000 | 8 | 4,000 |
| Delaware (Blind) | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | 50,000 | — | - 0 - |
| Florida | 6 | 600,000 | 4 | 500,000 | 3 | 15,000 | 2 | 1,500,000 | 2 | 200,000 | 19 | 1,000,000 | 20 | 12,000 |
| Georgia | 1 | 20,000 | 1 | 300,000 | 3 | 27,000 | 2 | 750,000 | 2 | 175,616 | 4 | 275,000 | 5 | 6,500 |
| Guam | — | - 0 - | 1 | 50,000 | 1 | 25,000 | 1 | 200,000 | 1 | 40,000 | 1 | 30,000 | 1 | 5,000 |
| Hawaii | 3 | 182,000 | 1 | 50,000 | 4 | 60,000 | 4 | 2,150,000 | 4 | 58,500 | 10 | 385,000 | 15 | 12,000 |
| Idaho | — | - 0 - | 2 | 200,000 | 3 | 750,000 | 3 | 1,200,000 | 3 | 300,000 | 4 | 500,000 | 4 | 8,000 |
| Iowa | 3 | 75,000 | 1 | 125,000 | 15 | 150,000 | 10 | 1,250,000 | 10 | 200,000 | 15 | 300,000 | 10 | 10,000 |
| Kansas | — | - 0 - | 1 | 65,000 | — | - 0 - | 1 | 200,000 | — | - 0 - | — | - 0 - | 10 | 5,000 |
| Louisiana | 2 | 100,000 | 3 | 300,000 | 5 | 50,000 | 7 | 2,500,000 | 4 | 150,000 | 15 | 1,000,000 | 12 | 12,000 |
| Maine | 2 | 80,000 | 1 | 40,000 | 2 | 10,000 | 1 | 1,000,000 | 1 | 90,000 | 3 | 120,000 | 5 | 4,000 |
| Maryland | 3 | 250,000 | 2 | 270,000 | 4 | 32,000 | 4 | 400,000 | 8 | 480,000 | — | - 0 - | 15 | 7,500 |
| Minnesota | — | - 0 - | 1 | 125,000 | 2 | 30,000 | 5 | 1,250,000 | 2 | 100,000 | 3 | 250,000 | 10 | 5,000 |
| Missouri | — | 250,000 | — | 450,000 | — | 25,000 | — | - 0 - | — | 750,000 | — | 100,000 | — | 50,000 |
| Missouri (Blind) | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | — | - 0 - | 2 | 600 |
| Montana | 1 | 25,000 | — | - 0 - | — | - 0 - | 2 | 500,000 | — | - 0 - | 1 | 80,000 | 8 | 2,000 |
| Nebraska | 2 | 100,000 | 1 | 160,000 | 1 | 75,000 | — | - 0 - | — | - 0 - | 3 | 200 | 15 | 7,500 |
| Nevada | — | 900,000 | — | 50,000 | — | 1,000,000 | — | 10,000,000 | — | 4,000,000 | — | 1,000,000 | — | 10,000 |
| New Hamp. | 2 | 20,000 | 7 | 232,600 | 3 | 15,000 | 1 | 41,000 | 1 | 22,000 | — | - 0 - | — | 7,500 |
| N.J. (Blind) | — | - 0 - | — | - 0 - | — | - 0 - | 1 | 500,000 | — | - 0 - | 1 | 35,000 | 2 | 1,200 |
| SOS TOTAL | 37 | 3,312,000 | 40 | 4,637,600 | 67 | 2,564,000 | 57 | 29,441,000 | 52 | 7,996,116 | 97 | 6,270,000 | 158 | 210,800 |

## STATEMENT OF DR. RICHARD D. REMINGTON, PRESIDENT, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Mr. Chairman and Members of the Committee:

I am Dr. Richard D. Remington, President of the Association of Schools of Public Health, and Dean, School of Public Health, University of Michigan. As President of the Association, I am speaking for the Nation's 19 accredited Schools of Public Health, the names and addresses of which have been appended to this Statement as "Attachment I."

We greatly appreciate this opportunity to appear before the Committee to express our view concerning the Labor-Health, Education, and Welfare appropriation for Fiscal Year 1978, as it applies to the Nation's Schools of Public Health.

In our Statement we address the priorities, directions, and funding levels which we believe are desirable at this stage of the Nation's public health manpower training efforts, and we suggest specific dollar amounts for moving the programs forward. These appropriation recommendations are summarized in Table I, together with relevant comparative data.

### CAPITATION GRANTS

The Association of Schools of Public Health recommends that 100% of the authorized $9.74 millions be appropriated for Fiscal Year 1978 funding of Capitation Grants assistance. This recommendation is based upon §770 required increases in enrollment, as well as upon anticipated additions to the total number of Schools of Public Health now accredited.

These Capitation Grant funds will be used to support tenured faculty, teaching assistants, and administrative activities, just as did the old Formula Grants authorized by §313 (c) of the Public Health Service Act. They provide stability for the basic educational core program areas, including chronic disease epidemiology (e.g., cancer and heart disease), biostatistics, health-care administration, and environmental and occupational health.

Critical Need for Full Capitation-Grant Funding

As the Committee is, no doubt, aware, basic support for the schools of health is now made available through this Capitation Grant funding mechanism. This year, funding for the schools of public health is especially critical, because of the new legal requirements under §770 and, also, because of the uncertainty of continued financial support which existed in the recent past.

Among the present Schools of Public Health, our contacts with the Deans reveal that many of them would be severely adversely affected by appropriations cutbacks. Indeed, some may well be forced to cease operations of their Schools of Public Health entirely under the Administration's request. The majority of the remaining schools are in a situation similar to that at the University of Michigan, where level funding over a period of years has forced reduction of faculty size approximately 30% and continuing budgetary factors are signaling the possibility of departmental closure, unless at least some adjustment for the erosion effects of inflation is provided.

Despite the above adverse funding condition that is already affecting the public health manpower training mission so inexorably, the new Manpower Act requires that school enrollments must increase to meet the conditions for capitation funding. In fact, it was upon the anticipated need for these additional students to carry out the Public Health Service Act programs, as amended, that the authorization, itself, was based. If the Administration's request becomes appropriation fact for Fiscal Year 1978, then the Federal Government will have fostered National health program initiatives without providing the necessary financial resources to competently train health manpower personnel to carry them out.

STUDENT TRAINEESHIPS

The Association of Schools of Public Health recommends that $7.5 millions be appropriated for Fiscal Year 1978 funding of Student Traineeships authorized by §748 (replacing §312 of the

Public Health Service Act). This recommendation is based upon present enrollments and statutorily mandated enrollment increases, as well as upon a statutorily mandated shift to older, more experienced (and more expensive to educate) students. The wisdom of financially implementing the acquisition of new knowledge by professionals who have community health at the top of their professional goals is also a factor.

The appropriation of the $7.5 millions would be of great long-time value to the Nation. It is a fact that graduates of the Schools of Public Health overwhelmingly enter public service. A recent Bureau of Health Manpower study showing over 95% of them in public service positions distinguishes Schools of Public Health from all other health professional schools in this regard. This is even more interesting when attention is paid to the fact that colleagues in private medical or legal practice receive a great deal more income than do these public servants.

In regard to new law, the Student Traineeships funds will be absolutely essential for carrying out the requirement for training older, more experienced students. This category of students ordinarily has financial burdens outside of the usual academic expenses. Furthermore, because the potential incomes in the public health sector are small relative to the potential in private medical or similar practice, it is both unwise and unfair (especially considering the older student's work experiences and prior educational achievement) to expect them to heavily mortgage this lowered income, after already having made a not-so-common decision to relinquish future high earnings in favor of serving this Nation's public health need. (This point is emphasized by survey data which indicates that 69% of all responding graduates (2,016) would not have attended a School of Public Health had it been necessary to rely upon personal or family resources or upon loans.)

It is the obvious truth that money spent on these Student Traineeships will be paying this Nation health benefits in the general

population for many, many years to come. In fact, it is not inconceivable that the recommended appropriation level will be crucial to this portion of the National health mission.

PROJECT GRANTS

The Association of Schools of Public Health recommends that $5.0 millions be appropriated for Fiscal Year 1978 funding of Project Grants authorized by §792 of the Public Health Service Act. This recommendation parallels the request of the President.

The new Act authorizes Project Grants for accredited Schools of Public Health in the same areas targeted for emphasis by Student Traineeships; viz., biostatistics or epidemiology; health administration or policy analysis and planning; environmental health or occupational health; dietetics or nutrition. The purpose that underlies these Project Grant funds is to furnish a means to expand existing programs or to start new ones. The grants are intended to aid both accredited Schools of Public Health and accredited graduate programs in health administration.

In the past these Project Grants have been decisive in bringing health benefits to all Americans. The Association of Schools of Public Health is certain that these Project Grants will continue to be a vital source of institutional support for the Schools of Public Health.

CONCLUSION

Funding for Schools of Public Health has always received strong support from members of the Congress, and the continuing support of the Congress is very encouraging to health professionals with concerns in this area. Inasmuch as members of both the authorizing Committee and the appropriations Committee have been among those supporting stronger efforts in provision of public health manpower for the Nation's health programs, the Association of Schools of Public Health wants this Committee to know that we have carefully considered our recommendations in light of the need for overall Federal fiscal restraint and the counterpoised need for better health care in the future of this country.

Thank you for the opportunity of being able to submit our views on this important subject.

ATTACHMENT I

ACCREDITED SCHOOLS OF PUBLIC HEALTH AND DEANS

REVISED: APRIL 1, 1977

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-Berkeley

Dr. Stewart H. Madin
Acting Dean
School of Public Health
19 Earl Warren Hall
Berkeley, California 94720
415/642-2523

University of California-Los Angeles

Dr. Virginia Clark
Acting Dean
School of Public Health
Center for the Health Sciences
Los Angeles, California 90024
213/825-6381

Columbia University

Dr. John Bryant, Director
School of Public Health
600 West 168th Street
New York, New York 10032
212/694-3929

Harvard University

Dean Howard Hiatt
School of Public Health
665 Huntington Avenue
Boston, Massachusetts 02115
617/732-1025

University of Hawaii

Dean Jerrold Michael
School of Public Health
1960 East-West Road
Honolulu, Hawaii 96822
808/948-8491

University of Illinois

Dr. Alan W. Donaldson
Acting Dean
School of Public Health at
the Medical Center
P. O. Box 6998
Chicago, Illinois 60680
312/996-6620

The Johns Hopkins University

Dean Donald A. Henderson
School of Hygiene and Public Health
615 North Wolfe Street
Baltimore, Maryland 21205
301/955-3540

University of Loma Linda

Dean Mervyn G. Hardinge
School of Public Health
Loma Linda, California 92354
714/796-7311 (Ext. 3711)

University of Massachusetts

Dr. William A. Darity
Dean, School of Health Sciences
Arnold House
Amherst, Massachusetts 01003

University of Michigan

Dean Richard D. Remington
School of Public Health
Ann Arbor, Michigan 48104
313/763-5454

University of Minnesota

Dean Lee D. Stauffer
School of Public Health
1360 Mayo Memorial Building (Box 197)
412 Union Street, S. E.
Minneapolis, Minnesota 55455
612/373-8065

University of North Carolina

Dean Bernard G. Greenberg
School of Public Health
Chapel Hill, North Carolina 27514
919/966-1113

University of Oklahoma

Dean Philip E. Smith
College of Health
624 Northease 15th Street
Oklahoma City, Iklahoma 73190
405/271-4688

University of Pittsburgh

Dean Herschel E. Griffin
Graduate School of Public Health
111 Parran Hall
Pittsburgh, Pennsylvania 15261
412/624-3000

University of Puerto Rico

Dean Jose M. Saldana
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Medical Sciences Campus
San Juan, Puerto Rico 00936
809/765-3991

University of Texas

Dean Reuel A. Stallones
School of Public Health
Health Science Center at Houston
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Tulane University

Dean James E. Banta
School of Public Health
and Tropical Medicine
1430 Tulane Avenue
New Orleans, Louisiana 70112
504/588-5397

University of Washington

Dr. William Richardson
Acting Dean
School of Public Health
and Community Medicine, SC-30
Seattle, Washington 98195
206/543-1144

Yale University

Dr. Robert McCollum
Department of Epidemiology
and Public Health
School of Medicine
60 College Street
New Haven, Connecticut 06510
203/436-3280

TABLE I. SUMMARY RECOMMENDATIONS
(in millions)

| | | 1978 Recommended Appropriations | | | |
|---|---|---|---|---|---|
| | Actual Approp'ns (1975 & '76) | Continuing Resolution Level 1/ | 1978 Author-ization | President's Request | Association of Schools of Public Health |
| Formula Grants (§313 (c)) | $ 5.9 | $ ? | lapsed | n/a | n/a |
| Capitation (§770) | * | * | $ 9.74 | $ 0 | $ 9.74 |
| P.H. Proj. Grants (§313 (a)) | $ 5.5 | $ ? | lapsed | n/a | n/a |
| Project S P H (§792) | * | * | $ 5.0 | $ 5.0 | $ 5.0 |
| P.H. Traineeships (§312) | $ 9.12 | $ ? | lapsed | n/a | n/a |
| Traineeships S P H (§748) | * | * | $ 7.5 | $ 0 | $ 7.5 |
| TOTAL | $ 20.52 | $ ? | $22.24 | $ 5.0 | $ 22.24 |

* Indicates "no statutory authorization."

1/ As of April 4, 1977, final funding levels have not been determined on FY 77 Supplemental Appropriation for Labor-HEW.

## STATEMENT OF DR. RAYMOND B. HOXENG, DIRECTOR OF DEVELOPMENT AND PUBLIC RELATIONS, ARKANSAS CHILDREN'S HOSPITAL

Mr. Chairman, my remarks today concern the Arkansas Children's Hospital, which is of vital importance in providing health care to children of Arkansas, and which is presently experiencing a crisis which threatens the quality of children's health services in Arkansas. It is my hope that a solution may be initiated for the problems which endanger this institution, and, with the assistance of all concerned, enable it to continue its good works.

The Arkansas Children's Hospital is located in Little Rock, Arkansas. For the last six years it has experienced growth in both inpatient admissions and outpatients visits unprecedented among pediatric health care institutions in the United States. During this period inpatient admissions have increased by 250 percent and outpatient visits by 900 percent and census statistics indicate this growth rate will continue into the future.

This dramatic growth of patient services is further illustrated by the following statistics:

| | 1971 | 1976 |
|---|---|---|
| Inpatient admissions | 1,540 | 3,752 |
| Outpatient visits | 6,885 | 51,930 |

The Hospital's present 93-bed capacity lacks about 50 percent of the space required to handle the present patient load.

This tremendous increase in patient services has severely taxed the Hospital's present facilities. Its administrators have accordingly initiated efforts to determine what the Hospital must do to accommodate the present influx of patients and also provide for future growth. A master plan is being developed to predict expansion needs through the year 2000, with initial studies in various stages of completion.

These initial studies have revealed the need for an immediate expansion of the Hospital's capacity. The Hospital has therefore commissioned an architectural firm to develop detailed plans and cost projections. Preliminary plans have been completed, and land purchased to accommodate the expansion. The first phase of this expansion will expand capacity from 93 to 160 beds, and from 72,000 to 212,000 square feet of gross area. New facilities will include a modern Level III nursery, to be the first in Arkansas, which can be used as a referral nursery for all other hospitals in the State. Surgical

suites will be expanded to accommodate modern surgical and diagnostic techniques. Outpatient facilities, presently containing approximately 30 clinics which are severely overtaxed, will also be expanded.

Preliminary cost estimates indicate that the first phase of the expansion program will require $10,000,000 to $15,000,000, including renovation of the present facility which will be incorporated as an integral part of the expanded hospital. The time schedule for finalizing all approvals and completing construction indicates that this first phase expansion could be ready for occupancy by 1981.

The Hospital, however, is currently inundated by more patients than it can safely handle, notwithstanding its expansion plans. It has been forced to make immediate efforts to meet the pressures of currently expanding patient loads. For example, a building has been renovated on the land purchased by the Hospital to accommodate 8,000 square feet of new outpatient clinic space. The $750,000 cost of this renovated facility and adjacent property was underwritten by the Hospital. In addition, a four-bed expansion of intensive care facilities was completed in March, 1977.

These efforts, however, continue to fall short. To accommodate the continual increase in patient load until the first phase of expansion is completed in 1981, several interim improvements must be made to avoid serious deficiencies in patient care. Improvements in facilities must be made in such areas as respiratory therapy, radiology, and cardiology. The intensive care nursery must be expanded and other changes made to expand the medical library and provide offices for additional medical staff. This modification of the existing facility, purchase of new equipment, and acquisition of temporary space for expanded services will cost at least $1,000,000. Such improvements are absolutely essential for an orderly transition to the expanded facilities as they are constructed, as the current demands on the Hospital's facilities threaten to swamp existing programs.

The Hospital has initiated construction of those interim improvements which it has been able to finance by borrowing. It can only do so, however, with improvements which create additional revenue to offset amortization costs. Unfortunately, few of the interim improvements which must be made can be financed in this manner. The Hospital is doing everything in its power to obtain funds to finance the rest of these improvements which it must have.

Mr. Chairman, the position occupied by the Children's Hospital in Arkansas is unique. Indeed, its dominant position in providing children's health services for a majority of Arkansans is approached by the patient reach of only a few hospitals in the entire country. It has been the pioneer agency in providing health services to Arkansas children since 1912. Over the years, despite a continuous plague of financial problems, the Hospital has steadily increased the quality, type, and amount of services it provides. At the present, it provides the majority of medical care for critically ill children from the entire State of Arkansas.

It has developed close relationships with many Arkansas medical education institutes, and through such relationships, has become a center for pediatric education and research. The Hospital has further utilized the expertise and personnel of these institutions over the past few years to expand its services into new areas, such as rheumatology, pulmonology, and pediatric hematology.

The Hospital's unique status is further enhanced by the characteristics of the patients it serves. Consistent with the Hospital's philosophy of turning away no child needing medical care, regardless of financial status, religious preference or ethnic background, the Hospital's patients represent all social and economic levels of the residents of Arkansas. Its patients are the children of the State of Arkansas from their birth until twenty-one years. In recent years every one of the 75 counties of Arkansas have sent patients to the Hospital.

Historically, the Hospital has maintained broad support from all sections of Arkansas. The Arkansas State Legislature has provided annual support, starting with $3,000 in 1929, to help offset the cost of non-reimbursed care. This support has grown steadily as needs have increased. For example, during the last six years, the cost of non-reimbursed care increased from $162,000 to $760,000, and state support increased from $37,000 to $350,000 per year for the 1977-79 biennium. In addition, the Arkansas State Legislature recently approved a one-time capital construction grant for urgently needed renovation of the Hospital's radiology department.

Arkansas' County Quorum Courts have also recognized the statewide scope of the services provided by the Arkansas Children's Hospital. Approximately

50 of the 75 Arkansas counties have been making annual appropriations to the Hospital for almost four decades.

In addition, the Hospital draws upon a broad base of individual support across Arkansas. A yearly mail solicitation yields contributions from 45,000 individuals and corporations. The Hospital has also been the recipient of endowments from individual Arkansans.

As the Hospital anticipates the financing of a major expansion, all possible sources of support are being investigated. In addition to the sources I have mentioned above, the Hospital is coordinating its efforts with the Central Arkansas Health Systems Agency. An application for a Certificate of Need for the proposed expansion is being prepared following a pre-application review meeting with HSA officials. This application should be processed through the Arkansas HSA Facility Review Committee and the Arkansas HSA Board by June, 1977. The Hospital's administration further intends to pursue all avenues of inquiry open to it under HSA regulations.

In addition, the Hospital hopes to raise at least 50% of the $10,000,000 to $15,000,000 expansion cost from state, local, and private donors. A $3,000,000 to $4,000,000 public fund-raising campaign is intended, and the Hospital expects to derive at least matching funds from state and local governments.

Mr. Chairman, it is my hope the information I have provided illustrates the unfortunate circumstances experienced by the Arkansas Children's Hospital. The demand for the Hospital's services has grown at a faster ratio in the last six years than any other similar institution in the United States. The Hospital must expand or be overwhelmed. Its administrators have recognized this, and are expanding as fast as they can.

Mr. Chairman, the Hospital can develop expansion plans to carry it through the long run. It is in the process of doing so. It is the immediate future of the Hospital, however, which poses the greatest threat. These astounding growth rates in demand for patient services which could not be predicted have strained the Hospital's facilities to the utmost. As I have stated, the Hospital has done what it can by borrowing to finance immediate improvements. It is, however, at the limits of its borrowing power. Unless it can obtain funds from other sources, the quality of the health care which it provides children of Arkansas will be imperiled in the immediate future.

# STATEMENT OF AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

## INTRODUCTION

The American Association of Colleges of Podiatric Medicine (AACPM) is a not-for-profit educational organization, which represents all five of the colleges of podiatric medicine in the United States. All the colleges are private, not-for-profit, free-standing institutions, which provide education to more than 2,200 podiatric medical students. The colleges offer a four-year post-baccalaureate curriculum, which leads to the first professional degree of doctor of podiatric medicine. Doctors of podiatric medicine are licensed by all 50 state and the District of Columbia.

## SUMMARY

The AACPM makes the following recommendations to the Subcommittee concerning FY 78 Appropriations:

1) Restoration of capitation funds for podiatry. These funds should be at a level which reflects the increased authorization in capitation level provided only to podiatry in the 1976 Health Manpower Act.

2) That more funds be allocated for certain designated and general special projects and that the Subcommittee specify in its report that podiatry and the other VOPP professions be allocated a fair portion of the funds commensurate with institutional and national goals.

## DISCUSSION OF ISSUES

Having presented a summary of our recommendations, we present the background and justification for our proposals.

### I CAPITATION

Continued capitation support at the maximum level which budgetary allocations will permit is essential to the viability of the five colleges of podiatric medicine and the quality of the educational programs provided by these institutions.

In enacting the Health Manpower Educational Assistance Act of 1976, the Congress, itself, recognized the important role of capitation as an institutional support mechanism for podiatry and the other VOPP professions. In its report on S 3239, the Subcommittee on Health stated:

> "7. Veterinary Medicine, Optometry, Podiatry, and Pharmacy.
>
> The Committee is aware of the recommendation of the Administration to sharply curtail Federal support for schools of veterinary medicine, optometry, podiatry, and pharmacy. The Administration proposes to terminate institutional support for schools of veterinary medicine, optometry, and podiatry.
>
> The Committee believes that these schools and their students are an important resource to the Nation and the quality of its health care system. The Committee believes that these institutions and their students could not withstand the impact of implementation of the Administration's legislative recommendations without dire consequences.
>
> Accordingly, the Committee has included in its bill continued Federal support for these institutions and their students, which the Committee believes to be vitally important to America's health care."
>
> Health Manpower Educational Assistance Act of 1976, Senate Report No. 94-887, pp. 231-232.

In the Health Manpower Act, (P.L. 94-484), Congress recognized the particular needs of the colleges of podiatric medicine when it increased the capitation authorization from $800 under the 1971 Act to $965 in the present Act. Podiatry was, in fact, the only profession among the MOD-VOPP professions which received an increase in its capitation authorization.

The specific reasons which apparently formed the basis for Congress' decision to increase the authorization for podiatry capitation are still valid today and should be enumerated and emphasized:

1. Podiatric medical colleges, as well as schools of the other MOD-VOPP professions, responded to the Congressional directives in the 1971 Health Manpower Act by increasing enrollments, expanding programs, hiring more and better qualified faculty members, and engaging in major construction or renovation programs. Now that the colleges have made the dramatic improvements which the Congress directed, the challenge facing the colleges is the ability to main-

tain the enrollments, programs, faculties, and physical plant at a level which will meet accreditation standards and which will enable the colleges to provide quality programs to their students. The cut-off of capitation funds would have damaging effects on the institutions ability to meet their financial commitments. This issue will be discussed below at greater length.

2. All five of the colleges of podiatric medicine are private, free-standing institutions, which do not have access to state or university funds as primary sources of income. However, three of the five colleges receive aid from the states where they are located and the other two are seeking such aid. In addition, AACPM has initiated a national program to solicit funds for the colleges from the 45 states which do not have a college of podiatric medicine. Since this program was begun only recently, it has not yet produced any substantial results.

3. Under the capitation program, podiatric medical education has received a comparatively small percentage of its net educational expenditures (as determined by the Institute of Medicine). The table below indicates how podiatry fared for the 1972-73 academic year - the year on which the Institute's study was based - in relation to the other professions:

| | Net Education Expenditures Per Student* | Average Capitation Grant Received | |
|---|---|---|---|
| | | Amount | Percentage of Net Ed. Expenditures |
| Medicine | $ 9,700 | $1,961 | 20 |
| Dentistry | 7,400 | 1,982 | 27 |
| Osteopathy | 7,000 | 1,346 | 19 |
| Vet. Medicine | 5,500 | 753 | 14 |
| Podiatry | 4,900 | 403 | 8 |
| Optometry | 3,100 | 333 | 11 |
| Pharmacy | 3,050 | 386 | 13 |

* "Cost of Education in the Health Professions," Institute of Medicine, National Academy of Sciences, 1974.

Since this study was completed, the cost of podiatric medical education has risen to approximately $8,000 per student for academic year 1976-77. Capitation for the current year is at about the same level as it was in 1972-73.

We fully understand that the short span of time available to the new Administration to make its revisions in the FY 78 budget made it impossible to review thoroughly all facets of this Budget. As a result, we feel that the reason given in Budget message for eliminating VOPP capitation was not based on adequate evaluation of all available information and data on support needed by colleges of podiatric medicine.

The reason given is that there is already a sufficient supply of podiatrists. This is simply not supported by all the available evidence, including that gathered by the DHEW or under its auspices:

1. After careful review of manpower availability and demands for podiatric services, DHEW concluded that 46% of the counties in the U.S. should be designated as podiatry shortage areas. This determination was based on a ratio of 1 podiatrist for every 25,000 Americans, which is a very conservative measure.

2. A DHEW funded contract conducted by the American Podiatry Association found that Americans were receiving only 40 million of the needed 60 million visits for foot health care. [An Assessment of Foot Health Problems and Related Health Manpower Requirements. HRA contract #231-75-0210, 1976.]

3. The National Center for Health Statistics reported in 1975 that 39% of U.S. podiatrists were 55 years of age or older. On the other hand, only 28% of all physicians in the country were over 55. This figure indicates that a higher percentage of podiatrists will be leaving avtive practice sooner than physicians and other health professionals.

The line of reasoning used by the new Administration can only impose harsh burdens on podiatry colleges, their students, and the public, which utilizes podiatric medical services.

First, this line of reasoning ignores the heavy burden which the requirements of the 1971 Act imposed on the colleges. As we indicated above, the colleges increased enrollments from approximately 1,300 students in

academic year 1971-1972 to more than 2,200 students in academic year 1976-1977.

ENROLLMENT DATA 1/

TOTAL OF SCHOOLS UNDER DISCIPLINE:

| ACADEMIC YEAR | 1ST YEAR | 2ND YEAR | 3RD YEAR | 4TH YEAR | TOTAL | GRADUATES |
|---|---|---|---|---|---|---|
| 1970-71 | 351 | 266 | 289 | 242 | 1,148 | 242 |
| 1971-72 | 399 | 315 | 267 | 286 | 1,267 | 286 |
| 1972-73 | 478 | 359 | 307 | 259 | 1,403 | 259 |
| 1973-74 | 548 | 425 | 353 | 304 | 1,630 | 303 |
| 1974-75 | 561 | 503 | 421 | 351 | 1,836 | 352 |
| 1975-76 | 642 | 529 | 490 | 420 | 2,081 | 496 |
| 1976-77 | 667 | 600 | 526 | 411 | 2,204 | 490*(estimated) |

1/ Data obtained from schools or from capitation applications as follows: Academic years 1970-71 and 1971-72 from FY 72 applications, 1972-73 from FY 73 applications, 1973-74 from FY 74 applications, 1974-75 from FY 75 applications, and 1975-76 and 1976-77 from annual school reports.

"Health Professions Schools, Selected Enrollment Data 1970-1971/ 1976-1977," U.S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, p. 223.

The colleges also greatly expanded course offerings and clinical programs. In addition, the colleges increased the number of full-time faculty members from 90 to 134 and the number of part-time faculty from 320 to 563.

With the aid of federal construction grants and the contributions from private sources, all five of the colleges undertook major capital improvement programs: 2 colleges have completed new buildings, 2 other colleges acquired already existing structures and renovated them, while the fifth college has broken ground for a new building, which is scheduled for completion in 1978.

The total cost of construction and renovation programs was approximately $28.9 million dollars, of which about $12 million were federal funds.

As a result of this expansion, the colleges of podiatric medicine were able to double the number of graduates and offer more sophisticated clinical and basic science programs, but at the same time, the colleges increased their operating expenses from approximately $5.4 million in 1971-72 to approximately $16.5 million in 1976-77. At one school alone, the cost of maintaining the physical plant and amortizing the debt on the buildings is about $1,700 per student for the current academic year.

Unfortunately, the expansion of the colleges has led some of the colleges into deficit financing and even into serious fiscal difficulties. Financial distress grants totaling about $2 million have been received from DHEW since the 1971 Act was signed into law. Continued federal capitation support is needed to achieve fiscal stability in the colleges of podiatric medicine.

Secondly, the line of reasoning outlined above ignores the duty incumbent on the colleges of podiatric medicine to provide to its students a level of education commensurate with the responsibilities and scope of practice which state licensing laws and federal programs demand of doctors of podiatric medicine. The podiatrist is, in effect, the primary health care provider whose detailed functional knowledge of the lower extremity and specific techniques help him to diagnose the great variety of conditions and to treat both acute and chronic problems of the foot and to practice preventive medicine in relation to the foot.

The podiatrist provides comprehensive primary care for a specific portion of the anatomy - the lower extremity - in that his range of concerns and activities cuts across many traditional specialties: dermatology, orthopedics, pathology, neurology, anesthesiology, pharmacology, and surgery. He must also have a high index of suspicion for systemic diseases which are manifested in the foot, e.g. diabetes, peripheral vascular and neurovascular disease, arthritis, and venereal disease. Yet, the podiatrist not only provides primary care; he also, like the dentist, is a specialist who treats a specific portion of the anatomy.

Colleges of podiatric medicine are, in effect, single track medical schools, providing a "specialty" medical education in their first professional degree programs. This is in contrast to medical schools, which provide a "general" medical education in their first professional degree programs. Consequently, the education and training which the podiatric medical student receives must be equivalent to medical education. Thirdly, the Administration's line of reasoning overlooks the adverse effects which the withdrawal of institutional support from the colleges

of podiatric medicine will have on the public utilizing podiatrists' services. The colleges of podiatric medicine are a national resource, educating podiatrists for the entire United States.

Podiatrists provide a wide range of foot health services ranging from palliative treatment of the foot to major surgery on the foot. Podiatrists also treat a large number of geriatric patients, who, without the podiatrists' services, might be unable to remain ambulatory. If these individuals were forced to be bedridden, they would require more extensive medical and social services, which could ultimately increase federal expenditures in the areas of health and social services. As was indicated above, the public may also be damaged if the colleges of podiatric medicine lack the institutional capabilities to provide the level and quality of education commensurate with the legal responsibilities and scope of practice of podiatrists.

Thus, national priorities in health professions education which do not include institutional support for colleges of podiatric medicine are clearly adverse to the federal government's interest in providing the highest quality health care.

## ALTERNATIVES

What are the alternatives which the colleges of podiatric medicine might consider if capitation is reduced or eliminated?

1. They can reduce the number and quality of programs.

2. They can increase tuition to make up for the reduction or loss of federal capitation support.

The first alternative will clearly have untoward effects on the institutions and their ability to meet their responsibilities to the students and to the public. Cut-backs in programs and staff can only impair the quality of education in the colleges of podiatric medicine. This is especially true since the colleges must maintain enrollment if they are to qualify for insured student loans provided in P.L. 94-

484. As was indicated earlier, the scope of practice permitted podiatric medical doctors is such that program and staff reductions would make it extremely difficult for the colleges to prepare the student for his professional practice. If the student, then, is not properly prepared to meet his professional responsibilities, he will be unable to provide the services which the public needs and demands.

The recent federally sponsored study of the "Assessment of Foot Health Problems" revealed not only the wide variety of foot disorders which podiatrists treat, but also the unmet needs of the public for foot health care. The report identified those groups of Americans which have a high prevalence of foot health problems: the elderly, the poor, minorities, women, and individuals who live in the South. [HRA Contract #231-75-0210, pp. i-ii]

The second alternative is to raise tuition to replace the funds which are currently being provided under the capitation program. While it may be desirable for health professions students, including podiatrists, to bear as much of the cost of their education as is possible, there are practical limits to what the students can pay. Tuition levels must be sensitive to market place conditions. Since colleges of podiatric medicine currently charge tuitions comparable to those of private medical schools, there is a limit to the tuition increases which the market place (i.e. tuitions charged in other health professions schools) will permit. Admittedly, the capitation level is a relatively small amount which could be absorbed by tuition increases, but the issue is that the rising cost of podiatric medical education is already forcing substantial increases, and tacking on an additional increase to cover the loss of capitation could make it impossible for many students to continue their education. Podiatry students' tuitions already cover half the cost of education. The average tuition projected for 1977-78 will approach $5,000. It is our contention that the opportunity for podiatric medical education should be open to all Americans and not merely to the affluent.

AACPM was one of the strongest advocates of the new Federally Insured Loan Program (FISL), authorized under Title IV of new Health Man-

power Act. We remain strong supporters of this program precisely because, if successful, it is a mechanism which will enable students to pay a still higher percentage of the cost of their education and repay the money borrowed during the years of professional earnings.

However, it is not clear at this point how quickly the loan program can be implemented. We commend the Congress for earmarking $1 million in the FY 77 Supplemental Appropriation for use in the implementation of the FISL program. Yet, because of the continuing difficulties which financial institutions have experienced with the Guaranteed Student Loan Program (GSL), there may be reluctance on the part of lending institutions to participate in the program or there may be willingness to make only a limited commitment to the program. Moreover, podiatry students will have to compete for loans with other students in the new FISL as well as those in other loan programs.

Therefore, we do not know at this time to what extent podiatry students will be able to meet their financial needs through this new loan program. The recent consolidation of student assistance programs into a single unit, the Bureau of Student Financial Assistance, in the Office of Education, hopefullv will effect the necessary overhaul of the administrative structure of student loan programs and provide lenders with the kind of assurances which will induce them to participate in the new FISL.

However, we believe that several years of operations are required before a firm judgment can be made about the effectiveness of the new FISL. After DHEW and the lenders have had some experience with functioning of the program, the Congress will be in a better position to determine whether this is a viable means of financing health professions education in general and podiatric medical education in particular. Until that time, it would be premature and ill-advised to eliminate or reduce institutional support which the colleges receive in the form of capitation grants.

To summarize the discussion of capitation - the first issue presented in this testimony: AACPM and its member institutions urge the Sub-

committee to restore the podiatry capitation funds which the Administration has recommended be eliminated and to recommend to the full committee a level of capitation support which reflects the increased authorization given to podiatry alone under P.L. 94-484. To do less than this would be to jeopardize the continued operations of the colleges and prevent them from offering quality education to their students, who will be providing health services to the American public.

III SPECIAL PROJECTS

The second major issue which we wish to bring to the Subcommittee's attention is that of Special Projects, which were authorized in Title VIII of 1976 Act. The term "special projects" covers a wide and diverse range of endeavors which the Congress has determined to be of national significance, but which are generally beyond the ordinary scope and means of the health professions educational insitutions.

We would like to comment on several of the program areas authorized as special projects because of their impact on podiatric medical education.

A. Financial Distress

The Administration has recommended $2 million for financial distress grants. This compares with $3.5million approved by the Congress for FY 77 Supplemental Appropriations and $5 million which was authorized under the Continuing Resolution which expired March 31, 1977. Section 788(e) of P.L. 94-484 authorizes the Congress to appropriate up to $5 million for financial distress grants.

Since 1971, colleges of podiatric medicine have received nearly $2 million in financial distress funds. This money has been instrumental in enabling the institutions to meet their financial obligations resulting from rapid expansion. Yet all the institutions have not yet achieved the financial stability for which they are striving and which would make financial distress grants unnecessary.

It is our contention that, because of the rapidly rising costs of health professions education and the possibility of inadequate capitations funds to meet the institutional needs of the schools, the Subcommittee recommend to the full Committee an increase in the appro-

priation for financial distress to the full authorization of $5 million. It is essential that this amount be earmarked for financial distress to meet any contingencies which may arise during FY 78.

B. Educational Assistance to Individuals from Disadvantaged Backgrounds

In its report on S 3239, the Committee on Labor and Public Welfare made known its findings on the status of minorities in the health professions and singled out the VOPP professions, including podiatry, for their inadequate efforts to improve minority enrollment:

"4. Student Assistance

A. Support for students of exceptional need. Minority and low income students historically have been under-represented in health professions schools. However, over the last six years, some progress has been made in increasing the number of minority students enrolled. Despite substantial improvements, in the Committee's view, the racial and socio-economic composition of health profession students is still in need of better balance if equality of access to a health profession career regardless of family income or background is to be assured.

Minority enrollment - Health professions schools, particularly medical and dental schools, recently have made strong efforts to recruit a higher number of qualified minority candidates. Minority students represented 4.2 percent of first year medical students in the school year 1968-69, and by school year 1973-74, the figure had risen to 11.5 percent. In dental schools, the proportion of blacks in first year classes rose from 3.1 percent in 1969 to 5 percent in 1972. First year enrollments of black Americans has leveled off since school year 1971-72, however. The percentage of first year medical students who were black Americans rose from 2.7 percent in 1968-69 to 7.1 percent in 1971-72. However, over the last two years the percentage of first year students who are black Americans has remained stable.

The improvement in minority enrollment has not been consistent for all health professions schools. In particular, the percentage of candidates in schools of veterinary medicine, osteopathic medicine, and podiatry is considerably less than the percentage in schools of medicine, dentistry, and pharmacy.

Income distribution of students - Health professions students - particularly physicians and dentists - have traditionally come from high income families. The relative proportion of medical students from the highest end of family income distribution continues to be over-represented and the proportion of students from low income families (those earning $10,000 or less) remains low.

Although schools cannot force more low income students to apply for admission, the ways in which schools have distributed Federal student assistance dollars suggests that inadequate concern has been placed on encouraging the entry of low income candidates.

Accordingly, the Committee's bill includes a special scholarship program for students of exceptional financial need. The Committee directs HEW in the administration of this vitally needed program to assure that funds appropriated under it be restricted to students whose financial need is the greatest."

Colleges of podiatric medicine have made progress in the area of increasing enrollments of women, who now make up about 7% of the student bodies. Six years ago, women comprised less than 1% of the student bodies. Members of minority groups comprise about 6% of the student enrollment in the colleges of podiatric medicine, and two of the colleges currently have special project grants to recruit more women, minorities, and individuals from disadvantaged backgrounds or from underserved areas.

However, if the colleges of podiatric medicine are to continue their efforts in this area of minority recruitment and retention, it is vital that there be sufficient federal funds available to meet the needs of all the VOPP professions, which have shown far less progress in this area than medicine and dentistry.

There is a considerable gap between the $8 million requested by the administration and the $20 million authorized under section 787 of the Health Manpower Act. Our question to the Subcommittee is: Will the $8 million be adequate to make more progress in minority recruitment and retention? We think it might be sufficient if the VOPP professions are allocated adequate funds needed to make the dramatic steps which medicine and dentistry have made in assisting minority and disadvantaged students. However, we urge the Committee to make clear in its report that an equitable share of the appropriations for this category be made available to podiatry and the other VOPP professions.

C. General Special Projects

We are particularly distressed that so many of the special project funds are earmarked for specific areas of need. This seriously curtails the abilities of the VOPP schools in general and the colleges of podiatric medicine in particular to develop the kinds of special projects which have in the past contributed to the overall improvements of podiatric medical education and have met national goals set by the Congress. Above all, the projects already completed or still underway could not have been accomplished without federal

support. Projects of this type are simply beyond the financial capabilities of the colleges. Yet they are vital to podiatric medical education, to interdisciplinary health education, and to the delivery of services to the public.

For example, one of the colleges of podiatric medicine recieved in the late 1960's substantial special project support for curriculum revision. This enabled the school to hire more full-time clinical faculty, to develop course syllabi and laboratory manuals. In general, the project enabled the school to develop a curriculum which was modeled on the curriculum of medical and dental schools. Moreover, the results of the project were able to be adapted to the other colleges of podiatric medicine.

However, since the completion of the project, there have been such sweeping changes in health care delivery and in education techniques that curriculum revision has again become a critical area of concern for the colleges of podiatric medicine.

Another project enabled a college of podiatric medicine to bring podiatric services to certain populations of patients which had previously been without them, e.g., residents of nursing homes, participants in alcoholism centers, and patients at city health clinics. The program also enabled the college to expand and strengthen its clinical education program by rotating its students through 19 institutions outside the college and by providing students with an opportunity to be involved in the treatment of more patients with a wider range of pathologies than would have been possible at the colleges alone.

As a result of this special project, both patients and students received benefits which might otherwise have been impossible. Yet, such benefits are vital to the nation's health and health professions education.

A third special project of paramount significance involves an interdisciplinary training program, which brings together students and faculty

from medicine, optometry, podiatry, pharmacy, and nursing. The purpose of this project is to foster understanding among the professions in their clinical training and to provide the students with an opportunity to learn from each other while they are receiving clinical education and delivering services. The project involves five health educational institutions and a number of hospitals, clinics, and other health facilities. If we are to achieve the Congressional goals of a truly integrated system of health delivery and if we are going to initiate and operate an efficient national health insurance system, more projects of this nature must be supported by federal funds.

In addition, there is a pressing need for colleges of podiatric medicine to establish working affiliation agreements with academic health centers and other schools of the health professions. Since the colleges are private, free-standing institutions, they do not have access to the level and quality of clinical programs and clinical staff available in academic health centers. Affiliation with academic health centers would open up this opportunity and would permit the colleges to achieve cost savings through the sharing of facilities, services, and personnel. In this way, the colleges hope to keep down the cost of podiatric medical education and be able to improve the education offered to their students.

In light of the value of these projects to the institutions, the students, and the public, it is vital that more funds be made available for VOPP special projects. In particular, we urge the Subcommittee to recommend funding for section 788(c), which includes projects to foster the team approach to health care delivery. We also urge the Subcommittee to include a recommendation for funding section 788(d), which contains a wide range of special projects. In order to insure that funds will be available to podiatry, it is critical that Subcommittee include report language that an appropriate portion of these 788 c and d funds be made available to the VOPP profession. This is particularly crucial since the VOPP group will be able to qualify for only a limited number of special projects under the current categories of the appropriations bill.

In conclusion, Congress and podiatric medical education have had a partnership in health education for many years. Until now, Congress has fulfilled its responsibility by providing the funds to assist the institutions in providing quality educational programs, and podiatric medical education has responded with results that far exceeded the original goals . We are eager to continue this relationship and need your continued support, encouragement, and commitment.

## STATEMENT OF AMERICAN ASSOCIATION OF COMMUNITY AND JUNIOR COLLEGES, AMERICAN ASSOCIATION OF STATE COLLEGES AND UNIVERSITIES, AMERICAN COUNCIL ON EDUCATION, ASSOCIATION OF AMERICAN UNIVERSITIES, NATIONAL ASSOCIATION OF INDEPENDENT COLLEGES AND UNIVERSITIES, AND NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND-GRANT COLLEGES

Mr. Chairman and Members of the Subcommittee:

INTRODUCTION

For several years, you have graciously granted our Associations the privilege of presenting the views of a major portion of the higher education community on the Nation's health programs. We would like to express appreciation to this Subcommittee for its leadership in recent years when it prevented vetos and unreasonably low budget requests from undermining the health, education and research systems created over the past several decades in the Nation's institutions of higher education. We are grateful for your continued support and ask for your consideration of recommendations for FY'78.

In past years, we have emphasized in our testimony that while dozens of witnesses appear before your subcommittee, we do so as the unique representative of the institution. We believe it appropriate that the institution's special role in serving the health care system of the Nation be recognized and supported. The institutions represented in this testimony train most of the Nation's health personnel and perform much of its sophisticated biomedical health research. The quality of education and research done in our medical schools is affected by the quality of the many science departments throughout the university, particularly those engaged in biomedical research.

As in the past, the Nation will continue to seek out our health professions institutions to train professional personnel and to provide the new knowledge for use in fulfilling their mission. The Nation calls for more doctors and our institutions exert major efforts and expand enrollments to meet shortages of health personnel. The Nation demands new treatments and new drugs to combat diseases and the research scientists at our institutions bend every effort to help solve health problems. The Congress has recognized that the structure of health research, training and services is a highly integrated and fragile one. The failure to fund programs adequately impairs not only the quality of education of the health professions, but science education and research throughout the institution, and, ultimately, the people served. Following are our budget recommendations.

We are in general agreement with the recommendations of the Coalition for Health Funding presented to this Subcommittee on April 4, 1977. We recognize that in the light of the FY'77 level of $7.3 billion and the Administration's request for only a $20 million increase, the Coalition's recommendation of $9 billion for funding controllable health programs may seem unrealistic. However, the Coalition sought to answer a basic question: at what levels should authorized programs be funded if they are to achieve the objectives set forth by the Congress in authorizing these programs? The Coalition's recommendations are not ideal funding levels, but wise ones. They are mindful of the budget constraints on this Subcommittee and Congress as a whole, and recognize, as our testimony for many years has stressed, that too often the funding levels for health programs have not been sufficient to achieve program objectives.

NATIONAL INSTITUTES OF HEALTH

The Administration has totally failed to justify its standstill budget for biomedical research -- a budget that, accounting for inflation, really means a cutback in research activity. Several years ago, we expressed concern at the apparent disproportionate emphasis being placed on the Cancer and the Heart, Lung and Blood Institutes at what appeared to be the expense of the other research institutes of NIH. We do not believe, however, that the problem of providing stable, balanced support should be rectified by cutting back on these two Institutes, making all equally underfunded.

We are at a crucial period in the history of federal support of biomedical research. During the next two years, Congress will conduct hearings which likely will go far beyond the reauthorization of existing programs. Fundamental issues such as health services, cost containment, technology transfer, and possibly even national health insurance will be investigated. Important changes could be developed affecting the role and conduct of biomedical research, the goals set for it, and the relationships between research and education.

In the interim, for FY'78, it seems imperative that the health of the existing system be maintained to enable it to move easily into any new assignments which Congress may direct in new authorizing legislation. The current

FY'77 level of funding for NIH of $2.54 billion inherently casts doubt on the credibility of the Administration's funding request of $2.57 billion for the coming year. Inflation alone would call for increase of approximately $150 million. As will be discussed elsewhere in this testimony, the cut of $35 million in Research Resources can be ascribed only to budgetary convenience and not to any rational approach to the conduct of biomedical research for the Nation.

With regard to training, the proposed concentration of attention on postdoctoral research where the "payoff" is probable would make sense only if we were engaged in a one or two or three year battle against disease. But failing to fund potential research scientists in pre-doctoral research could leave us in short order with too few postdoctoral scientists to support.

BIOMEDICAL RESEARCH SUPPORT PROGRAM

On October 31, 1976, the Research Resources Evaluation Panel appointed to evaluate the scientific mission of the NIH Division of Research Resources published its report Assuring the Resources for Biomedical Research. The panel judged the Biomedical Research Support Program to be "extremely valuable" and noted that "sudden elimination of the program would be a definite detriment to biomedical research." Central to the Evaluation Panel's support of the program was its agreement with the President's Panel on Biomedical Research which stressed the "critical need to assure the maintenance of the nation's institutions as a vital biomedical and behavioral research resource."

The Carter Administration (perhaps because it has not yet had a chance to review the situation) opposes continued funding of the Biomedical Research Support Program by treating it as if it had a temporarily limited objective which has now been achieved. The real purposes of this program will continue as long as biomedical research is sponsored by NIH and other segments of the Public Health Service. The relatively small sums of funds involved are important to the NIH research program to a degree greatly disproportionate to the dollars provided. These funds enhance institutions' capacity and flexibility to perform research productively. They lubricate the large complex project system to allow it to operate more smoothly. The economy, effectiveness and efficiency of all the biomedical research programs are vastly improved as a result.

It is also argued that the funds involved would be better spent on more targeted research across the entire spectrum of biomedical disciplines. The allegation that the program duplicates other research programs is erroneous. A central objective of this unique program is to complement and strengthen, not duplicate, the project system. For example, at a major university in the Southwest, a young scientist appears to have isolated some secretions in the endocrine gland system which may have cancer prevention qualities. It is too early in his work for him to apply for major funding from NIH. His university will support his work at its current exploratory level for the next year or two, using Biomedical Research Support Program funds. On the West Coast, a small group of accomplished biomedical research scholars a few years ago shifted the focus and approach of their research, and a year of more would pass before their new work could reasonably be considered for major funding by NIH. Their institution used Biomedical Research Support Program funds to continue their work.

New research ideas and highly innovative or unorthodox ideas frequently need to be tested before major investments are made for definitive studies. The process of research needs to be able to respond to unforseen opportunities as well as emergencies, e.g. to be able to repair or replace an instrument which has broken down. Generally, relatively small amounts of funds are required to meet these needs. The Biomedical Research Support Program now supports some 8,000 projects with an average grant of $3,000. Many projects may need only $50 or $500 for crucial timely support. The alternative would be to apply for funds to yet another competitive grant program at NIH, thereby incurring the disproportionate high costs of reviewing and funding. To obtain support for a proposal from NIH may take anywhere from 4 to 9 months -- a delay which could result in loss of valuable persons and facilities in "down time."

There is still another need to which the program is directed. Contemporary biomedical research often requires highly costly and sophisticated equipment and supporting services. A single project investigator might need the equipment and its technician only five or ten percent of their time, clearly not enough to justify the entire expense. However, on a given campus, a large number of projects, sharing equipment and personnel resources can well make it practical for such sophisticated research to be pursued. Such centrally shared equipment and personnel resources now account for about 25 percent of the funds of the program.

In summary, we support the recommendation of the Research Resources Evaluation Panel which called for support of the Biomedical Research Resources Support Program at a 3.7 percent level of total biomedical research funded by the federal government, or at a current rate of approximately $50 million.

ADAMHA

The same arguments presented for NIH are applicable to the National Institutes for Alcohol Abuse and Alcoholism, Drug Abuse, and Mental Health. With alcohol identified as one of the major diseases affecting the physical and social health of the Nation directly, one of the major sources of injury and death on the highways, a fundamental cause of the instability of the American family, and a cause of many other social ills, the FY'78 budget request for less than the FY'77 appropriation seems beyond comprehension. Inflation, again, must be considered, and real increases likewise are required for research, for training, and for the operation of community programs. The same can be said for the support of the National Institute on Drug Abuse and the National Institute on Mental Health.

HEALTH MANPOWER

The Administration's reason for cutting back support for health manpower programs and health professions institutions in a non sequitur. The argument goes: the objective of capitation was to increase the numbers of students enrolled and produced by the Nation's health professions institutions. This goal has been achieved. Therefore, there is no need to continue capitation support.

The question remains: who will pay for the cost of educating this increased number of students? Funding the newly expanded National Health Service Corps Scholarship Program is not an alternative to capitation. Rather, it will provide another means of resolving the problem of geographical maldistribution of health professions. A shift of $10 million from capitation into the scholarship program will assist 1,000 of the almost 60,000 medical school students with a $10,000 grant for one year. It also will require the institution not receiving those funds to secure perhaps $150 more for each student, most likely by raising tuition by that amount for all students.

The reauthorization of the comprehensive health manpower laws established a series of conditions which institutions must meet to continue to receive capitation. The conditions were enacted with the understanding that capitation would be funded. We strongly urge fully funding the National Health Service Scholarship Program at $75 million so that the objective problem of geographical maldistribution can truly be dealt with by an adequate supply of skilled professionals. We also urge funding at $16 million, three times the Administration's request, for the program of scholarships for the financially needy.

We are particularly concerned over proposed funding levels for nursing programs. The recommendation not to fund the traineeship program, funded at $13 million last year, or the student loan program, funded at $22.5 million last year, would leave critical gaps in support of nurse training programs. We are equally concerned that nursing research programs are not recommended for support in FY'78. We urge funding at no less than the $5 million and $1 million 1977 levels for project grants and training fellowships respectively, and more wisely the $7 million and $3 million levels supported by the Coalition for Health Funding. The Administration's 80 percent cut in funding from 1977 levels would do serious damage to nurse training programs in the United States.

ALLIED HEALTH

The Administration requested for allied health programs, only $8 million, a level of funding which would seriously cripple federal efforts to improve the training and delivery of allied health services that are a vital part of an efficient health delivery system.

The full authorization of $22 million for project grants and contracts is needed to continue the current level and to implement the new legislation, including improved state, regional and institutional planning, curricula and programs for new roles and functions for allied health personnel, and new or improved methods of credentialing. About 300 projects are now supported, about 200 of which will require additional years of funding to achieve project goals. Under the reduced funding requested by the Administration, most of these projects would have to be terminated and few additional projects could be funded.

The Administration's request includes no funds for traineeships for Advanced Training of Allied Health Personnel. Current funding of $3.7 million permits more than 400 people to engage in long-term training and 3,000 individuals to participate in the training institute program designed to develop existing faculty. We believe that the traineeships should be funded at the authorized level of $4.5 million.

Finally, the authorized $1 million should be appropriated for the program of "educational assistance to disadvantaged individuals in allied health training" to continue efforts to attract disadvantaged persons into this field.

HUMAN SUBJECT RESEARCH REGULATIONS

Appropriation bills for the past years have introduced significant new language affecting the conduct of human subject research by institutions supported by HEW. This language radically changes the manner in which research may be carried out, especially in the behavioral sciences and especially where minors are involved. It authorizes HEW to require written consent prior to research, even if the subject is in no real way at risk. (For example, a social scientist observing how a particular class of students in a public shool reacts to new material in a newly-designed curriculum would be required to obtain the written consent of both parents of the minor children in the class. Even if this were possible, and giving the family structures in the contemporary United States, that is doubtful, the costs in time and funds for obtaining the written documents and the nightmare created, would negate the conduct of such useful studies.) Decisions determining the absence or presence of danger are placed in the hands of the Secretary of HEW or the courts. This language should not be included in the FY'78 appropriation bill. First, its objectives are redundant since the publication on March 13, 1975 of strict guidelines for the conduct of any research which could in any way put a human subject at risk. HEW is monitoring research conducted at institutions in all the sciences, and requires that Institutional Review Boards take careful note of the potential risks of subjects of research in determining whether to authorize the conduct of such research. The existing regulations evaluate

legally informed consent with the understanding that some social science research cannot always use written consent consistent with its objectives and the safety of subjects.

The second reason for deleting the provision is that the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, the official qualified body studying the entire range of concerns regarding human subject research, will soon publish final definitive regulations for scholars engaged in science research. Since existing regulations already assure protection against real risks, and since definitive recommendations are about to be issued, the further regulations called for by Section 411 are gratuitous and unnecessary. Dropping Section 411 will in no way remove the responsibility of researchers in the biomedical and behavioral sciences for the safety of human subjects. It will, however, remove a great deal of the confusion which resulted from the existence of conflicting government regulations on this issue.

CONCLUSION

While our recommendations are directed to funding levels for FY'78, we respectfully urge the Subcommittee to undertake a review of long-term patterns in the funding of national health programs. Until procedures can be established to assure institutions of continued program funding over a reasonable period of time, institutions, trustees and state legislatures will be reluctant to invest funds in training and research programs contributing to national objectives.

Last year, we noted that rapid increases in uncontrollable programs such as Medicare and Medicaid threatened to squeeze support for the controllable programs institutions of higher education are most involved in. We continue to urge that attention be given to monitoring those programs to prevent abuses.

The quality of national health care programs are directly dependent on the quality of the health education of those who serve the population, and on the quality of the research which produces the treatments and drugs used in health care. The Nation must fulfill its obligation by funding health education and research, as well as services.

SUBCOMMITTEE RECESS

Senator BROOKE. The subcommittee will stand in recess until 11 a.m. tomorrow morning, when we will continue to hear public witness testimony.

Thank you.

[Whereupon, at 5:30 p.m., Monday, April 4, the subcommittee was recessed, to reconvene at 11 a.m., Tuesday, April 5.]

# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1978

TUESDAY, APRIL 5, 1977

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
*Washington, D.C.*

The subcommittee met at 11:15 a.m., in room S–126, the Capitol, Hon. Richard S. Schweiker presiding.

Present: Senators Schweiker and Magnuson.

## NONDEPARTMENTAL WITNESSES

### ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES INSTITUTE

**STATEMENT OF WILLIAM F. DONALDSON, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS**

**ACCOMPANIED BY:**

**ARVIN B. WEINSTEIN, M.D., PRESIDENT, NATIONAL KIDNEY FOUNDATION**

#### OPENING REMARKS

Senator SCHWEIKER. The subcommittee will please come to order.

This morning we will continue our public witness testimony on the various health programs. We have eight panels scheduled for today and are underway in a very tight time schedule.

Our first panel will discuss programs in the Arthritis Institute.

Before we do that, we have my good colleague here, Senator Heinz, who has a witness that he would like to introduce. We will be hearing from the witness later, but in view of the Senator's time, we will let him come forth now.

Senator HEINZ. Thank you, Senator Schweiker, thank you very much.

Let me thank the people of this distinguished panel for allowing me to introduce some of the people who will be appearing before the hearing today.

I don't have a prepared statement as such, Mr. Chairman so you can be assured my remarks will be brief.

It is a particular pleasure to introduce a group of witnesses who are from my own State, our Commonwealth of Pennsylvania. Of course, it is Senator Schweiker's State, too, which we are so privileged to represent.

Senator SCHWEIKER. It is an all-Pennsylvania day here this morning.



84-877 (Pt. 4) O - 77 - 36

Senator HEINZ. It is a great day.

The individuals I would like to introduce today first are Mr. J. Gilpin Allen and Mrs. Marian Allen of Devon, Pa.

I do understand that Mr. Allen can't be present here today, but for the record, Mr. Chairman, Mr. and Mrs. Allen are private citizens who bear frightening burdens imposed on them by diabetes. They are two extraordinarily courageous people. Together they demonstrate two different kinds of diabetes.

Mrs. Allen is one of the 85,000 insulin-dependent juvenile onset diabetics reported by the National Commission on Diabetes. Mr. Allen is one of the more than 9 million nonketosis prone mature type diabetics reported by the same commission. He represents one of the 80 percent whose diabetes is diagnosed after their 40th birthday.

Both bear the brand for what in time happens literally to all diabetics. Between the two of them they represent a spectrum of incurable nonremedial, nonreversible complications which grow worse with time and which are without remedy.

They also clearly identify with the social and economic burdens that are the reality and risk to all afflicted.

Second, I wish to introduce Dr. Thomas Behrendt, professor of ophthalmology, Jefferson Hospital Retinal Service; chairman, State Committee, Intermedical Institutions, Early Vascular Detection Service.

The Intermedical Institution's Early Vascular Detection Service is composed of eight senior faculty from the University of Pennsylvania, Temple and Jefferson Medical Schools. With your permission, Mr. Chairman, I would like to enter in the record the names and credentials of these distinguished physicians who are members of the Detection Service.

Senator SCHWEIKER. Without objection, so ordered.

[The information follows:]

STEERING COMMITTEE—INTER-MEDICAL INSTITUTIONS EARLY VASCULAR DETECTION SERVICE

*Jefferson Medical College.*—Thomas Behrendt, M.D., Chairman, Professor of Ophthalmology; Leslie Weiner, M.D., Professor of Medicine, Department of Cardiology; Norman Lasker, M.D., Professor of Medicine, Director of Dialysis Unit.

*University of Pennsylvania.*—D. Walter Cohen, D.D.S., Dean, School of Dental Medicine, University of Pennsylvania; Joel Morganroth, M.D., Assistant Professor of Medicine, Cardiovascular Section, Hospital of the University of Pennsylvania.

*Temple University Hospital Health Sciences Center.*—Frederick A. Richle, M.D., Associate Professor of Surgery, Chief of Peripheral Vascular Surgery, Department of Surgery.

*Scheie Eye Institute.*—William E. Benson, M.D., Associate Professor of Ophthalmology, University of Pennsylvania Medical School.

## COMPOSITION OF DIABETES INSTITUTE

Senator HEINZ. Finally, I would like to introduce Ms. Terry Hyde, who is associated with the Pennsylvania Diabetes Institute and I think, Mr. Chairman, you're aware that Mr. Carl Stenzler, who is currently executive director of the Institute, is also here.

For the record, I would like to indicate that the Diabetes Institute is a unique multidisciplinary coalition, quite prestigious doctors drawn from all over the United States. It also includes lay leaders and representatives of the General Assembly of the Commonwealth of Pennsylvania.

Since its inception, the Diabetes Institute has been a strong and uncompromising advocate for research, funded in proportion to priority needs developed in all areas that offer the promise of discovery which can lead to arrest, therapies and eventual care.

I know the chairman and I both know personally of the very significant work of the Diabetes Institute and how it has been a help both to the Senate and to the House. In deference to requests by the committee staff director to coordinate and consolidate testimony, the Pennsylvania Diabetes Institute, the Intermedical Institution's group and Mrs. Allen—Mr. and Mrs. Allen—have developed a logical strategy.

The Allens demonstrate the problem. Dr. Behrendt will discuss what we know, what we don't know and recommendations as to what we do. Ms. Hyde will develop the historical and current thinking with categoric recommendations.

As I mentioned before, Mr. Chairman, I was informed earlier this morning that Mr. Allen is ill and unable to attend. Since Mrs. Allen is totally blind, she is unable to present her husband's statement.

Mr. Stenzler, who with Dr. Behrendt worked with the Allens to develop this format, will read Mr. Allen's statement. Mrs. Allen is prepared to respond to any and all questions.

Mr. Chairman, I very much appreciate this opportunity to introduce so many fine people from our Commonwealth of Pennsylvania. It is not strictly a matter of State pride. These are all individuals who have made a very significant national contribution and you are, Mr. Chairman, to be commended for holding these hearings.

Thank you, Mr. Chairman.

Senator SCHWEIKER. Thank you very much, Senator Heinz. We appreciate your introduction and will be glad to hear from the distinguished group of witnesses led by Carl Stenzler when we come to the diabetes panels.

PREPARED STATEMENT

I think we do have a very difficult time frame, so I think we are going to ask witnesses to put their prepared statement in the record. Then they can take a few minutes to highlight what they think the main concerns are, the main points that they would like to get across. Also, at this time we will include written statements for those who could not attend this hearing today.

[The statement follows:]

# STATEMENT

IN BEHALF OF

American Association of Community and Junior Colleges
American Association of State Colleges and Universities
American Council on Education
Association of American Universities
National Association of Independent Colleges and Universities
National Association of State Universities and Land-Grant Colleges

Mr. Chairman and Members of the Subcommittee:

INTRODUCTION

For several years, you have graciously granted our Associations the privilege of presenting the views of a major portion of the higher education community on the Nation's health programs. We would like to express appreciation to this Subcommittee for its leadership in recent years when it prevented vetos and unreasonably low budget requests from undermining the health, education and research systems created over the past several decades in the Nation's institutions of higher education. We are grateful for your continued support and ask for your consideration of recommendations for FY'78.

In past years, we have emphasized in our testimony that while dozens of witnesses appear before your subcommittee, we do so as the unique representative of the institution. We believe it appropriate that the institution's special role in serving the health care system of the Nation be recognized and supported. The institutions represented in this testimony train most of the Nation's health personnel and perform much of its sophisticated biomedical health research. The quality of education and research done in our medical schools is affected by the quality of the many science departments throughout the university, particularly those engaged in biomedical research.

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research throughout the institution, and, ultimately, the people served. Following are our budget recommendations.

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With regard to training, the proposed concentration of attention on postdoctoral research where the "payoff" is probable would make sense only if we were engaged in a one or two or three year battle against disease. But failing to fund potential research scientists in pre-doctoral research could leave us in short order with too few postdoctoral scientists to support.

BIOMEDICAL RESEARCH SUPPORT PROGRAM

On October 31, 1976, the Research Resources Evaluation Panel appointed to evaluate the scientific mission of the NIH Division of Research Resources published its report Assuring the Resources for Biomedical Research. The panel judged the Biomedical Research Support Program to be "extremely valuable" and noted that "sudden elimination of the program would be a definite detriment to biomedical research." Central to the Evaluation Panel's support of the program was its agreement with the President's Panel on Biomedical Research which stressed the "critical need to assure the maintenance of the nation's institutions as a vital biomedical and behavioral research resource."

The Carter Administration (perhaps because it has not yet had a chance to review the situation) opposes continued funding of the Biomedical Research Support Program by treating it as if it had a temporarily limited objective which has now been achieved. The real purposes of this program will continue as long as biomedical research is sponsored by NIH and other segments of the Public Health Service. The relatively small sums of funds involved are important to the NIH research program to a degree greatly disproportionate to the dollars provided. These funds enhance institutions' capacity and flexibility to perform research productively. They lubricate the large complex project system to allow it to operate more smoothly. The economy, effectiveness and efficiency of all the biomedical research programs are vastly improved as a result.

It is also argued that the funds involved would be better spent on more targeted research across the entire spectrum of biomedical disciplines. The

allegation that the program duplicates other research programs is erroneous. A central objective of this unique program is to complement and strengthen, not duplicate, the project system. For example, at a major university in the Southwest, a young scientist appears to have isolated some secretions in the endocrine gland system which may have cancer prevention qualities. It is too early in his work for him to apply for major funding from NIH. His university will support his work at its current exploratory level for the next year or two, using Biomedical Research Support Program funds. On the West Coast, a small group of accomplished biomedical research scholars a few years ago shifted the focus and approach of their research, and a year of more would pass before their new work could reasonably be considered for major funding by NIH. Their institution used Biomedical Research Support Program funds to continue their work.

New research ideas and highly innovative or unorthodox ideas frequently need to be tested before major investments are made for definitive studies. The process of research needs to be able to respond to unforseen opportunities as well as emergencies, e.g. to be able to repair or replace an instrument which has broken down. Generally, relatively small amounts of funds are required to meet these needs. The Biomedical Research Support Program now supports some 8,000 projects with an average grant of $3,000. Many projects may need only $50 or $500 for crucial timely support. The alternative would be to apply for funds to yet another competitive grant program at NIH, thereby incurring the disproportionate high costs of reviewing and funding. To obtain support for a proposal from NIH may take anywhere from 4 to 9 months -- a delay which could result in loss of valuable persons and facilities in "down time."

There is still another need to which the program is directed. Contemporary biomedical research often requires highly costly and sophisticated equipment and supporting services. A single project investigator might need the equipment and its technician only five or ten percent of their time, clearly not enough to justify the entire expense. However, on a given campus, a large number of projects, sharing equipment and personnel resources can well make it practical for such sophisticated research to be pursued. Such centrally shared equipment and personnel resources now account for about 25 percent of the funds of the program.

In summary, we support the recommendation of the Research Resources Evaluation Panel which called for support of the Biomedical Research Resources

Support Program at a 3.7 percent level of total biomedical research funded by the federal government, or at a current rate of approximately $50 million.

ADAMHA

The same arguments presented for NIH are applicable to the National Institutes for Alcohol Abuse and Alcoholism, Drug Abuse, and Mental Health. With alcohol identified as one of the major diseases affecting the physical and social health of the Nation directly, one of the major sources of injury and death on the highways, a fundamental cause of the instability of the American family, and a cause of many other social ills, the FY'78 budget request for less than the FY'77 appropriation seems beyond comprehension. Inflation, again, must be considered, and real increases likewise are required for research, for training, and for the operation of community programs. The same can be said for the support of the National Institute on Drug Abuse and the National Institute on Mental Health.

HEALTH MANPOWER

The Administration's reason for cutting back support for health manpower programs and health professions institutions in a non sequitur. The argument goes: the objective of capitation was to increase the numbers of students enrolled and produced by the Nation's health professions institutions. This goal has been achieved. Therefore, there is no need to continue capitation support.

The question remains: who will pay for the cost of educating this increased number of students? Funding the newly expanded National Health Service Corps Scholarship Program is not an alternative to capitation. Rather, it will provide another means of resolving the problem of geographical maldistribution of health professions. A shift of $10 million from capitation into the scholarship program will assist 1,000 of the almost 60,000 medical school students with a $10,000 grant for one year. It also will require the institution not receiving those funds to secure perhaps $150 more for each student, most likely by raising tuition by that amount for all students.

The reauthorization of the comprehensive health manpower laws established a series of conditions which institutions must meet to continue to receive capitation. The conditions were enacted with the understanding that capitation would be funded. We strongly urge fully funding the National Health Service

Scholarship Program at $75 million so that the objective problem of geographical maldistribution can truly be dealt with by an adequate supply of skilled professionals. We also urge funding at $16 million, three times the Administration's request, for the program of scholarships for the financially needy.

We are particularly concerned over proposed funding levels for nursing programs. The recommendation not to fund the traineeship program, funded at $13 million last year, or the student loan program, funded at $22.5 million last year, would leave critical gaps in support of nurse training programs. We are equally concerned that nursing research programs are not recommended for support in FY'78. We urge funding at no less than the $5 million and $1 million 1977 levels for project grants and training fellowships respectively, and more wisely the $7 million and $3 million levels supported by the Coalition for Health Funding. The Administration's 80 percent cut in funding from 1977 levels would do serious damage to nurse training programs in the United States.

ALLIED HEALTH

The Administration requested for allied health programs, only $8 million, a level of funding which would seriously cripple federal efforts to improve the training and delivery of allied health services that are a vital part of an efficient health delivery system.

The full authorization of $22 million for project grants and contracts is needed to continue the current level and to implement the new legislation, including improved state, regional and institutional planning, curricula and programs for new roles and functions for allied health personnel, and new or improved methods of credentialing. About 300 projects are now supported, about 200 of which will require additional years of funding to achieve project goals. Under the reduced funding requested by the Administration, most of these projects would have to be terminated and few additional projects could be funded.

The Administration's request includes no funds for traineeships for Advanced Training of Allied Health Personnel. Current funding of $3.7 million permits more than 400 people to engage in long-term training and 3,000 individuals to participate in the training institute program designed to develop existing faculty. We believe that the traineeships should be funded at the authorized level of $4.5 million.

Finally, the authorized $1 million should be appropriated for the program of "educational assistance to disadvantaged individuals in allied health training" to continue efforts to attract disadvantaged persons into this field.

HUMAN SUBJECT RESEARCH REGULATIONS

Appropriation bills for the past years have introduced significant new language affecting the conduct of human subject research by institutions supported by HEW. This language radically changes the manner in which research may be carried out, especially in the behavioral sciences and especially where minors are involved. It authorizes HEW to require written consent prior to research, even if the subject is in no real way at risk. (For example, a social scientist observing how a particular class of students in a public shool reacts to new material in a newly-designed curriculum would be required to obtain the written consent of both parents of the minor children in the class. Even if this were possible, and giving the family structures in the contemporary United States, that is doubtful, the costs in time and funds for obtaining the written documents and the nightmare created, would negate the conduct of such useful studies.) Decisions determining the absence or presence of danger are placed in the hands of the Secretary of HEW or the courts. This language should not be included in the FY'78 appropriation bill. First, its objectives are redundant since the publication on March 13, 1975 of strict guidelines for the conduct of any research which could in any way put a human subject at risk. HEW is monitoring research conducted at institutions in all the sciences, and requires that Institutional Review Boards take careful note of the potential risks of subjects of research in determining whether to authorize the conduct of such research. The existing regulations evaluate legally informed consent with the understanding that some social science research cannot always use written consent consistent with its objectives and the safety of subjects.

The second reason for deleting the provision is that the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, the official qualified body studying the entire range of concerns regarding human subject research, will soon publish final definitive regulations for scholars engaged in science research. Since existing regulations already assure protection against real risks, and since definitive recommendations

are about to be issued, the further regulations called for by Section 411 are gratuitous and unnecessary. Dropping Section 411 will in no way remove the responsibility of researchers in the biomedical and behavioral sciences for the safety of human subjects. It will, however, remove a great deal of the confusion which resulted from the existence of conflicting government regulations on this issue.

CONCLUSION

While our recommendations are directed to funding levels for FY'78, we respectfully urge the Subcommittee to undertake a review of long-term patterns in the funding of national health programs. Until procedures can be established to assure institutions of continued program funding over a reasonable period of time, institutions, trustees and state legislatures will be reluctant to invest funds in training and research programs contributing to national objectives.

Last year, we noted that rapid increases in uncontrollable programs such as Medicare and Medicaid threatened to squeeze support for the controllable programs institutions of higher education are most involved in. We continue to urge that attention be given to monitoring those programs to prevent abuses.

The quality of national health care programs are directly dependent on the quality of the health education of those who serve the population, and on the quality of the research which produces the treatments and drugs used in health care. The Nation must fulfill its obligation by funding health education and research, as well as services.

Dr. DONALDSON. Thank you, Senator.

This is Dr. Calandruccio, who is current president of the American Academy of Orthopaedic Surgeons and chairman of the Department of Orthopaedic Surgery, University of Tennessee and Chief Orthopaedic Surgeon, Campbell Clinic in Memphis.

Dr. Weinstein will introduce himself.

Needless to say, it is a pleasure to appear before you. Orthopaedic surgeons not only surgically treat the various disabilities afflicting the musculoskeletal system, but also render medical care of those afflictions of the spine and the extremities not requiring surgery—such as sprains, strains, chronic degenerative conditions, and infections—as well as the more commonly considered matters such as degenerative joint disease, low back problems, athletic diseases, and industrial disabilities.

There is one area of concern we feel has not been stressed sufficiently in research efforts by the NIAMDD and we would like to bring it to your attention. We often see and treat, in conjunction with internists, many patients with osteoporosis; what laypersons would call softening of the bones. These bones may break with only minor trauma.

To date, research has been sporadic in both the cause and treatment of this very disabling disease that all of us, if we live long enough, will surely develop. The NIAMDD should spearhead and coordinate research in this area.

Our research efforts have many areas in common with the rheumatologists for we are both interested in the diseases affecting joints. The cooperation between our two disciplines remains high and productive. We support the recommendations contained in the report to Congress of the National Arthritis Commission and the budgetary requests on behalf of this Commission's report we also support.

Research in orthopaedic surgery deserves significantly more support than it has received to date. The establishment of the intramural program within the NIAMDD, as provided for in the National Arthritis Act of 1974, will provide the necessary leadership and focus for our efforts. A budget of at least $550,000 for fiscal year 1978 is a minimum requirement. I am pleased to inform you we have recruited a renowned orthopaedic research scientist to head it.

Extramural research must be supported so that we may find solutions to many of the problems with which orthopaedists must struggle in their attempts to reduce and eliminate the pain and suffering among our citizens. For example, we must learn more about total joint replacements, their design, wear properties and fixation. We need to know more about how joints function, how fractures can be made to heal more rapidly and more predictably. Our understanding of the mechanics of low back disorders is meager and must be expanded through research.

Last year when I appeared before you, I introduced part of our research, giving a look as to where we were, where we have been and where our research efforts must be focused. I would like again to bring this report to the attention of the committee.

Further, we have just begun a study to identify the demographics of the problems as they affect our citizens from the musculoskeletal point, studies to be done at Yale, and feel that this study will highlight

those areas where breakthroughs might be most important, so our research would not only be to expand the knowledge, but also would be directed toward our patients' problems in a more direct fashion.

We have considered the needs of the various medical disciplines housed within the NIAMDD and, recognizing their merit, we feel that the budget recommendations as contained in the citizens budget of the coalition for health funding of $285 million is justified. We urge you to support research within the NIAMDD at this level.

In addition, we feel that the research effort for orthopaedic surgery deserves funding at a minimum of $12.4 million of which $550,000 should be provided for the intramural program in orthopaedic surgery. Funding at this level will provide a modest but necessary increase in research in our discipline. We have discussed this with the leadership within the coalition for health funding and they concur with this recommendation.

Senator, I have a more formal and longer statement which I would like to have entered into the record. It has been a pleasure to appear before you today and present the needs of research in the musculoskeletal system on behalf of the orthopaedic surgeons of this country.

PREPARED STATEMENT

Senator SCHWEIKER. Let me thank you, Dr. Donaldson. I certainly commend you for your fine summary and I hope the others will follow suit because we have eight panels with three or four people on a panel. We only have 2½ hours and even at 5 minutes each we are going to have a hard time doing it. I think you have set a good tone and I think you gave very good highlights of your statement, and your full statement certainly will be included in the record.

Dr. DONALDSON. Thank you.

[The statement follows:]

STATEMENT OF WILLIAM F. DONALDSON, M.D.

Mr. Chairman:

I am Doctor William F. Donaldson, a Past President of the American Academy of Orthopaedic Surgeons. I am Clinical Professor of Orthopaedic Surgery in the School of Medicine, University of Pittsburgh, and I was a member of the National Commission on Arthritis and Related Musculoskeletal Diseases. With me is Doctor Rocco Calandruccio, the current President of the American Academy of Orthopaedic Surgeons. He is Professor and Chairman of the Department of Orthopaedic Surgery, University of Tennessee School of Medicine, and Chief of Orthopaedic Surgery at the Campbell Clinic, Memphis, Tennessee.

It is a pleasure to appear before you and the Committee to present information relative to the appropriations for the National Institute of Health (NIH) and, in particular, the National Institutes of Arthritis, Metabolism and Digestive Diseases (NIAMDD). I am familiar with the Citizens' Budget of the Coalition for Health Funding and I support it.

Orthopaedic surgery is that branch of medicine concerned with the diagnosis, treatment and research of the disabilities, illnesses and deformities that affect the musculoskeletal system. Specifically, we are responsible for the medical problems that disturb the function of the spine and the extremities. Thus, we have an interest in and the responsibility to seek answers to the myriad of problems that affect our bones, joints, muscles, tendons, nerves and blood vessels that support, nourish, ennervate and mobilize our body's motor functions.

Orthopaedic surgeons not only surgically treat the various disabilities affecting the musculoskeletal system; but, also, render medical care to those afflictions of the spine and extremities not requiring surgery such as sprains, strains, chronic degenerative conditions and infections. We have a particular interest

in problems of the low back, athletic injuries and industrial accidents and disabilities.

In our practices, usually in conjunction with an internist, we treat many patients who have osteoporosis - softening of the bones. Many of these patients are older women, but others are those who suffer from a wide variety of disabling diseases or injuries or who have had to receive prolonged medication such as Cortisone. These patients' bones are fragile, breaking easily, some requiring only a very minor trauma to produce a compression fracture of the spine or a fracture of the hip. Research efforts in this area have been sporadic and the problem of how to combat this progressive and exceedingly disabling condition remains unsolved. Various treatment programs, such as the use of hormones, flourides or calcitonin have been proposed. None of these have resulted in a cure and, at best, only slow the process. The NIAMDD should spearhead and coordinate research in this area. It has significance for all of our citizens as they become older. Each of us with increasing age will develop some degree of osteoporosis. Those of us who develop chronic diseases and/or who require drugs like Cortisone will develop it sooner. The solution to osteoporosis will do much to reduce the chronic disability of our people.

Orthopaedists have much in common with rheumatologists. Many of our activities in the care of patients with arthritis overlap and are often performed in cooperation with them. As a member of the National Commission on Arthritis, I participated in the development of the report to Congress and I support the Commission's recommendations. Of necessity, additional monies will have to be appropriated if the far-reaching benefits to our citizens of the Commission's plan to implement the National Arthritis Act, PL 93-640 are to become a reality. We support their testimony presented before this Committee.

And now, I would like to speak specifically to the needs of

research in orthopaedics. Research in orthopaedic surgery deserves significantly more support than it has received to date. Congress, in its wisdom, established an Intramural Program within the NIAMDD as a provision of the National Arthritis Act of 1974. We have just recruited a most renowned orthopaedic research scientist from Johns Hopkins University to head this program. Because of the lack of adequate research space on the campus at NIH, it is necessary to temporarily house the research laboratories for the Intramural Program in Orthopaedic Surgery at Johns Hopkins. With the completion of the new clinical center at NIH, this branch research effort will return to the main campus. A minimum staff for the NIAMDD to conduct this program consists of a Chief of the Intramural Orthopaedic Program, two professional associates and appropriate supporting staff. A budget of at least $550,000 for fiscal year 1978 is a minimum requirement. Among the projects to which the Intramural Program will address itself 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, improved modalities of fracture treatment and the further understanding of the structure and function of bone, cartilage, muscle, tendon and connective tissue.

The presence of an intramural program in orthopaedic surgery will compliment and enhance the work being performed within the Intramural Program for arthritis within the NIAMDD. Close cooperation and coordination will occur between these two programs in their areas of mutual interest. The appointment of an Associate Director of the NIAMDD responsible for arthritis and related musculoskeletal diseases as provided for in the National Arthritis Act of 1974 has furthered this combined effort.

Last year I provided the Committee with the report of our workshop held in New Orleans from December 14 to 17, 1975. This workshop was jointly sponsored by the NIAMDD and the American Academy of Orthopaedic Surgeons. The purpose of the workshop

was to review the past accomplishments, the current status and to project the future needs of research in orthopaedic surgery. Both needs and opportunities for research relative to the musculoskeletal system were identified. This effort represented a most unusual, a most vital study by which a medical discipline, orthopaedic surgery, took stock of its research efforts and developed a program for research with nationwide input. We are justly proud of the results of this workshop. The budget figures contained within the report are those that would be necessary to seek the answers in each of the many areas of needed research. With the establishment of the Intramural Program in Orthopaedic Surgery within the NIAMDD and with increased financial support for research in orthopaedics, we can appropriately phase into the suggested research program within the next few years. Additional appropriations for research in orthopaedics is vital to the development of this research effort.

Based on this report, we have planned additional workshops to explore in greater depth the research effort that must be undertaken in those areas where there appears to be the greatest chance for a breakthrough, where the answers found through research might have the greatest benefit to our patients and where a coordinated approach by our research community might be most beneficial.

Further, our Academy has just recently funded a study to determine the demographics of disability due to musculoskeletal afflictions. This study should clearly identify the characteristics of patients who suffer from those afflictions and then relate them to lost time from work, lost wages, the dollar cost to our society and the associated morbidity (the suffering amongst these patients). This study will, therefore, identify those areas where research might have the greatest relief of suffering and the greatest cost benefit, if the identified musculoskeletal conditions could be ameliorated or eliminated.

Ongoing and new research can be expected to further the suc-

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cess of artificial joint implants. The development of the total hip joint replacement has been a landmark in the history of medicine. This has resulted in the most successful method, by far, to rehabilitate the hip joint destroyed by arthritis. This surgical procedure has gained widespread acceptance and has returned many patients to a more comfortable and a more productive life. While our successes are many, there are still many problems to be solved through research. Wear of the component part of the artificial joint remains a problem, particularly as the procedure is considered for younger persons who are more demanding of their hip joints. This is an increasing problem as patients, whose functional capabilities are not otherwise limited by systemic disease or other joint involvement, are considered for total joint replacement. For example, the patients severely afflicted with rheumatoid arthritis, while markedly benefiting from a successful replacement, are often severely limited in their total functional capacity. Therefore, the demands they place upon their artificial joints are less. We must develop joints that will last a lifetime for the younger, active, more athletic working person whose hip joint is so damaged that replacement is required.

In addition to component part wear, we also have the problem of fixation of the implanted artificial parts. Loosening of these parts results in failure of the reconstructed joint. New fixation materials must be developed. Exciting work is currently underway in the experimental use of ceramics and cintered metals. Neither of these has reached the level of development where clinical application is possible.

As we extend the artificial joint replacement to other destroyed joints, additional problems arise for which solutions must be developed through research. For example, in attempting to replace the knee joint we have greater problems in developing and maintaining stability of the joint. Further, the arc of motion required of the knee joint is much more complicated and more

difficult to reproduce than the ball and socket arrangement of the hip. This decreased tolerance for error results in an increased incidence of wear and loosening. In our attempts to expand this technique to other joints such as the shoulder, the ankle, the elbow, the wrist and the finger joints, a host of new design, fixation, wear and fatique problems present and these require extensive research before solutions can be developed. To accomplish this requires the cooperative efforts between bioengineers, orthopaedists and many other disciplines.

Our current understanding of how joints function and what factors result in degeneration of the joints by osteoarthritis is, at best, meager. Osteoarthritis is the most common form of arthritis affecting our citizens. Erroneously, many of them feel that nothing can be done for them. Others feel that it is just a part of growing older and, therefore, must be accepted. Such an attitude upon the part of society and, in particular, medicine is no longer acceptable. Too many of our citizens suffer, are disabled and limited in their activities and, therefore, in their employability for us to tolerate such indifference.

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 joints afflicted with osteoarthritis. These studies will lead to the understanding of those things that can be done to reduce the incidence and to lessen or eliminate the disability which occurs with the degeneration of joints damaged by trauma, by athletic endeavors, by disease or by everyday activity.

Over two million of our citizens sustain a fracture each year. Recent experimental work suggest that fracture healing may be accelerated by passing electrical current across the fracture line. These and other studies are necessary if we are going to reduce the morbidity, the residual disability, and the time loss from work for those patients unfortunate enough to sustain

such an injury. The economic return will more than justify the cost for such research efforts.

As is detailed in the report on the workshop on Research in Orthoapedic Surgery, there are many areas of deficient knowledge that must be explored if our citizens are to have their musculoskeletal disabilities understood, their suffering reduced and their function restored so that they again become productive citizens. To do this we need to develop the young, emerging research worker in orthopaedic surgery. Through some mechanism such as a training grant program, funds must be made available to support these young investigators during their formative years. They represent our most valuable commodity in meeting these research needs.

Further, I would encourage the establishment of a musculoskeletal study section within the NIH. Research in the musculoskeletal system in orthopaedic surgery is so essential a part of the understanding of the diseases, injuries, deformities and disabilities affecting our citizens that it deserves its own study section.

We have considered the needs of the various medical disciplines housed within the NIAMDD and, recognizing their merit, we feel that the budget recommendations as contained in the Citizens Budget of the Coalition for Health Funding of $285 million is justified. We urge you to support research within the NIAMDD at this level.

In addition, we feel that the research effort for orthopaedic surgery deserves funding at a minimum of $12.4 million of which $550,000 should be provided for the Intramural Program in Orthopaedic Surgery. Funding at this level will provide a modest but necessary increase in research in our discipline. We have discussed this with the leadership within the Coalition for Health Funding and they concur with this recommendation.

It has been a pleasure to appear before you today and present the needs of research in the musculoskeletal system on behalf of the orthopaedic surgeons of this country.

## NATIONAL KIDNEY FOUNDATION

### STATEMENT OF DR. ARVIN B. WEINSTEIN, PRESIDENT

#### INCREASED FUNDING SOUGHT

Dr. WEINSTEIN. I am Dr. Arvin Weinstein, professor of medicine at the University of Wisconsin, Madison; director of the artificial kidney program at that institution. I am currently the president of the National Kidney Foundation.

I come here, of course, to speak on behalf of the National Kidney Foundation, the leading voluntary health organization dedicated to the needs of patients with kidney and urological diseases.

We have some 55 affiliates scattered throughout the United States, about 1 million volunteers, about 5,000 health professionals with the primary concern about kidney and urological disease.

I come to speak, of course, on behalf of increased funding for renal, kidney, and urologic research in NIAMDD.

I want to state that we have a very high level concern about the deterioration of funding for research grants that has occurred in this fiscal year.

In the view of many of us, this is nearly disastrous.

We have fallen from past experience of about 45-percent funding of approved grants to less than 20-percent funding of approved grants for fiscal 1977.

The list of unfunded programs and unfunded laboratories is indeed a matter of greatest concern to us. We would emphasize the importance of increasing funding for renal and urological research in fiscal 1978.

We feel that the urgency of this is heightened by the great concern that currently exists about the mounting costs of the medicare program for renal disease.

These are indeed by some criteria quite seriously mounting costs. Nonetheless, we continue to support our position that it is in fact good and wise public policy that there be a medicare program for end-state renal disease.

It only serves to heighten our awareness of the need to press on with research that will give us answers to the diseases that lead to progressive kidney failure, and the inevitable costs of supporting patients on dialysis and transplant when they do in fact develop end-stage renal disease.

We would target as the areas that require the largest expansion of research efforts first, nephritis, which accounts for over half of all of the patients who come to dialysis transplant with end-stage renal disease.

We would go on to add to that list of high-priority research areas: hypertension, congenital disease of the kidney and urinary tract, kidney stones, and, of course, diseases of the prostate gland.

In all these areas there are exceedingly encouraging developments to give us a reason to be hopeful that we will find answers to the basic mechanisms of these diseases.

I think that it is important to reiterate the fact that in addition to the inadequate level of funding for the individual investigator research grants and the marked reduction in the percentage of funding

of approved grants, that we want to also point out our concern about the low level of funding for the national research service awards and training grants.

These in 1977 fell to an exceedingly low level and have threatened the training programs in this country.

I would like to sum up, Senator, by suggesting that the committee consider an appropriation of approximately $30 million to support renal and urologic research.

This would represent an increase of approximately $7 million over fiscal 1977 budget for research in this area.

If this, in fact, were accomplished, we would be able to restore funding of approved grants through approximately 45 percent.

We would be able to restore the funding for national research service awards and training grants to the 1975 level and continue to support adequately the program mandated by the last Congress, namely the specialized centers for research in kidney stones and would also generously continue to fund the artificial kidney-chronic uremia program at their currrent levels.

We believe it is wise public policy to make a substantial investment in basic research.

Thank you, Senator.

Senator SCHWEIKER. All right.

As you probably are aware, the Senate did increase the NIAMDD budget by $13.7 million in a supplemental bill. That is the one in conference now at 1:30 today.

The House put $7.5 million in, so we are going have to battle between $7.5 and $13.7 million increase for this fiscal year.

While this isn't what you would like to see, at least it is an improvement, because the research has decreased in that institute with other competitive forces.

PREPARED STATEMENTS

So I think the supplemental at least is giving some relief to the problem you so well point out. Your full statement will be included in the record. Also, we will include all other written statements on this subject.

[The statements follow:]

# STATEMENT OF ARVIN B. WEINSTEIN, M.D.

Summary of the Testimony of Dr. Arvin B. Weinstein - President, National Kidney Foundation, in support of funding for the National Institute of Arthritis, Metabolism and Digestive Diseases, before the Committee on Appropriations, Subcommittee on Labor, Health Education and Welfare, United States Senate, 5 April 1977.

Position of the National Kidney Foundation on the Medicare End-Stage Renal Disease Program

Public Law #92-603 has virtually guaranteed access to dialysis and renal transplantations for all suitable patients with end stage renal disease by removing the financial barriers that existed prior to 1 July 1973. The Foundation remains steadfast in its support and endorsement of this landmark legislation.

Position of the National Kidney Foundation on Research Support for Kidney and Urologic Diseases

We remain committed to our previously articulated position that it is wise public policy to make substantial investment in basic research which addresses the causes of kidney and urologic diseases as well as fostering applied research. The ultimate goal is to increase our understanding of disease mechanisms and develop new technology which will enable us to prevent or cure the important diseases of the kidney and urinary tract. This is the goal which must be pursued if we are to prevent the suffering and disability associated with this group of diseases. There is therefore a pressing need to expand our research efforts in the following areas: glomerulonephritis, hypertension, congenital diseases of the kidney and urinary tract, stone diseases and infection as well as diseases of the prostate gland.

Current State of Funding for Renal and Urologic Research in N.I.A.M.D.D.

The reduction of funding of approved research grants in FY 1977 has resulted in a disasterous situation which threatens the viability of many high quality research programs.

We recommend an appropriation for NIAMDD which would provide $50,000,000 for Renal and Urologic Research. An increase of $7,000,000 over the FY 1977 budget in this category would enable the Institute to fund 45% of approved grants (rather than 20%), would restore funding of National Research and Service Awards and Training Grants to the 1975 level and support the SCORES for Kidney Stones and Artificial Kidney-Chronic Uremia Program at their current levels.

Mr. Chairman and members of the Committee:

I appear before you to testify on the need for increased support of Renal and Urologic research in the National Institute of Arthritis, Metabolism and Digestive Diseases. I am Dr. Arvin B. Weinstein, Professor of Medicine at the University of Wisconsin, Director of the Artificial Kidney Program at that institution and President of the National Kidney Foundation. I speak on behalf of the National Kidney Foundation, the leading voluntary health organization dedicated to the needs of patients with kidney and urologic diseases. Our organization includes 55 affiliates which virtually encompass the United States. Our membership includes nearly one million lay volunteers representing patients and consumers as well as about five thousand health professionals with a primary interest in patients with kidney and urologic diseases. We have a long record of commitment to support of research in this field.

Position of the National Kidney Foundation on the Medicare Program for End-Stage Renal Disease.

I would like to comment briefly on the position of the Foundation regarding the end-stage renal disease program which was authorized by Public Law #92-603 as a background to my more specific statements regarding appropriations to support research for kidney and urologic diseases in NIAMDD. We take considerable pride in the role that the National Kidney Foundation played in advising Congress of the importance of providing a Federal program to support the best available treatment for patients with end-stage renal disease. The Foundation remains committed to this position. Under this landmark program it has become a virtual right of all Americans to have access to artificial kidney treatment and transplantation without impediment or discrimination because of financial barriers. We are indeed proud of the fashion in which the private sector has increased its capability to provide access to care for patients with end-stage renal disease since the program went into effect in 1973. Prior to the development of the scientific background and technology which occurred between approximately 1945 and 1960 which enabled us to sustain life by artificial kidney treatment and kidney transplantation, virtually all patients with end-stage renal disease were doomed to an early death. Access to these life saving modalities of treatment was exceedingly restricted because of financial barriers prior to enactment of Public Law #92-603. Since 1973 we have extended the opportunity for a decent quality of life to tens of thousands of patients with end-stage renal disease. We recognize that there has been concern about the mounting costs of the Medicare End-Stage Renal Disease Program. It must be emphasized, however, that the costs are

related primarily to the expanding numbers of patients who have become beneficiaries of the program and the actual cost per year of treatment in dialysis has in fact declined since Medicare coverage became available. The decline is more impressive if we consider the inflationary rate over the last 3 1/2 years.

It is not my intent to question the wisdom of our national commitment to this program. On the contrary, as a spokesman for the National Kidney Foundation, I want to reinforce our previous position, namely that we cannot in good conscience withhold access to the life sustaining modalities of dialysis and transplantation from our fellow Americans. This review of the Medicare End-Stage Renal Disease Program is intended to heighten the awareness of the Congress to the urgency of increasing the appropriation for basic and applied research for the National Institute of Arthritis, Metabolism and Digestive Diseases so that we hasten the time when we will be able to prevent or cure the commoner renal diseases that produce end-stage renal disease.

Position of the National Kidney Foundation on Research Support for Kidney and Urologic Diseases

Our commitment in the National Kidney Foundation is not confined to patients with end-stage renal disease. Our concerns extend over the entire spectrum of kidney and urologic diseases. These include hypertension, which still remains one of the most important causes of severe kidney damage, diseases of the prostate gland, kidney stones, congenital diseases of the kidney and urinary tract and infections of the kidney and urinary tract.

If we consider the present situation and the very near future prospective, we can look to wider application of the best current medical practices. The latter are based on the existing level of knowledge and technology. Compared with our state of knowledge and practice in the 1940's and 1950's, we have indeed made impressive progress. This capability came out of past research supported by the National Institutes of Health as well as by foundations and other segments of the private sector. We cannot rest content with the current state of the science and the art in medicine. We are obligated to press on in our mission to gain the new knowledge of the basic causes of disease which will ultimately lead to rational methods of prevention and cure. New and fundamental insights into disease processes are only acquired by sustained and painstaking search. At times, progress appears exasperatingly slow.

Nonetheless, we as physicians and medical scientists find clear evidence that real progress is in fact occurring in terms of our understanding of basic mechanisms of kidney and urologic disease. The major targets are not difficult to identify. I would like to comment on them briefly.

Goals and Progress

1) Glomerulonephritis. This family of diseases accounts for approximately one half of all the kidney diseases leading to progressive impairment of kidney function and end-stage renal disease. We are heartened by the improved understanding that has occurred in this area during the last 10 years. There is every indication that the current research efforts which relate the destruction and scarring of kidney tissue to our evolving understanding of the immunologic basis of glomerulonephritis, will in the predictable future lead to the development of powerful tools to prevent and cure this group of kidney diseases. We strongly support increased support of research in this high priority area.

2) Hypertension continues to be an important cause of end-stage kidney disease. The currently available treatment methods, primarily by drugs, have already demonstrated their ability to not only control hypertension but prevent progression of disease of the kidney, heart and other parts of the blood vessel system. An enormous body of knowledge and experience has acummulated as a result of the many pronged attacks on this problem supported by research within the National Institutes of Health. We still lack, however, complete understanding of the causation of the commonest type of hypertension, i.e. essential hypertension.

3) Congenital diseases of the kidney and urinary tract refers of course to that group of diseases present from birth although in some instances manifested many years later. This group of diseases is not only responsible for considerable morbidity and disability in children and young and middle aged adults, but also leads to the end-stage renal disease requiring treatment by dialysis or transplantation. We still have only the most elementary insights into the developmental abnormalities that we characterize as congenital or hereditary diseases of the kidney and urinary tract. Yet it remains a relatively neglected and undeveloped area of research.

4) The occurrence of stones in the kidney and urinary tract results in many thousands of days of disability and hospitalization in the United States each year. It is encouraging to contemplate the fact that we now have the tools to probe into the disturbances of biochemistry leading to stone formation and there should be a rapid growth of knowledge in this area which could lead to ultimate prevention of stone disease. The funding of the Specialized Centers of Research (SCORES) for urolithiasis during the last Congress is a most appropriate and promising initiative.

5) Infections of the kidney and urinary tract produce a tremendous amount of illness and disability in Americans of all ages. Although we now have a considerable armamentarium of drugs and medications to control and prevent destruction of kidney tissue by infection, there is a crucial requirement to support ongoing investigative efforts designed to elucidate the basic causes of kidney and urinary tract infections.

6) Diseases of the prostate gland include prostatitis which is a poorly understood but important clinical problem in young and middle aged men. The entity called benign prostatic hypertrophy occurring in upper middle aged and older men is indeed a major cause of illness requiring hospitalization and surgical management. It may produce serious impairment of kidney function. The current research initiatives in the NIAMDD will ultimately give us a better understanding of the causation and prevention of this widespread problem.

Current State of Funding for Renal and Urologic Research in NIAMDD.

The reduction in support for individual investigator initiated grants for renal and urologic research in NIAMDD has had a demoralizing effect on the entire research community. Whereas in recent years approximately 45% of approved grants were funded, it appears that in fiscal 1977 only about 20% of approved grants will be funded. This disasterously low level of funding for approved grants is attributable to an increase in Congressionally mandated programs in NIAMDD without commensurate increase in appropriations to cover the costs. It is particularly distressing to analyze the grants that remained unfunded since many of them address the basic problems of the diseases that I have earlier described, and were from laboratories which have excellent records of research productivity. Our concern is heightened by contemplating the very limited amount of money available for support of Research Fellowships and Training Grants. Current funding remains substantially below that available in 1975. I cannot emphasize strongly enough the crucial importance that NIH supported fellowships and training grants have played in the development of our research capability. The viability and vigor of the entire research establishment is threatened by an inadequate funding of research experience for future investigators.

The NIAMDD budget for kidney and urologic research in fiscal 1977 is $23,223,000. A conservative estimate of what should have been allocated for the current fiscal year in order to provide funding for 50% of approved grants is $27,165,000. We strongly recommend that the Congress allocate 30 million dollars to support kidney and urologic research within NIAMDD for fiscal 1978. We appreciate the reluctance to seek Congressional mandate for directed funding. Nonetheless we urge you to provide directed funding of 30 million dollars for this purpose. This level of appropriations would restore funding of regular research grants to an appropriate level, restore the National Research and Service Awards and Training Grants to the 1975 level , continue to provide support for the Artificial Kidney-Chronic Uremia Contract Program at its current level, support the SCORES program for Kidney Stones at an adequate level as well as provide for a modest increase in Intramural Laboratory and Clinical Research.

In closing, I simply want to re-emphasize the fact that I and other members of the National Kidney Foundation perceive as a virtual crisis the inadequacy of funding for research in this area. It is our judgement that failure to fund at approximately the levels suggested would in fact have a profound and protracted adverse effect on the evolution of our research capability and ultimately our ability to make substantial progress in preventing and curing kidney and urologic diseases.

Thank you.

## STATEMENT OF SUZANNE R. ROSENTHAL

Mr. Chairman, and members of the Subcommittee, I appreciate this opportunity to appear before you as Vice President and Co-Founder of the National Foundation for Ileitis and Colitis, and as a member of the Advisory Council of the National Institute of Arthritis, Metabolism and Digestive Diseases.

The 1976 Annual Report of the NFIC was recently sent to every member of the Subcommittee on H.E.W. Appropriations, and we hope you found it informative. It was our natural inclination to share the Report with you, since we believe you are major partners with us in the struggle to conquer inflammatory bowel disease, which now affects over two million people.

We believe that together, the NIH and the NFIC have come very far, but not far enough. I would like today to provide updated information about the advances and the frustrations in inflammatory bowel disease research, training, and health care delivery.

### Advances by NFIC

In the fiscal year 1976, NFIC was able to spend 83% of its budget on research and educational programs. Specifically, this translates into 16 different research projects and a nationwide system of educating both patients and physicians through literature, seminars, and symposia.

To date, NFIC has sponsored close to $2 million in research grants, and in recent years has given special attention to the very promising areas of virology and immunology.

In addition, NFIC now has programs to meet two important needs:

(1) the development of a younger generation of research minds to sustain research in the future. NFIC has initiated a Research Training Awards or fellowship program to attract young gastroenterologists into this area.

(2) The translation of research findings into practical and usable clinical treatment methods. Towards this end we are publishing a scientific newsletter and a bibliography of scientific papers which permit easy reference and guidance for the clinical gastroenterologist.

### Scientific Progress and Priorities

Overall, as a result of the efforts of NFIC and the NIH, important progress

has been made. An elaborate federally-supported nationwide clinical trial, based on an NFIC-supported protocol, was conducted to evaluate the relative merits of corticosteroids, sulfa drugs and other medications used in the treatment of ileitis. Similarly, carefully conducted follow-up studies of large numbers of patients who underwent surgery have led to improvements in surgical techniques, with clearer understanding of the complications of certain types of bypass operations, and of the varying risks of disease recurrences following different types of surgery. And vast improvements have occurred in the techniques of the internal continent ileostomy and in diagnostic procedures with use of fiber optic instruments.

Based on a study of what has been done thus far, the most urgent priorities that must be addressed in the future are the following:

(1) Isolation of the "transmissible agent" of Crohn's disease. Since there are no real treatments for this inexorable inflammatory disease of the bowel, an all-out program is necessary to isolate and define the nature of the agent which several groups have now shown can transmit granulomas from Crohn's tissue to mouse and rabbit. Serial transmission from animal to animal is the next step and is essential to cultivate and discover the kind of virus agent operating in this disease process. 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.

(2) Ulcerative colitis and cancer of colon. The question must be answered of why long-standing ulcerative colitis leads to cancer of the colon in such an alarmingly high percentage of patients. This answer will allow treatment of the colitis patient without the sacrifice of the colon. Equally important, this answer will give needed information regarding one of the most prevalent cancers in man, cancer of the large bowel.

(3) In another area, fifteen 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.

(4) Mechanisms of injury and repair of intestinal (ileal and colonic) mucosa. More study is needed of the mechanisms which damage and also repair the bowel in a whole group of serious diseases: ulcerative colitis, ischemic colitis, antibiotic-induced colitis, and diarrhea. The interaction between the intestinal microbiological population (viral and bacterial) and the metabolic cycle of intestinal mucosal cell turnover can now be tackled and, if solved, will offer new ways of influencing the repair processes favorably.

(5) 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 "marker" 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.

(6) 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. Also, there are a few preliminary signs suggesting the involvement of a micro-organism in ulcerative colitis (the most common form of chronic colitis, an ulcerating inflammation of the inner lining of the colon).

We are pleased to inform you that the NFIC is currently supporting at least one project in each of the areas mentioned above. But our resources are limited and for every project that is funded, there are a dozen others which must be held in abeyance. Only the NIAMDD has the resources to sponsor the coordinated program of research needed so desperately in these priority areas.

Health Care Priorities

Probably the most significant event of 1976 for digestive diseases was the establishment of the Digestive Disease Commission, which is mandated to report on

a wide range of needs in prevention, diagnosis and health care delivery. NFIC is committed to cooperating with the Commission in every way possible, and believes that the Commission's report will be a milestone in all of our efforts to conquer digestive diseases.

Our only concern is that funds for the Commission's operation not be taken from the NIAMDD research budget, but rather be provided above and beyond these NIAMDD allocations.

Need for Funds in Digestive Disease

The NFIC finds the proposed budget for the National Institute of Arthritis, Metabolism and Digestive Diseases for fiscal year 1978 extremely disappointing. We believe that a more reasonable budget figure is $285 million for the entire Institute, with no less than $39,188,000 for Digestive Diseases alone. We emphasize strongly that this figure is a critical component of the overall budget, without which the total figure of $285 million would not be meaningful.

Our request is based on the following reasons:

(1) Digestive diseases are a unique health field in that so many different diseases fall within this category. While the overall allocation to Digestive Diseases seems large, the number of divisions necessary result in only a small sum for each digestive disease.

(2) Digestive diseases have always been a step-child in terms of national health priorities. While over 10% of the cost of caring for sick Americans is due to digestive diseases, less than one percent of the Federal government's budget for health research and education is spent in this area.

(3) Funds for National Institute of Arthritis, Metabolism and Digestive Diseases are not keeping pace with inflation, and even with the 1977 supplemental budget of $10.6 million, we are barely returning the budget to the 1976 level.

(4) With the advent of the Digestive Disease Commission, priorities will be understood and detailed even more clearly than in the past. To fund the $700,000 needed for the Commission from the 1978 NIAMDD budget now proposed would be to limit the very progress that the Commission was legislated to promote.

(5) Unless the Fiscal Year '78 budget is increased, current research studies will be discontinued, and new studies will remain in limbo.

(6) With increased funds, a geometric progression in digestive disease knowledge might be possible. Without it, we may have only the slow and painstaking steps of addition, one by one, as research is done consecutively.

Summary

In summary, the status of ileitis and colitis in 1977 remains the same. Cause: unknown. Cure: unknown. There are still 2,000,000 sufferers of all ages, with an estimated 100,000 cases reported each year.

While the social costs in human suffering are incalculable, we do know that the economic costs are a staggering burden to American society.

By appropriating $285 million this year, we know that millions of dollars can be saved in health care costs. We respectfully urge you, Mr. Chairman, and all the members of this Committee to give consideration to our concerns.

AMERICAN SPEECH AND HEARING ASSOCIATION

## STATEMENT OF VIVIAN DEMPSEY, AMERICAN SPEECH AND HEARING ASSOCIATION

### DESCRIPTION OF WORK

Senator SCHWEIKER. Our next group is here to testify on behalf of the many programs of the National Institute of Neurological and Communicative Disorders and Stroke.

Will the panel representing that institute's programs please come forward?

Ms. DEMPSEY. I am Vivian Dempsey.

We have close to 27,000 members now. Almost all are holders of master's degrees with an estimated over 200 health professions being licensed now by the various States.

If I could take a few seconds of our precious time to describe who we are. Speech and language pathologists are engaged with individual therapy with those with speech problems. Typically they work in the public schools with children who have problems severe enough to hamper learning. They also work with victims of stroke or accidents who have lost speech or laryngectomies. They are highly trained in the science of hearing and employ a whole battery of tests to find a solution of hearing problems tailor-made to the individual.

These solutions include not only fitting hearing aids but includes training people to listen through hearing aids and maximizing remaining hearing in any one ear.

Because communication is so pervasive and because disorders occur in all ages and stages of the population—there are 21 million according to current estimates—the American Speech and Hearing Association naturally has extensive interest in these hearings. While this panel is primarily concerned with NINCDS, I should address this first. But I would like also to comment on NICHD headstart.

NINCDS is the most underfunded of the National Institutes in relation to the amount of research activity going on in the field. They approve 60 percent of its—of the research proposals it receives. Because of its low level of funding it is unable to award grants to all but 10 percent.

The ratio of grants approved, to grants awarded is half that of the next lowest institute. These figures indicate that in the area of neurological and communicative research there is active research and willing and capable researchers in the field. They also indicate the fields of communicative and neurological disorders and strokes are being given short shrift vis-a-vis other demands on the dollar.

The field of research in communicative disorders has many unfinished projects. Hearing amplification is a ripe field for research. With 600,000 hearing aids being sold annually, it is indeed a shame that technology must wait in the wings for the fickle Federal research dollar. The natural aging process is generally accompanied by hearing loss. So far research has been unable to develop a technique for successful amplification for presbyacusis.

In a related area of needed research some progress has been made toward developing a prescriptive device which would accommodate the hearing aid to the individual's hearing loss.

In the area of speech disorders, additional research funds are needed for evaluating efficacy of implantation aids for laryngectomies and other severely impaired adults, such as those suffering from MS, Parkinson's disease.

Vocal aids must be developed. NINCDS with primary responsibility for research in the development of language skills needs additional funds for research into the effects of noise on language development and speech discrimination crucial in early childhood and important in elderly hearing-impaired individuals.

The clinical facilities of NINCDS are inadequate for care of its ambulatory and outpatients. Clinical research particularly in the area of hearing is thereby constricted. Both for purposes of its own research and as a model for other facilities, NINCDS needs complete clinical facilities with full auditory testing and training capabilities.

Cost of development and staffing is estimated at $1 million and 10 permanent positions.

I will now move to NICHD. Delay in the acquisition and development of language and speech may be the first and most obvious predictor of potential academic learning problems. Educational systems traditionally have made the assumption that a child comes to school with an intact oral language system.

This assumption is fundamental and implicit to the construction and curriculum that emphasizes read and written language.

However, some children come to school without such language skills. These children are predictably at risk for school failure. The development of communicative competence and performance in children is a central issue in learning disabilities for the speech language pathologist and audiologist.

The training of speech language pathologists includes training in the comprehensive assessment of oral language performance and related sensory and perceptual skills.

Every child with symptoms of learning problems should receive language, speech, and hearing assessments. These assessments should be provided by or under the direct supervision of qualified speech language pathologists.

Because of the critical nature of reading skills to learning, more emphasis must be given to uncovering the brain processes involved in dyslexia and its causes. NICHD needs an additional $2 million to fund research in areas which would augment its ongoing dyslexic research.

Two needed areas are objective measures for identification and research into causes of dyslexia.

In the headstart program 54 percent of the children who are categorized as handicapped are speech or hearing impaired. Speech and hearing impaired children also figure significantly in the categories of multiply handicapped, mentally retarded, and health or developmentally impaired, which together comprise an additional 28 percent of the headstart population.

Speech language training is by far the special service most greatly needed by the handicapped children involved in Headstart. Communication skills, of course, are essential to preparation of the headstart children for our educational system. Staff capability in working with handicapped children is a critical feature in quality services. Even

though headstart received $20 million for its handicapped program, it estimated that the average annual cost of providing special services to handicapped ranges from $1,150 to $1,490 per child above and beyond the average base per child cost.

Therefore, in order to provide full services for the speech and hearing-handicapped children, $12 to $28 million would be necessary. Rehabilitation Services Administration is one of our oldest concerns, yet we feel that there is a disparity in the funding between deaf and hearing-impaired within that agency.

Over 50 percent of the funds devoted to speech and hearing go to a small minority of the communicatively handicapped—only 140,000 who are presently vocationally deaf.

Although RSA uses the 1.8 million deaf figure, it is really providing services only to those who have not developed language skills before the time they were stricken.

Many of the techniques, such as speed reading, use of telecommunications equipment, improving understanding of coworkers, have equal applicability to the hearing-impaired as they do to the deaf, although their application has only been to deaf.

We believe that in—an $11 million increase contemplated by the administration would represent an effective reduction in RSA's budget vis-a-vis inflation. Therefore, we believe that a figure of $46 million as an increase over last year's budget would be a more realistic figure.

Thank you very much.

Senator SCHWEIKER. You say the funding level of the Institute in terms of applications is only 10 percent?

Ms. DEMPSEY. Yes.

Senator SCHWEIKER. Who is the second lowest?

Ms. DEMPSEY. I do not have the chart with me, although I can get that figure and provide it for you.

Senator SCHWEIKER. A valid point.

PREPARED STATEMENT

We will put your whole statement, which I find very complete, in the record. I think your point was very interesting.

[The statement follows:]

## STATEMENT OF VIVIAN DEMPSEY

THE AMERICAN SPEECH AND HEARING ASSOCIATION

The American Speech and Hearing Association (ASHA) is a national scientific and professional society made up of more than 26,000 speech-language pathologists and audiologists. The speech-language pathology and audiology professions are the primary disciplines concerned with the systems, structures and functions that make human communication possible. Our members are knowledgeable about the effects of delay, maldevelopment and disturbance in human communication and with the identification, evaluation and habilitation of individuals with speech, language and hearing disorders. Speech-language 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 year of supervised clinical internship. These standards, along with passing a national examination administered by the Educational Testing Service, are those set by ASHA for the award of the Certificate of Clinical Competence in speech-language pathology or audiology.

Speech-language pathology and audiology practitioners render their professional services in such settings as hospital speech and hearing clinics, freestanding speech-language pathology and audiology clinics, university outpatient clinics, outpatient rehabilitation centers, such as Easter Seal agencies, Veterans Administration hospitals, Head Start programs, private practice and private and public schools.

Those receiving the services of speech-language pathologists and audiologists are thousands of Americans (including 20 to 20 percent of the growing number of people 65 and older) who experience bilateral hearing losses of a magnitude sufficient to seriously restrict their understanding of speech, Our members also serve 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-neural impairments.

The most recent federal government data puts at 20 million the number of communicatively-handicapped Americans.[1] Some 8 1/2 million Americans have "hearing problems of one type or another which are less severe than deafness but which impair communication and hence social efficiency."[2] Americans plagued by central communication disorders (e.g., 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.[3]

Communication disorders occur in people of all ages. Over half of the nation's elderly have some degree of hearing loss and 5-20% of our school children (the broad range is due to the lack of accurate data) risk educational deficits because of a speech or language problem.

Because the people we serve range across all age and income strata, and we serve them in facilities ranging from schools, to hospitals, to clinics and in their homes, this statement of the American Speech and Hearing Association is equally broad-ranging.

Therefore, in this statement, ASHA will address the funding needs of (1) the Office of Education, Bureau of Education for the Handicapped, as well as six HEW health programs: (2) Office of Human Development, Office of Child Development; (3) Office of Human Development, Rehabilitation Services Administration; (4) National Institute of Neurological, Communicative Disorders and Stroke; (5) National Institute of Child Health and Human Development; (6) National Institute of Dental Research; and (6) National Institute of Mental Health. For your convenience, ASHA's health testimony begins on p. 14.

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[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, Maryland (1969).

[2] Ibid., p. 13.

[3] Ibid., pp. 16-17.

Office of Education

Bureau of Education for the Handicapped (BEH)

For nearly all of its 200 years, this country has been attempting to devise effective programs of service for handicapped individuals in the communities of America. To accomplish this end, policy makers must be able to estimate, among other variables, the number of persons in need of special services -- both those who are receiving them and those who are not. Accordingly, governmental agencies, state departments of health and education and professional organizations annually have need for and request prevalence data on handicapping conditions.

Prevalence is the term applied in reference to the number of people in a total population with a particular common characteristic and in this document refers to those with a given type of communicative disability. Incidence, as used in this document, may be regarded operationally as the number of new cases of a given disability occuring per year, by actual count.

The ASHA, supported in part by funds provided by the Department of Health, Education and Welfare, Bureau of Education for the Handicapped, Division of Research and by the Institute of Child Health ahd Human Development, National Institutes of Health, undertook a comprehensive review and critique of representative literature regarding the prevalence of handicapping conditions in the United States, with particular attention to those impairments affecting the process of communication.

Its major focus was to identify the many sources of information and to discuss the kinds of problems that confront any attempt to achieve consistency, in view of the contradictory definitions used to delimit handicapping conditions and the multiplicity of divergent techniques and procedures used to derive the data, as reported in the numerous studies, surveys, reports and other secondary sources.

It is our belief that, as data are being used routinely to plan and project program and manpower needs, to supply services and to allocate resources to support such services, it has become essential to ensure the adequacy of data categories and definitions and the accuracy of information therein.

In order to ensure full implementation of P.L. 94-142, the Education for All Handicapped Children Act, our comments are directed toward the goal of achieving consistent, dependable, accurate data.

Most estimates are based partly on empirical evidence and partly on the judgment of the estimator. The most frequently quoted estimates seem to take on an aura of authenticity due more to the fact that they appear to be the only available source rather than to their actual validity. Although most if not all prevalence data are fallible, the proportions of the problem are clearly indicated by the various reports of the size of the communicatively-inapired population.

Further, it should be noted that most of the succeding estimates, with the exception of statistics from the census of the deaf population, as reported by the various references were from the same source -- the NINDS monograph, Human Communication and Its Disorders: An Overview (1969). This document is the most quoted singular source of data on which succeeding estimates have been based routinely. The data are at least as old as 1950, dating to the mid-century White House Conference and should be regarded as conservative in that they are the lowest defensible estimates. These figures are appreciably higher at present because of the population growth since the time of the White House Conference.

The 1976 Department of Health, Education and Welfare Report to the House Committee on Appropriations indicates the actual prevalence of communicative disorders in the United States is double previous estimates. According to this document, approximately $20,000,000 have communicative handicaps.[4] Of this number, approximately 3 million possess learning disabilities severe enough to interfere with communication and the development of speech and language. About 5 million represent children and adults with significant speech and language difficulties generally unrelated, or only in part related, to learning disorders. Among these communicative problems are those related to stuttering (affecting approximately 1,000,000 children and adults), aphasia, articulation and voice disorders and developmental language disorders. These problems may be related to other handicaps such

[4] United States Department of Health, Education and Welfare Report on Hearing and Speech, a Report to the Committee on Appropriations, 1976, p. 17.

as cerebral palsy, mental retardation, learning disabilities, laryngectomy and emotional disorders.

The incidence and prevalence of language and language-learning problems are not known. Only recently has there been increased awareness of the problems many children have in using linguistic symbols in comprehension, transformation and/or expression for communication. Language development may be hindered or impaired from birth as a result of impaired hearing, mental retardation, infantile autism or specific brain damage. Children who do not exhibit any of these problems but still fail to develop normal language skills often have what is termed a developmental language disability. Those with multiple handicaps have a strong chance of having language handicaps as well. There is a high correlation between language disorders and neuromoter defects, perceptual handicaps, epilepsy and learning disabilities.[5]

The Department of Health, Education and Welfare document, cited previously, stated that language-impaired youth are usually grouped with the speech impaired,[6] and indicated that approximately 3.5 million children between the ages of 4 and 17 years had some degree of language disability.[7] The report, however, provided no discussion with respect to the procedure used to derive that number. The ability to read is critical to the process of normal learning. Recent studies have been undertaken to determine how reading skills are acquired and overlaid upon spoken language. Part of this focus of attention is an effort to understand dyslexia, a specific language-related dysfuction reflected in reading problems. Such difficulties are found in children who, ordinarily, would be expected to be able to learn to read; that is, children of normal intelligence who are without sensory impairment, primary emotional problems or obvious neurological deficit. It would appear that these studies represent a necessary focus of attention, in view of the fact that 8 million chiddren currently in Amer-

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[5] National Institute of Neurological Diseases and Stroke, National Institutes of Health, U.S. Department of Health, Education and Welfare. Human Communication and Its Disorders: An Overview, Bethesda, Maryland: NINDS Monograph No. 10, 1969, p. 15.

[6] Ibid, p. 6.

[7] Ibid, p. 45.

ica's elementary and secondary schools will not learn to read appropriately. One child in seven is handicapped in his ability to acquire essential reading skills.[8] The dimensions of this disability become even more relevant when confronted with the fact that approximately 26 million children, youth and adults cannot function effectively because of reading problems.[9]

Anything approaching comprehensive or reliable estimates of the size of the language-disabled population of children remains unknown. It should be noted that in its review of existing data, ASHA found no separate categroy to indicate prevalence figures or estimates for the language-disabled population. Most often, it would appear, this population is included with the speech-impaired group,[10] with the learning-disabled group or not at all. More precise definitions and diagnostic procedures are required before the size of this population can be delimited adequately.

Therefore, we recommend that the Bureau of Education for the Handicapped be funded to carry out a prevalence study of language-impaired handicapped children and that, in the future, BEH require reporting of data which includes the discrete category of language impaired.

Despite the fact that education represents one of the greatest investments of resources and is perhaps of the greatest developmental and rehabilitative benefit for the handicapped, accurate documentation and reliable research from the field -- with respect to the size of the population requiring services -- have been, and continue to be, relatively scarce. Estimates of the number of handicapped individuals by category vary widely depending on the definitions used, the data believed and the type of service needed. A major complication arises in view of the fact that definitions of handicaps are not consistent among service agencies. The handicap, if defined at all, is almost never clearly stated and, therefore,

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[8] "Reading Disorders in the United States," Report of the Secretary's [HEW] National Advisory Committee on Dyslexia and Related Disorders, August 1969, p. 4.

[9] Information provided in telephone conversation with a representative of the International Reading Association (Right to Read), Newark, Delaware, January 1977.

[10] Milisen, Robert. "The Incidence of Speech Disorders," in Travis, L.E. (Ed.) Handbook of Speech Pathology, New York: Appleton-Century-Crofts, Inc., 1957, p. 358.

reliable data on the prevalence of handicapping conditions generally are not available. One example of the data game is a state which simply moved the vast bulk of categorically handicapped into the category "other," thereby avoiding all definitional problems as well as any later earmarking requirement.

Several categories of handicap on which data is collected by BEH may prove more misleading than helpful.

Learning disabilities is the only category with a statutory definition. Despite this definition, there has been much subjectivity and opinion concerning the nature of deficiencies in learning. Isolated professional approaches have characterized much of the work.

It is apparent that the definition above is not very precise. Many responsible for identifying learning disabilities have not been trained for such work,[11] and as a result, many of the classifications are basically educated guesses unsupported by research evidence.[12]

Estimates of the prevalence of the learning disabled cover an extremely wide range, from approximately 3 percent used by the Bureau of Education for the Handicapped to as high as 20 percent.[13] As may be anticipated, the problem is due in part to the considerable variation in the terminology by which children are identified. For example, as part of a major study investigating minimal brain dysfunction in children, the Subcommittee on Education surveyed school administrators and teachers working with children identified as learning disabled.[14]

The terms used to identify special classes for children with learning disabilities were, in the order of frequency found in the replies:

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[11] Kakalik, James S., et al. Services for Handicapped Youth: A Program Overview, prepared for the Department of Health, Education and Welfare, Office of the Assistant Secretary for Planning and Education (R-1220-HEW), Santa Monica, California: The Rand Corporation, May 1973, p. 281.

[12] Frierson, E.C. and Barbe, W. Educating Children with Learning Disabilities: Selected Readings. New York: Appleton-Century-Crofts, 1967, p. 3.

[13] Fleischmann, M. Report of the New York State Commission on the Quality Cost and Financing of Elementary and Secondary Education, Vol. II, Albany, New York, 1972.

[14] Minimal Brain Dysfunction in Children, Public Health Service Publication No. 20015, 1969, p. 21.

| | Percent |
|---|---|
| Educationally Handicapped | 19.5 |
| Learning Disabilities | 19.5 |
| Perceptually Handicapped | 14.9 |
| Brain Injured | 9.2 |
| Minimal Brain Damage | 5.1 |
| Special Learning Disorders | 3.8 |

In all, 30 separate definitions were used to delimit the learning disabled population.[15]

It is believed that there are high incidences of speech and language disorders among the mentally retarded. However, here again data is completely lacking.

Current BEH guidelines require handicapped children to be counted only once, by their primary handicap. This fails to recognize the high correlation between other handicapping conditions and communicative disorders.

In order for the Commissioner of Education, through the National Center for Educational Statistics, to fulfill the mandate of P.L. 94-142 to report to Congress annually on the children, served and unserved, by disability, it will be necessary to collect data on the incidences of speech and language impairments among those listed in other handicapped categories. For example, a child classed as "learning disabled" who has a concomitant speech disorder but who is not receiving the services of a qualified speech-language pathologist will not be reflected in the data as presently collected as unserved for his speech disability.

Therefore, we recommend that BEH receive funds to let a contract to sample all categories of handicapped children to determine the incidence of communicative disorders. We have stressed the central importance of communication skills to the teaching methods in the public schools. If, as we suspect, there is a positive correlation between communicative disorders and other handicapping conditions, such a study would provide the needed impetus for BEH to ask for and collect data on secondary handicaps.

P.L. 94-142 indicates that local school districts must offer a continuum of placements for handicapped children. Service programs for the communicatively handicapped have typically used itinerant personnel to provide services on an intermittent basis. Little data exist on the most effective delivery of service models that could be used to meet the needs

[15] Derived from ASHA's literature review.

of the communicatively handicapped. If speech-language pathologists and audiologists are going to be required to use a variety of placement options, it is necessary to have data on the effectiveness of each component of the continuum in meeting the needs of the communicatively handicapped.

Therefore, we recommend that BEH receive money to fund a research project to determine the effectiveness of the various delivery of service models and continuum placement options. Further, little data exist on the cost of providing comprehensive language, speech and hearing services in the schools. Most cost analysis studies completed in special education have not provided an indepth analysis of the various special education and related service programs. There is little data that indicate the cost of providing various services necessary for a comprehensive language, speech and hearing program. As a part of the study on service delivery models, a cost analysis procedure should be developed that would indicate the services and costs necessary for a comprehensive language, speech and hearing program.

Last year, BEH funded a study of the hearing aid distribution system in the public schools in Los Angeles. The report, "Condition of Hearing Aids Worn by Children in the Public Schools," points up the lack of follow-up care for schoolchildren wearing hearing aids. While these children are being identified through hearing screening and appropriately fitted with aids, no one is following through to make sure the hearing aid is in working order, is operating with the specified parameters and has working batteries.

In order that the knowledge gained in the Los Angeles study not merely be filed away, we recommend a further study to identify the problems which are preventing effective follow-up, from lack of parent counseling, lack of teacher awareness or undersupply of audiologist follow-up in the public schools.

## Office of Human Development

### Office of Child Development

The Headstart, Economic Opportunity and Community Partnership Act of 1974 requires that for Fiscal Year 1976 not less than ten percent of the total number of enrollment opportunities in Head Start programs in each

state be available for handicapped children. Handicapped children are defined in the legislation as "mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired or other health impaired children or children with specific learning disabilities who by reason thereof require special education and related services."

The program thrust in response to this mandate was to enroll children with substantial and severe handicaps into Head Start programs. Children professionally diagnosed as handicapped account for at least 12.2 percent of the children enrolled in reporting full year programs. Comparison with 1975 indicates that the proportion of professionally diagnosed handicapped children increased from 10.2 percent to 12.2 percent. These data reflect more accurate information on the number of children professionally diagnosed, their handicapping condition and services provided to them.

Responding to the mandate under the statute, states are reporting an increased number of multiply handicapped children and an increased number of children in need of special services. Nearly one of every three handicapped children is reported as having multiple handicaps as compared to one out of every four handicapped children the previous year.

The distribution of handicapped children in Head Start by category of handicap is as follows: 47.96 percent speech impaired and 5.98 percent hearing impaired. Fifty-four percent of Head Start children are speech or hearing impaired.[16]

Speech and hearing-impaired children also figure significantly in the categories of multiply handicapped, mentally retarded and health or developmentally impaired, which together comprise an additional 28 percent of the Head Start population. Speech-language training is by far the spe-

[16] The percentage of speech impaired, according to Head Start data collection policies, reflects only those with a significant impairment. Thus, "conditions of a transitional nature consequent to the early developmental processes of the child" are not included in the 47.96 speech impaired figure. The Status of Handicapped Children in Head Start Programs, Fourth Annual Report of the U.S. Department of Health Education and Welfare to the Congress of the United States on Services Provided to Handicapped Children in Project Head Start, U.S. Department of Health, Education and Welfare, Office of Human Development/Office of Child Development, Washington, D. C. (December 1976), pp. i and 2.

cial service most greatly needed by the handicapped children involved in Head Start.

One of the most important factors in the development of the preschool handicapped child is the opportunity to be in a mainstream environment. Head Start provides a setting for the child to learn and play with children who are not handicapped. As the name implies, Head Start, by early intervention and habilitation, provides a greater chance for participating children to "mainstream" when they reach school age.

One major impetus behind the Head Start program was to ready children for the public schools. Communication skills are among the most important in our school system. And it is in this area that there is the greatest need for special services for Head Start children.

Close to five out of ten handicapped children enrolled in Head Start have been diagnosed as speech impaired. This reflects an increase over children so reported in the prior full year program (39.51 percent), but is consistent with national estimates of children requiring special assistance in speech and language development. BEH data report speech impairment constitutes 46.87 percent of handicapped between ages 0-19.[17]

Staff capability in working with handicapped children is a critical feature of quality services to insure appropriate educational and developmental experiences. Seven out of ten programs reported that their staff will require additional training for recognition of handicapping conditions; techniques of screening, diagnosis and assessment; working with children with learning disabilities; and speech and language development.

Head Start received $20 million in Fiscal Year 1976 for the handicapped effort. These resources were used to: improve diagnostic services for children; recruit additional qualified staff (professionals and paraprofessionals with expertise in special services); train staff in techniques of working with specific handicapped conditions; purchase services from other agencies when such services are not available without charge; purchase special equipment and materials; and modify physical facilities to meet the specific requirements of the children.

[17]Estimated Number of Handicapped Children Served by Type of Handicap as Reported by State Education Agencies to the Bureau of Education for the Handicapped, U.S. Office of Education, Fall and Winter 1975-76, dated March 1976.

Based on estimates of the data provided by the Head Start programs responding to the questionnaire, the average annual cost of special services to handicapped children ranges from $1,150 to $1,490 per child above and beyond the average base cost per child for the normal range of Head Start services.

Lack of resources has frequently been cited by local Head Start grantees and other state and local agencies as a major contributing factor to their inability to provide the full range of needed special services for all of the handicapped children diagnosed as requiring such services. Head Start programs have been confronted with severe pressure on available resources to maintain the basic comprehensive services for all children, including the handicapped.

While Head Start programs also added a significant number of specialists to their staff, thus increasing their capacity to diagnose and provide services to handicapped children, the greatest need for more specialists is for qualified speech-language pathologists.[18]

An additional $12 to $28 million is needed to ensure provision of full services, especially speech-language therapy, to handicapped Head Start populations.

Another category of Head Start children in need of special compensatory services is the multilingual and multicultural. Fifteen percent of Head Starters are Spanish-speaking, 50 percent are Black and 3 percent are American Indian. The funding for innovation and development of new techniques necessary to adequately serve this special population, particularly parent involvement, has remained the same since 1971. This represents a commitment only to maintenance level. We recommend that the budget for innovation and development be increased from $19.2 million to $25 million to substantiate Head Start's commitment to children from different cultures.

Rehabilitation Services Administration (RSA).

The Rehabilitation Services Administration (RSA) is charged by the

[18] "Qualified" speech-language pathologists, as defined under Medicare regulations, are those with master's degrees and a year's clinical internship. Services to Head Start children should be rendered only by such qualified providers.

Rehabilitation Act of 1973 (P.L. 93-112) to reduce the vocational and social effects of handicapping conditions. It accomplishes this end by grants to states for research, training, program development and special projects. The product of RSA's efforts -- improving the employability and quality of life of the handicapped -- make it one of the most humanitarian of all federally supported health programs.

RSA's long history of success in rehabilitating and securing employment for individuals obviates the need to examine the cost efficiency of RSA's programs. It is considered an established fact that every RSA dollar returns seven to the American economy. At this rate of return, it would seem that we can't afford not to substantially increase RSA's budget.

An eleven million dollar increase is contemplated by the Administration, representing an effective reduction in RSA's budget, vis-a-vis the rate of inflation, of about 5%. We believe a figure of $46.0 million is more realistic. Instead of losing ground, the RSA would then be able to make its programs more effective.

While RSA's charge is to address first the needs of the most severely handicapped, we believe that Congress intended its funds to be used proportionately. An examination of past funding patterns within RSA reveals that over 50% of the funds devoted to speech and hearing go to a small minority of the communicatively handicapped: the 1.8 million who are deaf. We seriously question wheter the needs of the nation's 21 million communicatively handicapped can be adequately served by RSA, given the disproportionate use of funds.

While it is true that the deaf as a group suffer different problems than the non-deaf hearing impaired, seeking their communication cues through other senses, there are areas of commonality. Only about 400,000 of the 1.8 million counted as deaf developed the condition before the age of 19. Most deaf individuals had the opportunity to develop speech and langugage skills, creating a greater similarity between them and the hearing impaired. Of these 140,000 counted as deaf but with onset after the age of 19, a substantial number can derive some benefit from the use of amplification and audiologic rehabilitation.

A demonstration project hsould be funded which would explore the benefits of amplification and audiologic rehabilitation to the more severely handicapped, many of whom could derive some benefit from hearing aids and from audiologic training, some of which is designed to supplement auditory cues with visual cues.

Conversely, the hearing-impaired suffer many of the same social problems that the deaf do -- inability to communicate effectively, and resultant isolation. Many of the techniques as speech-reading, use of telecommunications equipment, improving understanding of coworkers all have applicability for both deaf and hearing-impaired rehabilitants.

Vocational counsellors receive special training in manual communication. They should also receive briefings, perhaps in the form of regional workshops, in the special social and vocational needs of the heairng impaired. One important and often neglected aspect of placing a hearing impaired individual in a job is preparation, not only of the rehabilitant's supervisor, but of his coworkers as well. The vocational counsellor is the best able to undertake this task which will increase vocational adjustment and productivity.

RSA should fund research to improve the techniques for predicting success with a hearing aid. We believe that this could serve two objectives: to eliminate the unnecessary expense of unusable aids and to expand the range of hearing impairment considered to be amenable to amplification. We believe that even among the severely hearing-impaired, amplification would in some cases aid in speech intelligibility. Once predictability of success with an aid is improved, means of selecting appropriate aids more efficiently and effectively will be within reach. Generally, speech disorders have not been considered vocationally handicapping. Incidence of diseases and traumas which result in severe speech impairment have increased dramatically. Cancer of the larynx, resulting in laryngectomy, strokes, and automobile accidents resulting in head injuries are all the more tragic when they strike, as they do increasingly, the young to middle-aged.

RSA should fund research to develop guidelines for assessing the impact of these and other speech impairmenets on the ability to find and keep jobs. We believ that speech impairments -- affecting the output of communication

just as hearing disorders affect the input -- can be just as vocationally handicapping. Additionally, RSA should fund the development of casework standards to better assess the effect of treatment by speech-language pathologists. Methods for linking speech impairments to job performance, then measuring the benefits of therapy, are the first steps in directing adequate attention to this form of communication disorders.

Once this has been accomplished, RSA could then undertake to develop programmed learning methods for persons with communicative disorders. Implementation of these methods would substantially reduce the time and expense of rehabilitation.

## National Institutes of Health (NIH)

### National Institute of Neurological and Communicative Disorders and Stroke (NINCDS).

NINCDS is the most underfunded of the national institutes in relation to the amount of research activity going on in the field. NINCDS approves 60% of the research proposals it receives. But because of its low level of funding, it is able to award grants to only 10%. The ratio of grants approved to grants awarded is half that of any other institute. These figures indicate that the area of neurological and communicative research is very active and that there are willing and capable researchers in the field. They also indicate that the fields of communicative disorders, neurological disorders and stroke are being given short shrift vis-a-vis other demands on the research dollar.

While we are unable to address the research needs in the fields of stroke or neurological disorders, we can assure the Subcommittee of the need for and the demand for research to improve the diagnosis, treatment and prevention of diseases and disorders affecting hearing, speech and language. What makes the problem all the more pressing is that NINCDS is the only source of funding for most research in the area of communication disorders.

Technological advances in many areas are frozen, just short of practical application, because of lack of funds. NINCDS' shortage was graph-

ically illustrated two years ago when it put out Requests for Applications for Institutions of Excellence for evaluating cochlear hearing aid implantations. After receiving applications worthy of funding, NINCDS had to announce lack of the availability of funds.

The field of research in communicative disorders has many unfinished projects. Hearing amplification is a ripe area for research. With 600,000 hearing aids sold annually, it is indeed a shame that technology must wait in the wings for the fickle federal research dollar.

Presbycusis -- the natural aging process -- is generally accompanied by hearing loss. So far, research has been unable to develop a technique for successful amplification for presbycusis.

In a related area of needed research, some progress has been made toward developing a prescriptive hearing aid. This type of device will enable customizing the decibel range and frequency of the aid to an individual's hearing loss.

In the area of speech disorders, additional research funds are needed for evaluating the efficacy of implantation aids for laryngectomees. For other severely speech-handicapped and nonvocal adults, such as those suffering from multiple sclerosis, Parkinson's disease, amyotrophic lateral sclerosis, vocal aids must be developed.

NINCDS, with primary responsibility for research in the development of language skills, needs additional funds for research into the effects of noise on language development and speech discrimination, crucial in early childhood and important to elderly hearing-impaired individuals.

The clinical facilities of NINCDS are inadequate for the care of its ambulatory and outpatients. Clinical research, particularly in the area of hearing, is thereby constricted. Both for purposes of its own research and as a model for other facilities, NINCDS needs full clinical facilities with vestibular capabilities. The cost of development and staffing is estimated at $1 million and 10 permanent positions.

National Institute of Child Health and Human Development (NICHD).

The combination of an overall Institute budget decrease vis-a-vis in-

flation and the emphasis on heart, lung and cancer research to the detriment of other research needs has resulted in a shortage of funds for needed speech and hearing research. Only $340,000 of the total requested budget of $178 million for 1978 will be allocated to research in language, speech and reading, and most of this will go to funding research in dyslexia.

Delay in the acquisition and development of language and speech may be the first and most obvious predictor of potential academic learning problems. Educational systems traditionally have made the assumption that a child comes to school with an intact oral language system. This assumption is fundamental and implicit to the construction of the curriculum that emphasizes read and written language. However, some children come to school without an intact oral language system. Others fail to develop optimal oral, read and written language performance after entering school. These deficits arise from multiple interactions and etiologies. Some of these children predictably are at risk for school failures. The development of communicative competence and performance in children is a central issue in learning disabilities for the speech-language pathologist and audiologist. The training of speech-language pathologists includes training in the comprehensive assessment of oral language performance and related sensory and perceptual skills. Every child with symptoms of learning problems should be seen for language, speech and hearing assessments. These assessments should be provided by or under direct supervision of qualified speech-language pathologists.

Because of the critical nature of reading skills to learning, more emphasis must be given to uncovering the brain processes involved in dyslexia and its causes. NICHD needs an additional $2 million to fund research in areas which would augment its ongoing dyslexia research. Two needed areas of research are objective measures for identification of dyslexia and research into the causes of dyslexia.

Training grants are necessary to prepare researchers who can conduct scientific studies in a behavioral-biological framework and who can perform basic research on acquisition of language skills.

National Institute of Dental Research (NIDR).

While NIDR funding has emphasized speech and hearing problems associated with craniofacial anomalies, malocclusion and cleft palate, the Craniofacial Anomalies Program Branch is but one of NIDR's extramural programs which affects speech and hearing. Audiology and speech-language pathology could contribute to the objectives of the Pain Control and Behavioral Studies Program Branch and the Restorative Materials Program Branch.

Children with cleft palate suffer difficulties not only with speech articulation, but also with hearing. Studies reveal that a great majority of these children suffer from inflammation of the middle ear causing conductive hearing loss. While repair of the cleft palate alleviates the collection of fluid leading to the inflammation, additional research is necessary to develop diagnostic and prevention techniques. The Restorative Materials Program Branch should be funded to investigate the effect of cleft palate, cleft palate restoration and prosthesis upon eustachian tube and middle ear muscle activity.

The current lack of interaction between audiology and dentistry has resulted in a lack of data on the effect of dental instruments as a source of occupational noise. Investigation in this area is long overdue. The Pain Control and Behavioral Studies Program Branch should receive funds to stimulate investigation of noise as a method of pain control during dental treatment, the effect of drill noise both on dentist's and patient's hearing and the effect of drill noise on middle ear muscle activity.

Although adaptation to oral prosthesis has been examined, such investigation has not specifically focused on the elderly, whose oral musculature may take longer to adapt and may adapt in different ways. The Restorative Materials Program Branch should seek investigation in the area of adaptation to oral prosthesis in the elderly as related to speech production and speech perception.

The National Institute of Mental Health (NIMH)

Under authority of the National Research Act (P.L. 93-348), NIMH is charged with, among other things, researching the psychological effect and

adjustment problems of those with physical or sensory disorders; psychological processes involved in learning, memory and intelligence; language, communication and speech as forms of behavior.

There is a significantly higher incidence of communicative disorders among the institutionalized mentally ill than among the general population. The incidence of hearing impairment in an average adult population is estimated to be between 5 and 7 percent (National Institutes of Health, 1969). Among institutionalized psychiatric patients, however, the incidence of hearing impairment has ranged from an estimated 42 to 69 percent (Lamb and Graham, 1962; McCoy and Plotkin, 1967). A complicating factor is that communication problems resulting from organic hearing impairment may not be readily identified among pyschiatric patients because of their compounding mental and emotional problems. Audiometric screening requires patient cooperation and active participation. Subjects are generally instructed to raise their hands or to tell the tester each time a tone is heard, exact procedures modified as necessary to obtain valid results. In a recent test sampling using audiometric screening with psychiatric inpatients, 17.6% could not be tested with presently available audiometric testing equipment.[20]

There are comparatively few speech pathologists and audiologists working in psychiatric institutions. Of 271 psychiatric institutions surveyed in 1968, only 51, approximately 25%, provided speech and hearing services at all. In only 25 of these programs were their staff considered "qualified" by federal Medicare standards.[21]

Organic, as opposed to psychogenic, hearing loss has been a little-touched subject of study. Prevalence figures, while already high, probably do not fully reveal the extent of hearing loss among psychiatric patients since so few psychiatric patients are exposed to full audiologic testing.

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[20] "Unidentified Hearing Impairment Among Psychiatric Patients," Irma K. Jeter, Ph.D., Director of the Urban and Ethnic Program, American Speech and Hearing Association, Asha, the journal of the American Speech and Hearing Association (December 1976).

[21] The Medicare program requires audiologists and speech pathologists to hold a CCC (Certificate of Clinical Competence awarded by the American Speech and Hearing Association) or its equivalent and be licensed, if applicable, in the state in which one is practicing. It further requires one year of clinical fellowship training beyond the master's degree. Medicare Regulations, Sec. 405.1101(t).

In the 5% situation where a psychiatric patient has both been fully tested for hearing loss and where there are qualified speech and hearing personnel available, he will not receive all the help that he needs because there is little information available concerning treatment modalities of communication problems among the mentally ill.

Even with the limited amount of research that has been done regarding prevalence of communication problems among the institutionalized mentally ill, we can see that this is a problem of alarming proportions. And yet, nothing is being done to determine the exact proportions of the problems, provide sufficient personnel for uncovering and treating the problems, or to develop effective treatment modalities for use with the institutionalized mentally ill. In another institutional setting where the federal courts have determined that a right to treatment exists, prisons, the American Speech and Hearing Association received funding and conducted a survey of the needs for speech and hearing services. We recommend that NIMH's budget be increased to fund a similar study,[22] both to determine the extent of the problem and to develop and assess effective treatment modalities.

The primary federal psychiatric institution with a speech and hearing program is St. Elizabeth's Hospital. Its speech and hearing clinical staff is so overworked in providing clinical services that it is unable to provide needed research. St. Elizabeth's is the only facility which can provide the leadership in the provision of adequate speech and hearing services with research capability at the present time. We recommend, at minimum, that funding for St. Elizabeth's be increased $170,000.00 for additional audiological equipment and that four clinical staff positions be added to improve existing speech pathology services.

Impairment of communication ability is a complicating factor in mental illness. The higher incidence among the mentally ill of communication problems is demonstrable. Research capability, at present, is limited to St. Elizabeth's Hospital. Treatment modalities for those with speech and hearing problems is at a primitive stage of development. In order to pro-

[22] Task Force on Speech Pathology and Audiology Service Needs in Prisons, American Speech and Hearing Association (1973).

gress in the development of treatment modalities effective and appropriate to mentally ill patients with communication disorders, we recommend that Congress increase funding by an earmarked $2,000,000.00 for the development and staffing of 10 positions in a Communication Disorders Research Laboratory to be held on the St. Elizabeth's campus, independent from the St. Elizabeth's Hospital itself. It is our hope that federal leadership in this area will stimulate the staffing of qualified speech and hearing professionals and the needed attention to communication disorders in psychiatric institutions across the nation.

UNITED CEREBRAL PALSY, INC.

## STATEMENT OF DR. WILLIAM BERENBERG, HARVARD UNIVERSITY

### CITIZENS' ADVOCATE

Dr. BERENBERG. I'm Dr. Berenberg, professor of pediatrics at Harvard. I don't come in that capacity at all. I come as a citizens' advocate. I'm a volunteer, vice president of the medical affairs for United Cerebral Palsy.

As I listen this morning, I can't help but be impressed by the fact that the goal of our organization affects everybody in this room, blind, speech, hearing, we're talking about a multi-handicapped child or adult.

I would address my remarks to three different sections. I think one of the most exciting things that has happened has been this wedding of medicine and technology. The spinoff from NASA ought to be considerable from this.

I think if we look at the accomplishments of what the REC's have done since 1973, they are tremendous. The opticon, for example, comes to mind, as your co-Senator Heinz introduced Mr. Allen, because it would permit the blind to read.

A professor of West Virginia reads 100 words a minute——

I understand the difference between appropriations and authorization quite well, but $10 million was turned back and not spent; $10 million ought to clearly give the most help where it's needed most. Of course, that was your intent. But why not? Instead of having a personnel group of 10 at the RSA, there is one person and one secretary to carry out your mandate. I don't know how you do it. Also, you earmark it. The same is true about training people. You ought to be able to take the heavy braces my orthopedic brethren talked about this morning. If anybody has ever worn a brace, they know how unpleasant it is.

There are new ones which are lightweight. You can't get them to the marketplace, meaning the consumer, into the country, because we haven't trained enough people to deliver it.

I think there is a great need for something of the order of $2 million at this point, which is there. It's not been authorized, OMB has turned it back. I think there is an additional need for $2 million and I had hoped considering earmarking for such funds.

To move to my second subject, that relates to the National Institute of Allergy and Infectious Diseases. This institute has requested increasing appropriation from $153 million to $187 million. I really think it's extraordinarily modest.

I don't have to tell you the story of German measles and what the vaccine has done. I don't have to tell you the story of measles. Measles is a common disease, but even the great Commonwealth of Pennsylvania in an average year might have 100,000 or more cases of measles. One of those thousands can be brain damaged. That is 100 brain-damaged people added to the population. Both of those diseases should be nonexistent today because of vaccine. There remains still a host of other viral diseases which I would discuss, but for the sake of time, I can't.

At the moment, for example, I think we are in the middle of a national epidemic of a virus called CMV which produces mental retardation, cerebral palsy, blindness, deafness, speech, and hearing problems. Even in the mild cases, difficulties with IQ. We ought to be able to attack those.

You know, I think nobody believes in treatment more than I do, but you know, I think we are in the business of trying to put ourselves out of business as should be our ultimate goal. I think you know, you and I all know, that we can treat a lot of bacterial things. We have a lot of magic drugs, but we really don't have any as it relates to viruses and virus remains the major cause of brain damage today.

Now, I would summarize some of the other areas that DCP is interested in by simply naming them. I'm sure they are at least more familiar to you than they are to me. We are concerned about the Developmental Disabilities Act. There certainly is great need for implementation of the various mandates as they relate to education of handicapped children. We have done a good deal of talk about employment training. Mr. Carter has put this high on his list. The words "primary care" is so important today, that the handicapped individuals not only need special care for the handicapped, but need it in terms of ordinary health care which I think needs to be taken care of.

Those of you who have been disabled, even for a short time, recognize the needs for recreational facilities. I have been purposely brief within the constraints of time, Senator.

Senator SCHWEIKER. Thank you, Doctor.

The seven and a half, seven and a quarter million figure you referred to as RSA's request, which budget category does that come under?

Dr. BERENBERG. Rehabilitation Act of 1973.

Senator SCHWEIKER. No, it is a line item I'm having trouble finding it because it's probably diversified. This is one of our problems here. When you have a diversified service, it's hard to pinpoint it.

Dr. BERENBERG. My understanding is that RSA has requested appropriation at the same level as last year of $29 million.

Senator SCHWEIKER. $29 million?

Dr. BERENBERG. Of which 25 percent is mandated to go to rehabilitation centers.

Senator SCHWEIKER. Then it's under the research section.

Dr. BERENBERG. That's right. Part of the very same act mandates, perhaps that is a strong word, but at least it was congressional intent that the fruit of this be delivered to the handicapped people.

I come here as an advocate, I sometimes regard myself as a scientist, but it's frustrating to see something accomplished——

Senator SCHWEIKER. One of the problems, Doctor, which is not only true of the point you made here, but generally with all the areas on our agenda. Being on the health subcommittee as ranking Republican as well as on this committee, I see a tremendous need in the health research field.

There is no question of the validity of the statements here today. The problem is that the health part of the budget is what they call a controllable part of the budget. That is fair game. Whatever the breakdown, 70 or 80 percent of the budget, is uncontrollable, fixed by law. So whenever any administration, whether it's the Carter ad-

ministration or Ford administration or Nixon administration, wants to stop the increase in the budget or go after the deficit, one area they come to is health. The reason is very simple, because health is so-called "controllable."

In other words, it's catchable and reducable. It doesn't take a law to cut it. So this is an area that has always been a whipping boy ever since I have been here.This is really the problem, because health is in the controllable sector. It's always fair game. This is why we have a tremendous battle with the administration because the OMB always goes after health first, because these programs are not mandated such as an interest payment would be, or other commitment.

That is not a justification for not funding, but it is part of the political realities of why we always have such a battle in health funding.

Dr. BERENBERG. It was the exasperation that they might be earmarked that——

Senator SCHWEIKER. I think that is a worthwhile point. Part of the problem there is that some people oppose earmarking concept and some people support it. So it immediately gets into a political fight within the authorizing committees itself, sometimes, because of earmarking.

So, sometimes it can be done, but other times it creates more controversy.

PREPARED STATEMENTS

You may have your written statement included in the record, along with a statement by Laura E. Levine, also from United Cerebral Palsy, Inc.

[The statements follow:]

# STATEMENT OF DR. WILLIAM BERENBERG

## SUMMARY

A. Rehabilitation Engineering Centers

The dramatic accomplishments of space age engineering technology when applied to rehabilitation medicine justify the need for continued support of the Rehabilitation Engineering Centers created by Congress. The R.S.A.'s request for $7,250,000 is the same as last year's figure. The currently available technology has failed to adequately reach the consumer. This failure could be corrected if Congress would earmark (1) $300,000 to be used to support adequate staff for such implementation. (2) At least $2,000,000 additional funds to train and develop the necessary manpower **needed for successful transfer and utilization. (3) $2 million to stimulate research and training.**

B. National Institute of Allergy and Infectious Diseases

This Institute's request for an increase in appropriation from $153,000,000 to $197,000,000 is extraordinarily modest. There are a host of well documented infectious diseases currently resulting in massive numbers of brain damaged individuals. Many of these diseases desperately need the research effort necessary to promote eradication by appropriate vaccines or therapy by agents not currently available. The savings in human disease, the prevention of neurologic disability and the financial savings in care would be massive and inestimable.

Dear Mr. Chairman and Members of your Sub-Committee:

My name is Doctor William Berenberg. I have had a life long interest in problems of the handicapped individuals of this country. I hold the position of Professor of Pediatrics at the Harvard Medical School; Medical Director of the Cerebral Palsy Division of the Children's Hospital Medical Center of Boston; Past President of the American Academy for Cerebral Palsy; Member of the Committee on Handicapped Children of the American Academy of Pediatrics; Project Director of the Harvard - M.I.T. Rehabilitation Engineering Center and Vice President for Medical Affairs for United Cerebral Palsy, Inc.

I am privileged to appear before you representing the concern of United Cerebral Palsy and my personal concern not only as a physician but as a citizen advocate for the handicapped people of the United States.

In particular, I wish to address myself to two areas of the H.E.W. Appropriations (1) The Rehabilitation Engineering Centers created under the Rehabilitation Act of 1973, its needs and its dramatic potential for the future. (2) The needs for the National Institutes for Infectious Disease and Allergy with particular reference to the importance of research necessary to identify and prevent those numerous and important infectious diseases resulting in major and significant neurologic damage to massive numbers of individuals at all age groups from the unborn fetus to the elderly by numerous infectious

diseases which should be capable of prevention by various modalities including potential vaccines in the future.

I am fully cognisant of the financial restraints placed on H.E.W. expenditures but firmly believe that this country can ill afford the massive financial burden placed on it by mandated support of handicapped individuals who should be capable of returning to the mainstream of independent living and financial independence versus the alternative of remaining on the scrimpsful and financially devastating programs designed to provide for their current supportive welfare.

The exciting and dramatic advances in technology which have exploded during this era of space technology need to be applied to the welfare of the handicapped here on earth and should represent one of the major spin offs of the entire program of the National Aeronautics Space Agency. The Congress in its farsighted wisdom in the Rehabilitation Act of 1973 did designate a defined research program in the nature of Rehabilitation Engineering Centers to be created throughout the country and support it by 25% of the funds appropriated for the Rehabilitation Service Administration.

I recognize the requests for constraint which have been placed on various governmental agencies and note with dismay that the Department's (OMB's) request for RSA Appropriation in research for FY 1978 is $29,000,000 for Research (the same as last year) with a line item of $7,250,000 (25% of $29,000,000) for Rehabilitation Engineering. With inflationary costs, this actually represents a decrease in funds available for this most important area and would request an appropriation level of $35,000,000 with at least the minimum figure of $32,000,000 for FY 1978 which then would provide $8,000,000 for Rehabilitation Engineering. The accomplishments of these Rehabilitation Engineering Centers to date have certainly resulted in a savings which has far exceeded the amount of dollars appropriated for their research. The programs will need this amount to provide for research growth in areas not yet adequately covered by it's research efforts. Specifically, these are in such areas as Environmental Barriers (housing, transportation and vocational adaptation); Communication Systems for the deaf and non-vocal; and Model Rehabilitation Engineering Service Delivery Systems for the states.

We believe that ultimately this program of research will require approximately $50,000,000 per year to produce the benefits to the disabled envsioned under public law 93-112 as amended by the Congress. However, we do not see the need for more rapid growth at this time given the constraints of staffing in the office designated to manage a program of this size - a sad commentary on our failure to meet the needs of so many disabled who could be benefited almost immediately if adequate funds and staffing became available.

But, as you are aware, the law requires under section 3 (b) "the Secretary through the Commissioner in coordination with other appropriate programs in the department of H.E.W. in carrying out research under this act, shall establish the expertise and technologic competence to etc." In addition, all previous versions of proposed

legislation for the law (1972-1973)were even more specific relating to the management of the Rehabilitation Engineering Program. They required that a National Center for Technology Assessment be established within R.S.A., that the Director of such a Center be at the level of Assistant Commissioner and that there be a staff of 10 personnel positions to provide direction and evaluation of the programs of Research Training and Evaluation in the field of Rehabilitation Engineering. Unfortunately, with the exception of one professional (G.S. - 14 Administrative type) and one secretary!, neither the office of the Secretary nor the Commissioner of the R.S.A. has seen fit to provide the staff positions needed. It is amazing that the excuse given for such failure is a lack of funds to support such necessary staff. It is distressing and indeed aborhent that we have been able to accomplish so much in the area of Research & still lack the staff necessary to deliver the fruits of this research to those handicapped people in the country who are in desperate need of it.

I would suggest that the Congress and through appropriate action "earmark" at least $300,000 to be used to support staff and its needed expenses for implementing the Rehabilitation Engineering Program under the salary and expense category for research and training. If this is done, the appropriate members of the R.S.A. will have the opportunity to develop program managment in Rehabilitation Engineering Research, Training and service delivery to a more significant albeit less than optimal level.

With respect again to section 3 (b) of the law, R.S.A. is required "to stimulate the production and distribution of new & existing devices and techniques...to solve Rehabilitation problems and be responnible for carrying out the activities described in Section 202 (b) (3). To do this in anything approximating a meaningful fashion, would require the earmarking of at least $2,000,000 additional funds in the Research Appropriation. A study on this aspect done by the Electronic Industries Foundation, recommends that $2,000,000 will be necessary to carry out this mandate in FY 1978. Additional funds will be required in a few years and hopefully it will level up to $10,000,000 although this appropriation will probably need to be made gradually so that it can be done most efficiently and at the greatest savings. I would estimate that the need will probably be at an increment of $2,000,000 per year additional over a five year period and then stabilizing at that level. With the dramatic explosion in Rehabilitation Engineering Technology, with the commendable and exciting interaction and collaboration between the sciences of medicine and engineering, we should be able to look forward to the wedding of these two sciences so that the advanced technology which has placed man on the moon, will permit, promote and develpp an increasing number of advances for the benefit of those inhabiting our planet to emerge from their state of dependent existence into that of independent competitive participation. Our objective is to make their life meaningful and to take them off the welfare list of the country and make them self-respecting, independent, productive, taxpaying citizens and contributors to the lifestream of this country. The cost necessary to accomplish

this is miniscule in comparison to the social, emotional, medical and financial rewards which can and must be achieved.

In order to develop the necessary manpower in Rehabilitation Engineering, to assure that the products of successful research and technology transfer are effectively brought to bear to solve Rehabilitation problems through the application of technology, formal post-graduate training programs in rehabilitation engineering must be initiated. Major schools of engineering, medicine and related sciences are deeply interested in undertaking and developing such training programs. This interest has developed as part of a successful implementation of Rehabilitation Engineering Research Centers under Section 202 (b) (2). The need for these professionals actually working in clinical applications fields throughout the United States is expressed by innumerable state rehabilitation agencies, the medical profession and above all the handicapped individuals themselves.

Presently, such true and devoted practitioners in the field such as Prosthetists and Orthotists have not received the level of support necessary to aim for successfully dealing with and providing new devices and systems developed in ongoing research programs. As a result, the clinical manpower to apply the newly developed technology for the handicapped is inadequate and unfortunately, many research developments that should help to solve substantial problems are not being applied. How sorry to have labored so to develop improved methods without having the manpower necessary to get them into use.

The prosthetics and orthotics training programs supported by the R.S.A. has been extremely successful over the past years and should unquestionably be continued. In addition, funds should be made available for institutional grants to institutions of higher education to begin training rehabilitation engineers in a formal fashion for utilization within this profession.

The department's (OMB) request for RSA Appropriations FY 1978, is $20,000,000. It is incredible that this is the same figure as last year. For FY 1977, the Congress appropriated $30,000,000 and only $20,000,000 of the appropriated amount has been programed for expenditures during this year leaving a $10,000,000 surplus. I find this in many ways a disgraceful lack of accomplishment - not on the part of those deeply involved with the program at the National level but because of inadequate staffing in order to bring this to meaningful fruition. Again, I think that these funds could be used for the purpose that the Congress intended by earmarking an amount of $2,000,000 to support manpower development and training in the field of Rehabilitation Engineering including porsthetics and orthotics. These funds should be used for support of faculty and institutions of higher education to implement the educational programs necessary to achieve the purposes of the Congress's intent. These funds were not designed to be used for student stipends or traineeships since the office of Education is already sufficiently funded to do this. It would appear that R.S.A. is unable to appropriately

spend at the level that Congress has appropriated for training and I do not believe that additional funds need to be required, however, the problem could be readily solved by earmarking of $2,000,000 so that R.S.A. might appropriately reorganize its training program & separated from its overall research program. This would result in an important and major impact in an area which remains understandably limited. It is also important that the control over any such training program supported by the R.S.A. in the area of Rehabilitation Engineering be given to central office staff. Approximately four years ago control over R.S.A. training was decentralized into ten regional offices but the major and dramatic advances in the field of Rehabilitation Engineering has exploded to the point where reorganization needs to be considered in this area. I believe that H.E.W. could meaningfully recentralize this program and that appropriate earmarking of funds by the Congress with such a recommendation would result in a much more effective delivery of training and subsequently of the provision of advanced technology to the handicapped people of this country. I readily understand why the Congress may object to requests for earmarking of funds in the above areas, but the urgency to get new information into the field is paramount.

The need for continued research is self evident. Countless, brilliant, innovative, dedicated members of both the engineering and medical professions stand ready and anxious to participate in this exciting wedding of the sciences of engineering and medicine which must give birth to a population explosion of devices to aid the handicapped of the country. The current level of funding for such Centers is at best, meager and we will need to look forward to expanded funding in the future. However, at this time in the history of what is available, it is clearly frustrating and unforgiveable that we're at a point where the ability to deliver what is available is limited because of lack of adequately trained and poorly informed individuals in the field of Rehabilitation.

The problem of getting new information out into the field so that it can be utilized is critical and at the same time, we need to continue to move ahead to solve so many problems capable of solution by this unique joining of efforts of engineers and physicians working for the benefit of the handicapped individuals of the world.

National Institute of Allergy and Infectious Diseases

The present budget of the National Institute of Allergy and Infectious Diseases is $153,000,000 per year. The Coalition for Health Funding has approved this Institute's request for an increased budget at a level of $187,000,000 per year which is at best a very modest request for increase. Currently the Institute is funding only 22% of approved grants. I honestly believe that the Institute itself has grossly underestimated its potential for preventing important and serious neurologic damage due to a variety of infectious diseases.

I have personally contacted and discussed this problem with several of the most distinguished scientific experts in the country in this area and they unanimously join with me in the opinion that it is terribly important that this institute be

granted as a minimum its total request. These experts join with me in recognizing the importance of the need and they include such world reknown scientists such as Dr. John Enders, Professor Emeritus at the Harvard Medical School and a Nobel Laureate; Dr. Frederick Robbins, Dean Case-Western Reserve University School of Medicine, Nobel Laureate; Dr. Thomas Weller, Professor, Harvard University School of Public Health, and also a Nobel Laureate; Dr. Richard Johnson, Professor of Neurology and Microbiology, Johns Hopkins University School of Medicine; and Dr. Heinz Eichenwald, Professor of Pediatrics, Southwestern Medical School, Dallas, Texas. The opinion of these distinguished scientists is unanimous in terms of the need for adequate funding for this Institute. The specific views outlined below are in great measure my own and reflect my concern as well as that of United Cerebral Palsy, Inc. in the matter of the trerendous importance which this Institute could and should play in its mandated role re its potential for preventing brain damage due to a variety of infectious diseases. Certainly we all know what we were able to do with the vaccine which lead to the potential for eradicating German Measles, a disease which regularly produced massive brain damage, mental retardation, heart disease, blindness and deafness, if it occured during the early part of pregnancy and we were all but too familiar with the aftermath in the newborn. Appropriate and widespread use of the Measles vaccine has been similarly important. Although only one child in 1,000 who contracted regular measles developed significant brain damage as a result, the total numbers of individuals with measles in the United States for a year were so large that the total number of brain damaged patients was frightening. The current use of a safe and effective vaccine has all but eradicated this heretofore common disease. The poliomyelitis story is so familiar and comforting that we have been lulled into such a feeling of security and complacency that some of us neglect to recognize that there remain many other fields which need to be identified, attacked and hopefully eradicated in a comparable fashion. There remain a host of intrauterine, neonatal and childhood infections as well as those affecting adults which lead to subsequent serious neurologic diseases, mental deficiency, epilepsy and cerebral palsy. Currently, there is no preventive measure for the occurance of chickenpox (Varicella) which not only continues to be a common disturbing disease of children, but one which carries with it a significant mortality when it occurs in adults. In addition, a significant percentage who survive the disease develop encephalitis and permanent brain damage. Although the percentage figures may be small, the total number of cases is so large that the total number of involved individuals becomes truely significant. In addition, the relationship between this disease and shingles (Herpes Zoster) in the adult has been well established and this condition too, is not only beset by devastating discomfort but may be associated with significant neurologic damage. Much of the basic research has been accomplished in isolation of the virus but much remains to be done to develop a safe and effective vaccine.

Currently, I believe that the United States is in a midst of a major outbreak of

infection by a virus known as the cytomegalovirus which is particularly apt to infect pregnant women. If pregnant women are so infected, their offspring are at high risk for brain damage and other significant defects. The most conservative figures estimate that there are probably 31,000 such damaged babies per year born in this country. For the most part, these are overt examples of this infection. There is a very strong likelihood that this number may well be multipled several fold if one includes less severe cases resulting in mental retardation and various degrees of cerebral palsy. For each infant with recognizable symptoms, there probably are at least 10 without recognizable symptoms and these so called silent cases may often result in significant brain damage. The incidence of learning disabilities in these children seems to be extraordinarily high and probably those who go on to have IQ levels below 79 are apt to be something like 15.8%. Many experts believe that CMV (Cytomegalovirus) is currently the most common congenital infection in the U.S. To date, there is no specific therapy for this condition nor is there any known method of prevention. Clearly prevention might best be served by elimination of CMV from the mother or eventual preventive vaccination or the development of a drug capable of eradicating the infection. Research is needed to develop antiviral substances for treatment, improved techniques for early recognition of inapparent infection and hopefully the development of a safe vaccine for prevention prior to pregnancy.

There is a group of viruses known as the enteroviruses (Coxsackie viruses, Echo viruses, and polio viruses). Congenital and Newborn infections have been associated with many of these enteroviruses and positive correlation between maternal infection and abnormalities of the newborn have been made with several strains of Coxsackie viruses. When Coxsackie virus infection occurs in the newborn, it may result in fatal encephalitis or myocarditis. Newborns and very young infants infected with Echo viruses frequently develop devastating diseases such as meningitis, gastroenteritis, liver disease and encephalitis all of a serious nature and many leading to major sequellae. Again, there is no specific therapy for any enterovirus infection. Attenuated viral vaccines for enteroviruses other than polio, are not available but could be produced if sufficient disease could be demonstrated to occur by any single strain and if enough research effort was placed in that direction. Again, there is need for research to develop antiviral agents of value and treatment as well as specific vaccines.

The virus known as Herpes Simplex is that associated with the common cold sore. This infection in newborns may result in disseminated disease with or without involvement of the brain and may effect almost all organs. Frequently it is fatal in the newborn. It may result in significant localized infection not only in the brain but in the skin, eye or mouth. Again, it is possible that the infection may seem to be without symptoms and hence not recognized. It is believed that 75% of newborn infections are acquired from a mother's genital infection. The exact incidence is unknown and may range from 1 in 30,000 to as much as 1 in 3,500 deliveries and since approximately 1/4 of the

infected infants survive with neurologic or eye sequelae, it is obvious that this is an important situation. At the present time, we do not have enough information to provide figures as to the importance of this virus in abortions, stillbirths or congenital malformations produced in utero but of full term infants with this type of infection, 62% die, 24% survive with damage and only 14% survive without sequelae In the premature, these figures are 67%, 12% and 21% respectively. The aftermath in those who do survive this newborn disaster, usually involve abnormalities in normal development as well as eye defects. Again, there is no effective treatment and further research is needed for the development and testing of antiviral substances as well as a possible sub-unit vaccine for use prior to pregnancy.

Congenital infection with a protozoan parasite, toxoplasma has been recognized since about 1937 and results in serious consequences. Human infection with toxoplasma is quite common since antibodies to this parasite have been found in some 25% - 40% of adults and this is in most countries of the world. In certain cultures where ingestion of undercooked meat is common, the prevalence is even higher. Maternal infection during pregnancy has been estimated to be in the range of 6 per 1,000 in one study in the United States and as low as 2 per 1,000 in another study. The risk of infection to the fetus during material infection, is about 35% although a smaller figure has been identified as having obvious clinical evidence of disease but we still estimate something of the order of 3,000 cases of significant infection per year in this country.

Again, as in other examples noted, less obvious congenital infections may result in intellectual deficits which may not become evident until later school years, in contradistinction to the newborn those damage is overt and results in epilepsy, cerebral palsy, mental retardation or blindness. The treatment of this condition is partially effective but leaves much to be desired. Treatment of pregnant women may carry the risk of damaging the child in other ways. Vaccines may not be the answer to this problem but improved methods to detect recent infections during pregnancy and the development of more effective and safe drugs as well as improved pre-natal care could be more reasonable approaches.

Congenital syphilis is <u>not</u> a disease of the past. The figures for the year ending June 30, 1974 show 1,334 cases of congenital syphilis of which 23% were recognized in children under one year of age. There are no accurate figures for stillbirths and general figures give approximately 100,000 diagnosed cases of syphilis per year in adults and the figure which is probably growing. The sequelae certainly include permanent damage to the brain as well as damage to bone, eyes and hearing. Although the infant with congenital syphilis may be effectively treated with Penicillin, the best prevention should lie in the recognition of the disease in the mother and hopefully at some point in the future, the development of a vaccine for prevention of infection against this age old dread. Although pregnant women are usually subjected to blood tests early in pregnancy, there remain a significant number of women who

contract the disease after their initial blood test and hence may go unrecognized. Meningitis in the newborn remains an all too common disease and there are an estimated 19,000 such cases per year in the United States. Too often, this is a fulminant disease with a very high mortality rate and a disease with a very significant rate of subsequent brain damage. Other figures estimate that streptococcal disease alone may occur in as many as 3 to 4 per 1,000 births resulting in approximately 12,000 cases per year of meningitis with 6,000 deaths. Other figures also suggest a higher incidence in meningitis due to other infections such as E.Coli. Again the sequelae include mental retardation, cerebral palsy, epilepsy, hydrocephalus, deafness, abnormal speech and abnormal learning disorders even among those with the least damage. Probably something of the order of 6,000 children yearly will suffer from this type of damage. Although treatment is available, it lacks total effectiveness and further research needs to be done in the areas of antibiotic treatment as well as the development of vaccines against the most common forms of meningitis of the newborn. In older infants and children, bacterial meningits especially those types due to H. Influenzae, streptococcus, pneumococcus and meningococcus remain with us as daily occurances throughout the country. Infections with H. Influenzae are especially important in the age group under two years and we currently are experiencing at least 10,000 cases annually with approximately 1,000 deaths. Currently, there is an H. Influenzae vaccine which needs further testing for its value in prevention. Studies are necessary to evaluate new methods not only of treatment but particularly new methods of preventing brain damage which may occur despite adequate antibiotics. The need for developing effective vaccines for the various types of meningitis, can not be neglected.

Laboratory research has indicated that the virus which produces mumps may well result in hydrocephalus, a serious form of brain malformation, in the experimental animal. There is suggestive evidence at a theoretical level that certain types of viruses may be involved in the evolution of multiple sclerosis. There is a group of viruses known as the Parvo viruses which tend to like to infect cells which are duplicating and there are a group of scientists who theorize that these viruses might produce nothing more than an episode of diarrhea in the mother but if the virus is transmitted to the infant, during a period when his brain cells are duplicating, that they could result in damage of a significant source. This is another lead which needs to be pursued. There is a general feeling of uneasiness that there may be a host of viral agents capable of producing mild or no disease in the pregnant woman but which may result in significant brain damage in the developing fetus. Studies during the last several years, have given us reason to be very concerned about a group of viruses which are referred to as slow viruses which may produce little or no symptoms at first but tend to persist over long periods of time and gradually and

progressively result in serious brain damage not only in the fetus and newborn, but in adults as well.

We could go on with other data and other examples, but it becomes clear that the need for further research in this area is of paramount importance.

Frankly, I feel that the National Institute of Allergy and Infectious Diseases has been overly modest in its small and very conservative request for additional funding and if anything should be stimulated to procede with haste towards expanding its research program in this area - mandated to do so if possible. The Institute is doing a superb job in selecting the best research applications in the area but still is able to fund only 22% of grants which it was able to approve.

Mr. Chairman and Members of the Committee, I appreciate the opportunity of discussing these important problems with you and trust that you will give them your very serious consideration.

# STATEMENT OF LAURA E. LEVINE

## INTRODUCTION

United Cerebral Palsy Associations, Inc. appreciates this opportunity to testify before the Appropriations Subcommittee.

Our witness is Dr. William Berenberg, Vice-President for Medical Affairs, UCPA, Inc. Dr. Berenberg, Professor of Pediatrics at Harvard University School of Medicine and a senior physician at Children's Hospital in Boston, has had a long and distinguished professional association with cerebral palsy, most recently in his dual capacities as Medical Director of the Cerebral Palsy Unit at Children's Hospital and Project Director of the Harvard-MIT Rehabilitation Engineering Center.

Accompanying Dr. Berenberg is Laura E. Levine, Assistant Director, UCPA Governmental Activities Office.

## SUMMARY

The testimony prepared by United Cerebral Palsy Associations, Inc. for presentation before the Appropriations Subcommittee emphasizes the following areas:

1) Developmental Disabilities Act - expansion of state formula grants and funding of state protection and advocacy programs;

2) Education of Handicapped Children - support of increased appropriations for implementation of various mandates under the Education for All Handicapped Children Act (P.L. 94-142); supplementary appropriations to fund needs determination and progress assessment studies concerning implementation of P.L. 94-142;

3) Employment/Training - enhancement of opportunities for severely and multiply handicapped individuals to participate in programs of vocational rehabilitation and placement;

4) Health - support for CHAP concept and other preventive programs, including those dealing with immunization, family planning, and population research;

5) Supportive Services - increased/redirected appropriations for home health and attendant care services, in order to provide support for implementing deinstitutionalization and full integration into the community of persons with disabilities;

6) Recreation Opportunities for Persons with Disabilities - special appropriation for the development and improvement of recreational access and opportunities for persons with disabilities.

## PROPOSED APPROPRIATIONS BY AREA

| AREA | FY 1977 | FY 1978 (Ford) | FY 1978(Carter) | UCPA Proposals |
|---|---|---|---|---|
| 1) Developmental Disabilities | | | | |
| • State Formula Grants | 30,058,000 | 37,558,000 | 30,058,000 | 40,000,000 |
| • Protection and Advocacy Systems | 3,000,000 | 3,000,000 | 3,000,000 | Increase based on P & A plan analysis |
| 2) Education | | | | |
| • Education for All Handicapped Children Act | | | | |
| • Part B | 200,000,000 | 315,000,000 | 365,000,000 | 650,000,000 |
| • Preschool Incentive Grants | --- | --- | 50,000,000 | 100,000,000 |
| • Personnel Development | 45,300,000 | 45,000,000 | 45,000,000 | 50,000,000 |
| • Special Studies | --- | 1,735,000 | 1,735,000 | 1,735,000 |
| • Architectural Barrier Removal | --- | --- | --- | 300,000,000 |
| 3) Education/Training | | | | |
| • Special Projects for the Severely Disabled | 4,029,000 | 4,700,000 | 4,747,950 | 8,000,000 |
| 4) Health | | | | |
| • CHAP | --- | --- | 180,000,000 | 180,000,000 |
| • Immunization Project Grant | 13,000,000 | 13,000,000 | 19,000,000 | 19,000,000 |

Con't

PROPOSED APPROPRIATIONS BY AREA

| AREA | FY 1977 | FY 1978 (Ford) | FY 1978(Carter) | UCPA Proposals |
|---|---|---|---|---|
| Health Con't | | | | |
| • Community Health Centers | 215,000,000 | 215,000,000 | 229,000,000 | 229,000,000 |
| • Family Planning | 114,000,000 | 114,000,000 | 124,000,000 | 124,000,000 |
| • Bureau of Health Education | 5,000,000 | 3,000,000 | 7,000,000 | 7,000,000 |
| 5) Support Services | | | | |
| • Home Health | 12,000,000 | 3,000,000 | 3,600,000 | 12,000,000 |
| • Attendant Care | --- | --- | --- | 3,000,000 |
| 6) Recreation | --- | --- | --- | 1,000,000 |

DEVELOPMENTAL DISABILITIES ACT

Persons with developmental disabilities such as cerebral palsy require a multiplicity of comprehensive services throughout their lifetimes. The Developmental Disabilities Act serves as an effective linkage tool in this respect, planning, accessing, and providing services across traditional delivery lines.

Two specific components of the Act -- grants to states for planning and service delivery, and the newly-established protection and advocacy system, are at the heart of the developmental disabilities program concept. Both these areas require additional funding if they are to meet the needs of handicapped individuals as fully and as effectively as their mandates dictate.

(1) State Grants. Without a doubt developmental disabilities funds have served as the major incentive to establishing and expanding services to persons with cerebral palsy throughout the nation. State DD planning efforts have proved successful in increasing services for persons with developmental disabilities delivered by other service providers as well as state agencies. It is clear that nongovernmental providers would not have been able to outreach to the developmentally disabled population without the existence of DD state formula grants.

Despite past successes, however, the DD program has only scratched the surface in meeting needs. For example, the Illinois Developmental Disabilities Council estimates that the state serves only 10%-15% of the unmet needs identified for persons with developmental disabilities from all public and private sources of funds. There are still a great many program needs which no current service provider will support.

UCPA and other voluntary agencies serving developmentally disabled individuals must look to ongoing state financial support under the DD act to fund services such as specialized dental and optometric programs, client equipment banks (which make special adaptive equipment available to allow persons with severe physical disabilities to live more independently), respite care programs providing emergency, weekend, and vacation placements, and life skills/transitional training programs for individuals too severely involved to qualify for similar services under state DVR programs.

For these reasons UCPA strongly urges an increase to $40 million of the administration's requested $30.058 million for state formula grants under the DD Act, in order to expand current efforts and provide additional planning, access and service priorities such as those delineated above, for which insufficient monies are currently available.

(2) Protection and Advocacy Services. One of the major accomplishments of the Developmental Disabilities program at national, state, and local levels has been the development of creative and varied approaches to systematic advocacy for persons with developmental disabililites.

Because of the nature of their disability, many persons have experienced discrimination which diminishes their quality of life; these persons require an advocacy mechanism to guarantee respect for their rights and generate change. This frequently can be accomplished through state and federal DD program attempts to change the basic mandates and priorities of generic agencies which frequently neglect persons with developmental disabilities.

The Protection and Advocacy System mandated under Section 113 should, we believe, become a more centralized focus of the DD Act and program. UCPA is anxiously awaiting the state plans which will implement P & A systems in October, 1977. If the necessary incentives to states are to be developed, and if P & A systems are meaningfully to influence the quality of service to persons with developmental disabilities, the current $3 million authorization must be drastically increased with a minimum state allotment requirement.

We will have a better idea of the minimal necessary federal allotment when state P & A plans are submitted and analyzed this fall. At that time we plan to urge Congress to approach protection and advocacy services not in terms of a rigid or locked minimum appropriation, but as a vital structure for preserving the fundamental civil rights of persons with disabilities. Essential to implementing this concept is a realistic level of funding, with sufficient fluidity to meet the changing needs of a population whose short-term growth is virtually assured as the sophistication and efficiency of case-finding mechanisms improve,

and as the demand for such services increases with increasing public awareness of handicapped individuals'legal rights.

EDUCATION

Successful implementation of the Education of All Handicapped Children Act (P.L.94-142) will require a substantial funding base if state and local education systems are to meet their mandate to provide free appropriate public education to disabled young people. To accomplish this UCPA urges Congress to make available at least $650 million to implement Part B of the Act, grants to states. The $365 million requested in the revised 1978 budget is totally inadequate to meet the massive requirements of a new outreach and case-finding system, and the administrative restructuring which the expanding number of new entries into the educational mainstream will entail. An immediate and substantial increase in appropriated funding for these purposes alone is absolutely essential if the requirements and timetables established by P.L. 94-142 are to be met.

UCPA also supports a supplementary $50 million appropriation for the Preschool Incentive Grants to states to improve special education and related services to handicapped children age 3-5. As a result of the first count of handicapped children authorized under the Act (completed in October, 1976) $50 million was appropriated for this program. This count will increase dramatically during the coming year, as outreach and child-find mechanisms become more reliable, and as school districts and individuals become aware of the Preschool Incentive Program and actively seek it out. To provide sufficient funding for this inevitable rise in the number of children participating in the program, substantial additional monies must be made available to school districts, or the program will have created a perceived need without providing an adequate mechanism for fulfilling it.

Funds for personnel development must also be increased in order to insure adequate numbers of appropriately prepared teachers and aides for educational and related programs and services delivered under P.L. 94-142. UCPA suggests a supplementary $5 million appropriation in addition to the $45 million already proposed for training purposes. We strongly endorse the $1,735,000 supplementary appropriation requested by both the Ford and Carter budgets to fund needs determination and progress assessment studies in connection with implementation of P.L. 94-142.

A key element in the provision of free appropriate public education within a normalized environment will require a massive and concerted program directed toward the removal of those architectural barriers which prevent full access of all disabled children to the educational experiences available to their nonhandicapped peers. To that end, we support the Council for Exceptional Children's request for a one-year $300 million supplement to eliminate existing barriers as rapidly as possible.

EMPLOYMENT/TRAINING

UCPA is committed to the concept of enhancing opportunities for severely/multiply handicapped individuals to participate fully in programs of vocational rehabilitation and placement.

Experience has demonstrated that the majority of persons with severe disabilities have received minimal service from both State Vocational Rehabilitation agencies and private rehabilitation agencies. Vocational habilitation of persons with severe disabilities has a history dominated by an expectancy cycle that perpetuates low levels of success and low employment capabilities. Too often many employment efforts for persons with severe disabilities have consisted of simple, menial tasks requiring little training, skill, or attention. In fact, most program descriptions that are available focus on tasks that are labor intensitve rather than machine intensive, thereby accentuating the disabilities rather than the capabilities.

UCPA has been involved in several successful projects combining rehabilitation engineering and placement of severely handicapped individuals who had been rejected by state DVRs as too severely involved to participate in traditional rehabilitation programs.

- The TALL (Training Alternatives for Living and Learning) project of UCPA of Greater Kansas City operates on the premise of the necessity for complete partnership between business, industry, and the voluntary sector.

The TALL project team identifies potentially adaptable jobs, trains workers to maximum potential, and guarantees the worker's performance according to the employer's job requirements. At the same time business and industry steering committee representatives enable job analysis and engineering to take place, cooperate with sensitivity training efforts, and provide some benefits to the disabled worker.

- Center Industries Corporation (CIC) Wichita, Kansas. Center Industries aided by technical assistance from Wichita State University, is primarily a job shop operation providing support for local Wichita industry in the basic areas of fabrication, machining, and assembly. It employs the physically handicapped alongside the able-bodied in a 75% handicapped to a 25% able-bodied ratio. Diagnostic test procedures and testing hardware have been designed to determine the physical capabilities of severely physically disabled people, and the requisite job modifications made based on a comparison of client capabilities and job requirements. As a result of this application of sound engineering principles to solve the demands of rehabilitation, severely disabled workers are generally meeting industrial norms and receiving unsubsidized wages, thus marking their new status as contributors to society.

These programs are incontrovertible proof that severely and multiply handicapped individuals can attain a significant degree of vocational and economic independence, if they are given the opportunity to participate in rehabilitation and training programs designed to meet their special needs. Moreover, these programs have been demonstrated to be cost-effective in the long run, and highly attractive to a number of employer groups. To assist these individuals in entering the mainstream of a productive and independent economic existence, the federal government must be willing to address these special needs through innovative and realistically funded vocational rehabilitation programs.

UCPA is, therefore, particularly supportive of federal efforts to insure the inclusion of severely disabled individuals in all programs of vocational rehabilitation on an equable basis, and wholeheartedly support the philosophy underlying a proposed increase in the budget for special projects for the Severely Disabled under the Office of Human Development, Division of Vocational Rehabilitation. However, the proposed increase to $4,747,950 over the initial $4.7 million budget figure is negligible, particularly in light of the neglect severely disabled individuals have historically suffered under traditional vocational rehabilitation programs. We therefore urge Congress to extend this appropriation to a base of $8 million, in order to develop innovative new services for severely disabled potential workers, and to provide a far more comprehensive outreach and follow-along program than the relatively low-level efforts which currently exist.

## HEALTH

UCPA would like to express overwhelming support for proposed increases in preventive health programs for 1978. As a matter or organizational policy, we have been associated with the encouragement of programs of preventive health as an effective mechanism for reducing the incidence of cerebral palsy and other developmental disabilities.

We would like particularly to address ourselves to programmatic increases in the following areas:

(1) Immunization, Screening, and Treatment. The proposed $180 million appropriated for the CHAP program (Child Health Assessment and Primary Care Program), represents concrete assurance of a viable and effective successor to the dysfunctional EPSDT program. The importance of early diagnosis and treatment of developmental delays in young children is crucial to minimizing the physical and psychological effects of cerebral palsy; and UCPA is confident that an adequately funded program of screening, diagnosis , treatment, and follow-along procedures will contribute significantly to the achievement of that goal.

The immunization of children against infectious childhood diseases is an important corollary procedure to preventing cerebral palsy, which is frequently associated with the contraction of rubella or other childhood illnesses during pregnancy. In addition to immunization under the CHAP program, the proposed $6 million increase in the budget of the Center for Disease Control for immunization programs directed at poor children is a welcome addition.

(2) Family Planning and Population Research. Because cerebral palsy and other developmental disabilities are often the results of poor prenatal care, UCPA is pleased to see a proposed budget increase of $14 million for community health center activities in the areas of family planning, health education, and counseling and outreach services directed at teenagers; an increase of $10 million for family planning project grants designed to reduce unwanted teenage pregnancies; a $2 million increase in the Bureau of Health Education budget earmarked specifically for research and demonstration projects related to sex education; and restoration of $2 million for general preventive health education programs.

UCPA is convinced that a new preventive/primary care orientation in federal programming, coupled with adequate funding to implement meaningful activities in those areas, is one of the most reassuring manifestations of an ongoing and comprehensive federal commitment to eliminating cerebral palsy wherever possible, and to detecting and mitigating its effects at an early state in those cases where developmental disability or delay has already occurred.

## SUPPORTIVE SERVICES

Deinstitutionalizing persons with disabilities, and integrating them into their communities to the maximum extent possible, has long been a primary goal of UCPA policy; and our organization has been pleased to see an increased receptivity to this approach on the part of both Congress and the administrative agencies over the years. However, without adequate funding and ongoing encouragement of innovative mechanisms to facilitate deinstitutionalization, persons with disabilities will forever remain outside the mainstream of normal community life.

We should like to comment briefly on several distinct types of supportive services which, if funded in accordance with their potential, can be of significant benefit in facilitating and hastening the deinstitutionalization process.

(1) Home Health Services. Many Americans with cerebral palsy live in publicly operated residential facilities. However, UCPA affiliates have for many years provided a variety of home health services as an alternative to institutional care, and as a result we have been able to gauge virtually on a daily basis the many advantages of keeping persons with developmental disabilities in their own families wherever feasible.

A home health care alternative to institutionalization provides a psychologically and socially supportive method of integrating severely or multiply handicapped individuals into community life to their fullest potential. The importance to the handicapped person of living as normal as possible a family life in familiar surroundings cannot be overestimated. To assure this,the rupture of family ties should be minimized or avoided altogether wherever possible; and home health care has proven one of the most viable methods of keeping a family together despite the disability of one or more its members.

Moreover, in these inflationary times deinstitutionalization through the utilization of home health care is a highly cost-effective technique for delivering medical and social services to the severely and/or multiply handicapped. In Pennsylvania, for example, the daily cost of maintaining an adult in a state hospital is $39, or $14,235 per year. Home health services for adults delivered through United Cerebral Palsy's home health care system in the same area can be provided for approximately $8 per day, or $2,920 per year.

Clearly, then, both humanitarian and fiscal concerns dictate the continued encouragement and reinforcement of home health services as an alternative method of serving the nation's developmentally disabled citizens.

There already exist several pieces of legislation under which home health services are being provided,for persons with cerebral palsy including Titles XVIII, XIX, and XX of the Social Security Act (the Medicare, Medicaid, and Social Services provisions respectively), as well as a program of project grants for home health agency start-up and expansion administered by the Health Services Administration of the Public Health Service. Unfortunately, even today home health services represent one of the most critically underfunded segments of these legislative programs.

TABLE I. Medicare-Medicaid Expenditures. Totals and Home Health for Selected Years (In millions)

| Program | Year | Total | Home Health | Home Health as Percent of Total |
|---|---|---|---|---|
| Medicare | 1969 | $6,598 | $69.7 | 1.10 |
| | 1971 | 7,875 | 58.3 | 0.70 |
| | 1973 | 9,478 | 63.8 | 0.70 |
| | 1975* | 15,588 | 199.0 | 1.27 |
| Medicaid | 1969 | 4,167 | 10.5 | 0.25 |
| | 1971 | 5,939 | 28.3 | 0.48 |
| | 1973 | 9,111 | 24.3 | 0.28 |
| | 1975* | 12,100 | 73.0 | 0.60 |

*Estimate as of October 1976

Source: Social Security Administration, DHEW
Social and Rehabilitation Service, DHEW

In this context, UCPA strongly support restoration to the FY 1977 funding level of $12 million for home health services: $8 million for development and/or expansion of services, $4 million for manpower training. We cannot overstress the importance of a fully-funded federal commitment to home health care as a major mechanism for preventing inappropriate institutionalization, and for promoting and maintaining the optimal functioning and personal independence of persons with disabilities.

(2) Attendant Care. The promotion of noninstitutional living requires a variety of services geared to the daily living needs of persons with severe or multiple disabilities. Personal non-medical assistance where necessary to provide physical assistance in toileting, dressing, feeding, housekeeping, etc. is an essential component of independence for many individuals with cerebral palsy who without this type of help would be condemned to an institutional existence for life.

If deinstitutionalization is to become a reality for persons with disabilities, innovative approaches to maximizing their ability to live independently must be explored and encouraged. Categorical federal support of an attendant care system, whereby a disabled individual would receive a stipend to employ someone to assist him/her in accomplishing routine activities of daily living on a regularized basis, would represent a significant step toward improving chances for handicapped persons to become mobile, independent, and fully accepted members of their communities The state of California currently operates a highly successful attendant care program; and with a model already in place, it would be both relatively simple and highly profitable in long-term benefits to explore such a process under the federal imprimatur.

To that end UCPA recommends a $3 million supplement to the HSA home health services budget, for development of a experimental attendant care program.

## RECREATION

For several years United Cerebral Palsy Associations, Inc. has advocated the importance of recreational activities in adding to quality of life of persons with disabilities . With growing public recognition of the importance of recreation, and with awareness of the general unavailability or inaccessibility of public recreational opportunities to persons with disabilities, organizations such as affiliates of United Cerebral Palsy Associations, Inc. have assumed the responsibility for insuring that the recreational needs of persons with disabilities are met.

Recreation serves a relevant role in meeting the needs of the disabled adult. Due to the severity of their handicap, many disabled adults in our society are unable to do productive work and consequently have a great deal of leisure time. Through

exposure to recreational activities persons with disabilities can, to the degree dictated by their interests and capabilities, develop new interests and skills, acquire experiences relevant to developmental growth patterns, and create and contribute to society.

Despite growing sensitivity to these concerns on the part of public agencies, communities must now become more affirmative and organized in accepting their responsibilities to provide recreational opportunities and insure the basic rights of their disabled members. Encouragement and leadership through specific legislative and educational programs must be exerted by the federal government.

All federal, state, municipal and private recreational and parks facilities must be accessible if designed for public use. The Architectural Barriers Act of 1968 (P.L.90-480) mandates any building constructed in whole or in part with federal funds must be made accessible to and usable by the physically handicapped. Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112) states that"no otherwise handicapped individual , (shall) solely by reason on his handicap be excluded from participation under any program or activity receiving federal assistance." In addition, P.L. 88-27, which created the Bureau of Outdoor Recreation, declares, "it is desirable that all American people be assured adequate outdoor recreation resources and ... it is desirable for all levels of government and private interests to take prompt and coordinated action." Thus, the Department of the Interior clearly has only one course of action: to design all of its facilities free of architectural barriers, and to remove such barriers where they already exist in federal recreational facilities.

UCPA notes with dismay the omission of any budgetary appropriation for developing and improving recreational access and opportunities for persons with disabilities; and we urge Congresss to create a supplementary appropriation of $1 million for that purpose as part of the Department of the Interior's budget for FY 1978.

CONCLUSION

UCPA is gratified to see the federal government moving to implement a variety of programs targeted toward the deinstitutionalization and normalization of lifestyle for persons with disabilities. However, in many cases proposed appropriations are inadequate to meet the total universe of needs for handicapped individuals. Until realistic and adequate levels of support are assured to implement in a meaningful manner the statutory and programmatic initiatives already available, and to develop new remedies in areas in which need has been determined, disabled individuals in this country will continue to suffer the consequences of second-class citizenship.

CYSTIC FIBROSIS FOUNDATION/EPILEPSY FOUNDATION OF AMERICA

## STATEMENT OF DR. GOLDENSOHN, PROFESSIONAL ADVISORY BOARD, EPILEPSY FOUNDATION OF AMERICA

VOLUNTARY HEALTH ORGANIZATION

Senator SCHWEIKER. We will hear now from the Epilepsy Foundation.

Dr. GOLDENSOHN. My name is Dr. Goldensohn and I represent the Professional Advisory Board of the Epilepsy Foundation of America and am past president of the American Epilepsy Society and professor of neurology, College of Physicians and Surgeons at Columbia University.

The Epilepsy Foundation of America is a national grassroots voluntary health organization that has asked me to offer some observations concerning their research programs that are presently being conducted. That could, with additional funds, be undertaken by the epilepsy branch of the NINCDS.

As you suggested, Senator, I'm submitting a printed summary and will confine myself to a few major points that I would like to talk about.

Actually, I will focus on two phases of the epilepsy branch's work in research. The contract projects and the grant program.

Under the contract program, there are two major things being done now. One is a comprehensive epilepsy program. These programs are—have been funded in five centers throughout the country to deliver and test service and health delivery programs and do research toward increasing the health delivery care for epilepsy throughout the country. These five programs, none of them are located either in an area that has a major minority group, nor in the largest urban centers.

We think this is really inadequate to the problem of dealing with these special problems in health delivery, these two areas, and the Epilepsy Foundation recommends that three more comprehensive epilepsy programs be funded and that these be funded in minority and urban areas. The cost of these, Senator, would be something in the vicinity of $600,000 per year.

Another function in the contract program is that of development and evaluation of drugs for the control or treatment of epilepsy.

I might mention to you that the medical treatment of epilepsy is really the ultimate hope in epilepsy, to control the excessive excitability of the nervous system and particularly appropriate at this time to think about the fact that the highest level of the administration came out the other day with some proposals to rid ourselves of the abuses of the barbiturates. This, and there are really abuses, and terrible dangers from them.

From the epileptic point of view, phenobarbitol and related products are the cornerstone of treatment. It would be absolute calamity if these were withdrawn.

On the other hand, the development of new drugs which is part of the contract functions should be supported highly in order to develop drugs that will not be abused and cannot be abused by their nature and will be more effective.

Actually, there are a few drugs, one developed now that has not been approved to come this way. This is a crying need, as the expense of developing new drugs has increased so much that the drug firms have been unable to do this. These are the two major areas in the contract. The major areas in the research support for the branch, for basic research, is a sad one.

Dr. Dempsey mentioned a degree of funding I didn't know existed, but we're only funded 30 percent of the approved useful research that investigators are ready to do and are capable of doing to cover the problem of epilepsy and there are institutes that are funded at very high levels, as much as over 60 percent of their approved grants.

So, obviously, and I'm not going to mention all the areas that we need funding in, that people are ready to work in, but it includes the basic excitability of the brain, many, many features.

So, I would like to say that for this particular aspect, just to increase the basic research, we would like to ask for $3.7 million additional for the basic research program.

I think the things I have mentioned for the program, the increase in support for development of evaluation of new drugs and for use of the comprehensive epilepsy centers in large urban areas and minority areas would come to some $5 million, so accordingly it would be the $5 million plus the $3.7 million that we need.

I don't want to take up any more time, but I would like to make one further point, that we don't want this additional research money to be taken out of the hide of the NNCDS programs.

Senator SCHWEIKER. It's very generous of you to say that. We run through that exact problem. A lot of us who supported the cancer program were under the belief that the cancer funding increases would not deprive the other institutes. In fact, though, it has not worked out that way.

This is one of the reasons we're in a bind in some of the less dramatic research programs. Institutes such as we have just heard from here have been hurt because the administrations have not been willing to increase overall health research. Where they have boosted cancer, others have taken the brunt of it. That may be unfair, but it is a fact of life and makes our job a lot more difficult.

I can't quarrel with the merits of the argument you are making on that point. I do appreciate your comments about the institute, because the institute probably does bear on a lot of other related diseases.

## PREPARED STATEMENTS

I thank the panel very much for their presentation. We will include statements for the record at this time.

[The statements follow:]

## STATEMENT OF ELI S. GOLDENSOHN, M.D.

Introduction:

Eli S. Goldensohn, M.D., is the Chairman of the Professional Advisory Board of the Epilepsy Foundation of America. Dr. Goldensohn is Professor of Neurology, College of Physicians and Surgeons, Columbia University, New York, New York and attending neurologist, Presbyterian Hospital, New York, New York.

Research Needs:

The Epilepsy Foundation of America is the national "grass roots" voluntary health organization concerned with the control and prevention of epilepsy. The Foundation has been working closely with the National Commission for the Control of Epilepsy and Its Consequences, which has been investigating existing research efforts in the field of epilepsy and studying ways in which greater success might be achieved sooner. The Foundation would like to offer the following observations concerning the research program currently being conducted and what efforts could be undertaken with additional funds, by the Epilepsy Branch of the National Institute for Neurological and Communicative Disorders and Stroke (NINCDS).

Our comments will focus on the two phases of the Epilepsy Branch's research efforts: the research contract program and the research grants program.

Research Contracts:

The Comprehensive Epilepsy Program has now been established in five centers across the United States. The centers provide a patient population with whom important investigations of the clinical aspects of epilepsy, their epidemiological consequences and the evaluation of treatment can be conducted. The Comprehensive Epilepsy Program provides very valuable opportunities for testing service delivery models to aid indivuals with disabling neuroligical disorders, individuals for whom existing services have not been adequate, through the results of increased clinical investigation and research in patient service delivery methods for their needs.

Unfortunately, with only 5 Comprehensive Epilepsy Programs now in operation, there is not yet an adequate representation of all the types of communities within which service delivery systems are established. For example, there is no center located in an area which serves large minority groups.

The Foundation recommends that there be an additional 3 Comprehensive

Epilepsy Programs funded in fiscal year '78 at a cost of $600,000 per center. These three additional centers in conjunction with the existing five, would enable the epilepsy population to be better served.

Two other major program elements within the Research Contract Program deal with preclinical development of new drugs and clinical evaluation of new drugs. The Foundation recommends that both areas should receive substantially increased funding.

At present, proper medication is the major hope for seizure control in people with epilepsy. To achieve seizure control, most people with epilepsy are primarily dependent on phenobarbital and closely related compounds such as phenytoin.

Congress and the public are well aware that phenobarbital and other barbiturates are subject to abuse. Recently there has been discussion in the highest levels of government of taking these drugs off the market. We need not describe the grim situation such a move would make for people using these drugs for legitimate medical purposes.

NINCDS has a small drug development program trying to evaluate and/or develop compounds which can offer the promise of better seizure control without undesirable side effects. If the government wants to cut down upon or eliminate the use of phenobarbital, the most important step it can take is to fund the development of or evaluation of other drugs less subject to deleterious side effects.

These two programs, preclinical development of new drugs and clinical evaluation of new drugs, with increased funding can give much needed emphasis on a carefully structured sophisticated program of new drug development.

A detailed listing of the Program Elements of NINCDS Research Contract Program with the Foundation's funding recommendations for fiscal year 1978 is attached.

Grants:

The Administration's '78 budget request for research grants in epilepsy totals approximately $7 million. It is the Epilepsy Foundation's position that this sum is inadequate to meet the backlog of approved and promising, but unfunded, grant applications for basic research in the epilepsies. It is our understanding that within this overall NINCDS program for FY '77, only 30% of approved new applications will be funded. The immediate and long range impli-

cations of this low level of funding of a vital and ongoing program is difficult to contemplate. It is impossible for scientists to undertake a career of research when the potential for stable support is based on this limited probability of being funded.

There has been a disproportionate allocation of funds for the study of the brain and its function. As compared to the 30% "pay rate" for the NINCDS, the pay rate in the Heart Institute and Cancer Institute was 62% each and in the Institute of Child Health and Human Development it was 46%. The overall pay rate within the NIH was approximately 56%. The Foundation requests that an additional $3.7 million be specifically designated to cover basic research into the following approved but unfunded areas:

- The study of the mechanisms of convulsant and anti-convulsant agents
- The development of better experimental models for basic research into epilepsy
- The effects of toxicity on neuronal development
- Investigation of nonpharmacological therapies in the treatment of epilepsy
- Monitoring of electrical activities from the brain for the prevention of seizures
- Studies on the deleterious effects on the brain of repeated seizures

Research needs in these areas are urgent. Laboratories and individuals are waiting expectantly to answer these pressing questions. The problem is sufficient research funds are not available.

These research programs we've outlined are focused directly on the immediate needs of persons with epilepsy. However, the National Commission for the Control of Epilepsy and Its Consequences has identified $30 million in additional research currently being conducted in other branches of NINCDS that is either directly related or relevant to the problems of epilepsy. It is important that our additional $3.7 million request not be funded at the expense of any segment of this $30 million in basic research activities. This $3.7 million request should be "in addition to" rather than "in lieu of". These basic research activities are vitally needed to continue to develop fundamental knowledge about the nature of epilepsy and how the nervous system functions. We urge that the total NINCDS research budget continue to reflect a recognition of this fundamental research.

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EPILEPSY RESEARCH CONTRACT PROGRAM

National Institute for Neurological and Communicative Disorders and Stroke

| Program Element | EFA Recommendation |
|---|---|
| Preclinical Development of New Drugs<br>(1) Initial pharmacologic evaluation of chemicals for potential anti-convulsant activity.<br>(2) Investigation of anticonvulsant drugs in the primate. | 2,000,000 |
| Clinical Evaluation of New Drugs<br>(1) Evaluation of new antiepiliptic drugs for generalized tonic-clonic seizures; for absence seizures; and for complex partial seizures. | 1,500,000 |
| Pathophysiology and Pharmacology<br>(1) Evaluation of prevention of seizures after head injury by prophylactic drug treatment. | 300,000 |
| Comprehensive Epilepsy Programs<br>(1) Pilot programs in five locations are conducted for clinical research, for coordination of patient services and education. | 7,800,000 |
| Research Support<br>(1) Partial support of Epilepsy Abstracts makes research results widely available.<br>(2) A portable, wearable EEG device is developed as an aid to research on seizure disorders. | 500,000 |
| Total: | 12,100,000 |

It is estimated that 8 additional professional and support positions in grant and contract management would be required to conduct this level of research.

BUDGETARY NEEDS FOR FY-78

| Epilepsy | FY-78 Administration Request | EFA Recommendation |
|---|---|---|
| Total | 14,676,000 | 22,900,000 |
| Grants | | 10,800,000 |
| Contracts | | 12,100,000 |

## STATEMENT OF DORIS F. TULCIN

Cystic fibrosis is an incurable genetic disease.

Cystic fibrosis is the largest hereditary killer of children.

One out of every 1,600 is born with it.

Three children die each day from cystic fibrosis.

Carriers of the cystic fibrosis gene cannot be identified. One out of every 20 people in the United States carries the unknown gene.

Health care presently costs $50 million annually. By 1990, this figure will exceed $200 million annually.

A study of the state-of-the-art and future directions for cystic fibrosis, as mandated during the FY 1977 Appropriations hearings from the NIH, is currently underway and will be completed within the next year.

RECOMMENDATIONS:

1. VIGOROUS RESEARCH EFFORTS TO CONQUER CYSTIC FIBROSIS.
2. INCREASED RESEARCH ACTIVITY IN THE PURSUIT OF THE UNDERLYING METABOLIC DEFECT IN CYSTIC FIBROSIS.
3. CONTINUED SUPPORT OF THE SPECIALIZED CENTERS OF RESEARCH (SCORs) CONCERNED WITH CYSTIC FIBROSIS, BRONCHIOLITIS, ASTHMA, AND RESPIRATORY DISTRESS SYNDROME.
4. INCREASE OF INVESTIGATOR-INITIATED RESEARCH PROGRAMS CONCERNED WITH PEDIATRIC RESPIRATORY DISEASES.
5. EXPANSION OF EFFORTS TO ENABLE MULTIDISCIPLINARY ATTACKS ON CAUSES AND TREATMENT OF ACUTE AND CHRONIC DISEASES OF THE RESPIRATORY TRACT.
6. EXPLORATION OF NEW WAYS TO COMBAT BACTERIAL AND VIRAL INFECTIONS.
7. ADDITIONAL STUDIES IN BASIC GENETICS AND MOLECULAR BIOLOGY.
8. DEVELOPMENT OF A PEDIATRIC PHARMACOLOGY PROGRAM.
9. ENRICHMENT AND EXPANSION OF THE PEDIATRIC PULMONARY CENTER PROGRAM UNDER MATERNAL AND CHILD HEALTH.
10. STRENGTHENING OF MATERNAL CHILD HEALTH-CRIPPLED CHILDREN'S PROGRAM AND THE EXTENSION OF THESE SERVICES TO PATIENTS OVER 21 WITH CYSTIC FIBROSIS AND OTHER RELATED CHRONIC DISEASES.
11. INITIATION OF THE PROGRAMS AUTHORIZED IN THE GENETIC DISEASE LEGISLATION OF 1976.

APPROPRIATIONS RECOMMENDATIONS:

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES.....$285,000,000
NATIONAL HEART, LUNG, AND BLOOD INSTITUTE.....$461,000,000
NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES.....$240,000,000
NATIONAL INSTITUTE OF ALLERGY & INFECTIOUS DISEASES.....$187,000,000
MATERNAL & CHILD HEALTH
GRANTS TO STATES.....$320,000,000

RESEARCH & TRAINING.....$ 30,000,000
($3.5 million for enrichment of 11 existing
Pediatric Pulmonary Centers
$750,000 for 3 new Centers
$250,000 for program to strengthen linkages
with other health programs)
GENETIC DISEASES PROGRAM.....$ 30,000,000

MR. CHAIRMAN, my name is Doris Tulcin, and while I speak as the President of the Cystic Fibrosis Foundation, I speak first as the parent of a child who suffers from the disease, who has beaten long odds and grown to young adulthood with it.

We are indeed grateful for all of the support you and your Committee have given for the health programs of our Nation. We appreciate the support which has been provided for cystic fibrosis and related lung damaging and digestive diseases and are especially grateful for the Study of the state-of-the-art of cystic fibrosis which was requested during the FY 1977 Appropriation hearing and which is now underway. We respectfully urge your continuing support of the recommendations which are delineated in this testimony for inclusion in the FY 1978 Labor/HEW Appropriations Bill and those recommendations set forth in the testimony presented before the Committee by the Coalition for Health Funding.

The monies which further research at the National Institute of Arthritis, Metabolism, and Digestive Diseases, the National Heart, Lung, and Blood Institute, the National Institute of General Medical Sciences, the National Institute of Allergy and Infectious Diseases, and patient care through the Office of Maternal and Child Health for the Crippled Children's Services Programs and the pediatric pulmonary centers are vitally important to the children, the young adults and their families who suffer from these diseases.

Now I would like to speak to you about cystic fibrosis. It is a genetic disease which attacks the lungs and the pancreas. It remains... incurable, although we, in our vision, prefer to say that it is presently incurable. But whatever our hopes and how ever far we have come -- my daughter, who is now age 23 and is joining me in this testimony, is a living testament that we have come a long way -- we cannot gloss over the fact that three of our children

die of cystic fibrosis very day. Cystic fibrosis is the largest hereditary killer of children in the nation. One out of every 1,600 is born with it.

It is not an easy disease to comprehend. For reasons we do not fully understand, cystic fibrosis patients produce a thick, tenacious mucous, which affects the lungs and gastrointestinal tract most severely -- therefore, we consider that it is a single disease which attacks breathing and eating alike. Cystic fibrosis is, thus, not only a bizarre burden to the body but to the medical bureaucracy as well. Cystic fibrosis does not fall neatly into any niche of the Department of Health, Education and Welfare either in health care delivery or in research within the National Institutes of Health. We must obtain assistance from several government sources.

I would like to add that the Cystic Fibrosis Foundation, a voluntary health agency, supports -- besides cystic fibrosis -- research in many other chronic and debilitating children's lung diseases. We have established and help to fund a network of more than 100 treatment centers -- serving the patients, keeping them alive, saving them for that day when at last a cure or control for this maddening disease is found. However, without strong support from government, this mission cannot be accomplished.

The great sadness is that cystic fibrosis is not only crippling and painful, but ultimately fatal to the child who suffers with it. The insidious nature of the sickness is such that it is disabling to the whole family. I am a parent. I know all of this personally. It is estimated that the annual average cost of direct health care per cystic fibrosis patient exceeds $5,000. Because the disease is genetic, it is not uncommon for two or more in the same family to have the disease. My daughter lives, but a niece of mine died at age 17 of cystic fibrosis.

Often, until they are in the last stages of their decline, the children who are dying with cystic fibrosis look deceptively well.

And the families are not only burdened by a chronic illness, by great financial demands, but by pyschological agonies that we cannot begin to measure. The disease is so ubiquitous. It must be treated constantly, day in and day out. It destroys marriages. It scars the healthy brothers and sisters. It is now conservatively estimated that the cost of cystic fibrosis in direct health care amounts to $50 million annually in this nation. By 1990, this figure in today's dollars will exceed $200 million per year.

As a cystic fibrosis parent, as every cystic fibrosis parent, I am a carrier -- unaffected myself. It is very unlikely that an individual will know that he or she is a carrier until that person marries another unknown carrier and thus produces a cystic child.

But the laws of genetics are unyielding. One out of every 20 people in this country carries the gene for cystic fibrosis. That is a number equivalent to the population of the state of Illinois.

The odds are that some of you in this room carry the gene for this disease, just as I do, and but for the luck of the draw and the grace of God, your child would have cystic fibrosis...as mine does.

Now, MR. CHAIRMAN, I would like you to hear from my daughter, Ann (Tulcin) Kates.

MR. CHAIRMAN, I am Ann Tulcin Kates, and I am especially grateful to be here today because most of my contemporaries born with cystic fibrosis are no longer alive.

Sometimes, I feel very sorry for myself that I was afflicted -- and not my brother, not my neighbors, not my friends. But then, sometimes I feel very lucky, too. When I was born in 1953, the life

expectancy of a child with cystic fibrosis was three years. I was not given a diagnosis; I was handed a death warrant. The Foundation was formed in 1955, shortly after I was born, and today, half of us born with the sickness in 1977 will live past age 18. I live on a frontier, Sir. We simply do not know how far our lives may be extended. Few of us, until recently, have ever attained that age.

I must emphasize that I am a relatively mild case. My mother spoke of my cousin. She was close to my age and she died of cystic fibrosis several years ago. As you can imagine, that really brought it home to me. I could no longer avoid the hard truth, that we never get better. Cystic fibrosis is a progressive disease. Since my cousin's death, I have developed an infection caused by pseudomonis which invades the lungs and for which, to date, there is no really effective treatment.

And always, every day of my life, I must work to stay alive -- I cannot just get up and brush my teeth in the morning, put my clothes on and go about the business of living. I must work every day of my life to earn another.

A typical cystic fibrosis patient takes 60 pills every day of life. I do not mean only young people of my age. I mean babies, little boys, little girls. Sixty pills a day, every day. And there is much more for most of us.

Many of us must also employ mist apparatus to sleep with. We must take inhalation treatment, every day. We must endure special diets. And the typical cystic fibrosis patient must devote an hour or more every day to a tedious and uncomfortable form of physical therapy known as postural drainage. We must be turned sideways, upside down -- and then clapped about the chest in an effort to get that poisonous mucous up and out of our systems.

An hour a day, Sir -- often more -- every day of life...just to

maintain life. You can be shown the pills, Sir. But, I request you to visualize an hour a day to a child. That is not so easy to lay out before you.

But so long as I can take care of myself, keep myself alive, I can carve out a life for myself. I am married. I have a job. I teach children with learning disabilities. Other people say that they have a lot to live for. Well, I have a lot to keep myself alive for.

My mother and father taught me early on that if I were going to have any chance, I was going to have to be very tough. Sometimes that's difficult for a girl in this society. My husband calls me defiant...and I accept that. I don't think he considers me a hard person. Just tough. And I'm also very grateful -- to all the doctors and to all of you who have helped us get this far. Those of us who have cystic fibrosis so appreciate all that the Committee is doing. I urge you to approve the recommendations which are advocated in this testimony.

We thank you.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

At the National Institutes of Health, the National Institute of Arthritis, Metabolism, and Digestive Diseases is the focal point for cystic fibrosis-related research. The Institute is responsible for the Federal government's program of support for fundamental and applied research related to many inherited metabolic diseases and nutrition -- an area of particular concern in cystic fibrosis (CF). Research is supported through a grants program and in studies conducted at the NIH Clinical Center in Bethesda. In the FY '77 Appropriations hearings, the Congress took cognizance of NIAMDD's pivotal role in CF by directing the Institute to conduct within the year a study of research and clinical needs of cystic fibrosis.

This year, it is crucial that the research efforts of the Institute be supported with sufficient vigor so that ongoing CF research and research support will not falter and investigators will be sustained in their efforts to conquer this grave disease. In FY 1976, NIAMDD spent $2.05 million for conduct and support of CF research. In FY 1977, it is estimated that research spending for CF will increase little, if any, and this, compounded by the inflationary erosion of the dollar, may actually result in a decline in the number and scope of projects that the Institute will be able to support. In view of the seriousness of this disease, its lethal consequences to so many children and young adults, it is imperative that the present research thrust be sustained. The administration's budget level for NIAMDD in FY 1978 will not be able to do this in what we regard as an adequate manner. We strongly urge that a total of $285 million be made available to the programs of NIAMDD for FY 1978 so that the Institute can at least continue the current research effort in CF without losing headway.

Upon completion of the comprehensive study of the state of the art and future directions in CF that is presently being carried out by the Cystic Fibrosis Foundation under a contract with the NIH, it is anticipated that future research planning for NIAMDD and the NIH can be sharply focused on the particular areas of need.

We have confidence that, given new directions by this important study, and given adequate funds to pursue essential research in cystic fibrosis, vastly improved means of management of this devastating disease will be developed. Crucial for these efforts, however, is the provision of additional funds for such research in a more realistic fashion than is indicated in the administration budget. The underlying metabolic defect in CF must be identified in vigorously pursued research; given a realistic budget, the NIAMDD will be able to increase its CF-related research by about a half-million dollars -- our own knowing and lean estimate of essential

additional research for this disorder. We feel strongly that an overall allocation of $285 million for the NIAMDD budget for FY 1978 is needed at this time.

The Cystic Fibrosis Foundation wishes to urge you to do all in your power to support the continued productive activities of this and the other Institutes at the NIH with regard to cystic fibrosis and other inherited metabolic, digestive and pulmonary diseases with an adequate and realistic budget along the lines we have proposed.

NATIONAL HEART, LUNG AND BLOOD INSTITUTE

The National Heart, Lung and Blood Institute, through its Division of Lung Diseases, is involved in research activities of the greatest importance to our efforts to help provide solutions to the devastating lung problems which cripple young children in this country. Beyond this basic interest, the Division of Lung Diseases has expressed its great concern for these problems in co-sponsoring, with the National Institute of Arthritis, Metabolism and Digestive Diseases, the Study of the state-of-the-art and future directions in cystic fibrosis mandated by the 94th Congress in the FY 1977 Appropriations hearings. This Study, to be completed within one year, is being carried out by the Cystic Fibrosis Foundation, under contract with the National Institutes of Health.

Major efforts are concentrated on the following programs: 1) Specialized Centers for Research (SCOR) focus on cystic fibrosis, the respiratory distress syndrome, asthma, and bronchiolitis. Each of these disorders is capable of incapacitation and killing large numbers of children each year. Much remains to be learned on how and why they develop and how they can be prevented, diagnosed, and treated. The individual SCOR's, each focusing on a different one of the diseases mentioned, are capable of providing the new information needed to understand normal and abnormal development, regulation and function as they

apply to the system so critically damaged in the disorder; 2) investigator-initiated research programs which focus on the special substances suspected of being present in cystic fibrosis and which could provide the critical information allowing the prediction, prevention and early diagnosis of this genetic killer of young people.

Another major effort in pediatric pulmonary disease is directed at assessing the ability to train and educate children to handle their chronic respiratory problems in a manner which has the potential for not only reducing patient and family distress but also of affecting significant cost savings in the management of their health costs and need for health care resources.

The NHLBI Act as it is presently written requires that not less than 15% of the Institute budget be reserved for diseases of the lung (including cystic fibrosis, bronchitis, emphysema, asthma, and other lung diseases).

Therefore, we urge that $461 million be appropriated for the NHLBI for FY 1978 in order that these important programs can be carried forward.

NATIONAL INSTITUTE OF GENERAL
MEDICAL SCIENCES

The National Institute of General Medical Sciences relates to the cystic fibrosis problem in several important ways. Through its support of research on basic genetic mechanisms and genetic diseases in general, and because of its specific involvement in cellular and molecular biology, the NIGMS provides the foundation upon which the future effort in cystic fibrosis will undoubtedly rest. These broad basic scientific endeavors undergird programs at other Institutes whose missions are specifically disease oriented. Research in the field of cystic fibrosis is rapidly zeroing in on basic genetic and molecular phenomena which

many investigators believe must be involved in the production of of an abnormal mucous by the cells.

Support for the National Institute of General Medical Sciences has been kept constant during the past two fiscal years, while the 1978 budget request asked for approximately a 7% increase to the level of $219,896,000. We strongly recommend an appropriation of $240,000,000, or an increase of about $20 million for several reasons. One, the increment of $20 million would permit the funding of additional studies in the critical areas of basic genetics and molecular biology. Without this increase, only about 50% of approved grants can be funded by the Institute. Two, the additional funds would permit NIGMS to develop a pediatric pharmacology program, which holds the promise for developing the therapeutic armamentarium needed to treat cystic fibrosis effectively. As noted previously, a successful effort in this specific activity may result in a most significant reduction in the economic burden of the disease. The cost effectiveness of monies invested in this program is likely to be high. Three, funds available in the current year, 1977, are such that a greater than normal backlog is projected for 1978.

The Cystic Fibrosis Foundation therefore urges the Congress to support the budget of the National Institute of General Medical Sciences at the suggested level of $240,000,000.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

Control of infection is vital to the survival and well-being of victims of cystic fibrosis. NIAID research in infection and immunity is of major importance to the unfortunates suffering from this disease. Cystic fibrosis patients are particularly susceptible to chronic bacterial infections. Antibiotic therapy has enabled extension of productive life for many victims to adulthood. Yet the value of these lifesaving drugs is being threatened by the growing problem of antibiotic resistance in

commonly occurring bacterial infections. It is clear that new ways of combatting both bacterial and viral infections must be found if the advances of the past are to be preserved and still further years added to the longevity of CF victims. It is for this reason that we strongly support a budget of $187,000,000 for the NIAID in FY 1978.

The FY 1978 President's Budget request of $153,442,000 is about $12 million above the FY 1977 appropriation or an 8 plus percent increase. While on the surface this may seem to be more than a cost of living increase, it will not redress the underfunding of previous years or enable the Institute to fund more than a third of the approved grant applications. We estimate that an additional $34 million is needed to allow new or expanded initiatives which seek to capitalize on the fruits of basic research. Particularly related to the objectives of those concerned with CF are several programs which the Institute seeks to initiate or accelerate. Promising advances in antiviral therapy demand expansion of controlled clinical trials. These are expensive as are the clinical trials of new vaccines and have been made still more expensive by societal demands for safeguards. Increased emphasis on microbial genetics not only relates to the search for the basic genetic defect which underlies CF but is of major importance in combatting the problem of antibiotic resistance. Particularly important is the support of expanded Asthma and Allergic Disease Centers to enable multidisciplinary attack on the causes and treatment of acute and chronic disease of the respiratory tract. Of equal importance is the translation of rapidly emerging new knowledge about the immune system into clinical usage. Funding of a number of program projects in clinical immunology will enable continuation of efforts to identify the genetic control of susceptibility to a variety of diseases, including CF, will enable exploitation of methods of manipulation of the immune system to increase resistance to infection, and will further advance the efforts to find ways to correct disease caused by genetic defects.

The need for increased funding research in infectious disease and immunity has been underscored in the past year by events such as Legionnaires' Disease and the National Conference on Immunization. We believe our recommendation is modest and would represent a wise and prudent investment for the public.

MATERNAL AND CHILD HEALTH

Though the constituency of the Cystic Fibrosis Foundation has particular concern for the health care of patients with cystic fibrosis and related lung damaging and digestive diseases, there is also a special interest in the broader aspects of the Maternal and Child Health and Crippled Children's programs authorized under Title V of the Social Security Administration. This interest is generated by the many cross-connections between the cystic fibrosis patient now receiving care through the Pediatric Pulmonary Centers program or through the Cystic Fibrosis Centers and the more comprehensive programs supported by Maternal and Child Health. We believe a broad based program is essential for the health of the mothers and children of this nation. Such a program must have the resources to provide preventive services, specialized care and have the capacity to accept referrals and to provide follow-up health services to mothers, their infants and their children. The Maternal and Child Health program over the years has filled this role and has now become the "keystone" in the development of rational systems of health care delivery to families in need. We believe the program to be cost effective and certainly when physical, social and psychological values are considered, it is humanly effective as well.

In previous appearances the Cystic Fibrosis Foundation documented the need of cystic fibrosis patients and the need of additional centers to care for these unfortunately ill children. In a report submitted to the Congress in 1974 by the Department of Health, Education and Welfare, the recommendation was made to increase the number of centers geographically across the nation

from 10 to 22 by 1980. To date, funds have been allowed for only one new center to be added. I urge the Committee to reconsider the recommendation made in the report and to direct the Pediatric Pulmonary Center program to be expanded as scheduled. MR. CHAIRMAN, the Pediatric Pulmonary Center program is getting poorer day by day. The 1974 report recognized the need for additional support for the existing centers but as of this date, we have received no such consideration. We were appreciative of the 1976 Senate report language which directed that one new center be established. This was done (in Florida) and we believed a beginning had been made -- but the effort was not continued in 1977.

We have great concern for the strengthening of the Crippled Children's Services Programs throughout the country and for the extension of these services to those cystic fibrosis patients over 21 who live with this catastrophic illness. Therefore, we urge the Committee to appropriate $350 million for Maternal and Child Health. $320 million of this appropriation to be designated for formula grants to states and $30 million for research and training programs. Of the research and training monies, it is recommended that $3.5 million be appropriated for the continuation and enrichment of the eleven existing centers, $750,000 for the addition of three new centers and $250,000 for a program to strengthen linkages with other health programs providing health services to children.

We further strongly urge the Committee to appropriate the $30 million authorized under the Health Research and Health Services Amendments of 1976, for genetic diseases. The Maternal and Child Health program has moved forward with preparation to initiate this important national program which will provide basic and applied research, research training, testing, counseling and information and education programs with respect to genetic diseases which includes cystic fibrosis amongst others.

## STATEMENT OF DANA E. NEIMARK

Mr. Chairman and Members of the Subcommittee:

The National Society for Autistic Children is grateful to Senator Warren G. Magnuson, Chairman of the Senate Labor-HEW subcommittee on Appropriations and all of the Subcommittee Members for their sustained interest in the childhood disorder autism and related disorders of behavior and communication. The National Society for Autistic Children also wishes to thank the Subcommittee for permitting our testimony to be placed into the record.

As many members of the Subcommittee already know, autism is a severe disorder of language and behavior which affects 4-to-5 out of every 10,000 children born. Often manifest at birth, the condition strikes by age three, sometimes after what seems to have been normal early development.

While autistic children have in common characteristics associated with other developmental disorders -- and indeed sometimes have other developmental disorders in addition -- autistic children are set apart by their inability to "relate" or to respond appropriately to other people or to their environment, and show intellectual abilities in certain areas at developmental levels significantly inconsistent with abilities in other areas.

Particularly, the most able autistic children usually demonstrate aptitudes in areas involving computative functions, rote memory, spacial relationships, and music. In those areas critical for social interaction and survival, autistic children have drastic functional lags. Language concepts and expression, social awareness and judgment, certain aspects of "common sense" are dramatically lacking.

So, some autistic children may be able to master incredibly complex arithmetic feats, repeat with complete accuracy such things as television commercials or statistical sports' data, sing from memory in the correct key whole symphonies. But yet, these same autistic children are not able to grasp what children much younger than they are able to understand without explanation, almost intuitively. They lack a sense for usually understood but difficult to define social nuances, such as judgment not to ask embarrassing questions or not to breach appropriate social distance. They misunderstand the use of words that have double meanings, even when the context would make it obvious to most without second thought. The most intellectually developed fail to grasp implied or subtle meanings in conversation or writing.

But not all autistic children are able to express their abilities, or even begin to function in ways approaching normalcy. Some lack not only a grasp of subtle social amenities, but have behavior which can only be described as bizarre and unsettling.

Some sit alone for hours in a corner, mute, unresponsive examining the movements of their fingers.

Others scream without cease for hours, or tear frenetically through the house, destroying furniture, toys and whatever lies in their path. Yet others bang their heads until they develop severe head wounds, or mutilate themselves in other equally disturbing ways.

Yet, somewhat paradoxically, or possibly as nature's compensation, most autistic children are unusually attractive and graceful. It is also ironic that this disorder called autism whose effects are so pervasive, rendering those gifts bequeathed to some of the children almost useless, has a cause whose target is discrete enough to leave the afflicted children so physically intact, and in certain ways so mentally exceptional.

This strange and devastating condition has been recognized as a specific syndrome only since 1943, and until recently was incorrectly thought by most to be caused by faulty parenting, particularly cold and unresponsive mothering. Thus, the course of research and treatment and the provision of appropriate services has been set back for at least several decades at the expense of too many autistic children. Nevertheless, in the past several years scattered researchers in various parts of the United States and elsewhere have been gathering evidence which confirms organic, rather than psychogenic bases for the autistic syndrome.

Researchers have observed that in certain instances accidental brain injury produces autistic-like symptons in previously normal children.

The metabolic-genetic disorder phenylketonuria (PKU) often produces autistic-like features in untreated children. And as a matter of fact, in the past, before the simple biochemical test for PKU was routinely available, such children were often diagnosed as autistic.

Studies have shown that children with congenital rubella (infected in utero) have a higher incidence of autism than children not so infected.

Other studies have shown a statistically significant increase in the incidence of autism and related childhood behavioral disorders in children whose mothers experienced uterine bleeding during pregnancy, particularly the mid-trimester.

A British investigation of autism in twins, published early this year, corroborates earlier evidence for the biological basis of autism, indicating that this disorder can be caused by an inherited cognitive abnormality in some instances, by brain damage in the perinatal period in other cases, or by both factors operating together in which the biological insult manifests the disorder in a genetically vulnerable child.

AUTISM RESEARCH AT NINCDS

Last year, the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) sponsored a Workshop on the Neurobiological Basis of Autism at the NIH campus in Bethesda, Maryland. The Workshop was attended by over fifty scientists from academic institutions and government representing the spectrum of disciplines involved in finding the cause and treatment of autism: neurologists, pediatricians, psychologists, neurophysiologists, biochemists, psychiatrists, and speech, language and hearing specialists.

The Workshop clearly demonstrated the research issues concerning autism which should be addressed by the Institute. In fact a summary of the Workshop was transmitted to the Congress in March of last year.

This Subcommittee confirmed its interest in research on autism, again, last year in the Subcommittee Appropriation Bill Report which stated that the NINCDS "is urged to follow up on their [autism] Conference and report to the Committee with increased emphasis in this area. The Committee will want to discuss Institute achievements in this area during FY 78 Hearings."

To that end, the NINCDS has requested that all grant applications received by the Division of Research Grants, NIH which concern the neurobiological basis of autism be referred to the NINCDS for review. In addition, a Section on Autism and Behavioral Disorders is being created within the Developmental Neurology Branch.

While the President has asked Congress to hold the line on spending in all areas and to reduce spending wherever possible to help reduce inflation, the Neurology Institute budget is far too modest, even when compared to certain other health-related spending, to accomplish the Institute's task to reduce human suffering.

The President has requested $161 million for the

total NINCDS research program, a mere 4% increase over last year's budget, and an increase which does not even begin to compensate for inflation.

According to NINCDS budgetary data, the President's budget request will allow only for maintaining bare bone program survival. In order for the Institute to regain normal growth of its biomedical research program, a budgetary increase of at least 36% would be needed. It is significant to note that this 36% increase would not represent new initiatives, but would permit the Institute to fund highly relevant projects and to take advantage of high priority opportunities.

The President's frugal budgetary request is being presented to Congress at a time when the Institute has recognized and is planning a research assault on not only autism, but on other debilitating neurological disorders in the past neglected or just not recognized as distinct clinical entities -- and which may have mechanisms similar to those causing the autistic syndrome.

The Neurological Disorders Program, under which the new grants and contracts for studies on autism will be funded, has an allocation in the President's Budget of only $56.619 million. At least $78 million is needed to enable adequate research efforts in this program area.

Of these hold-the-line funds requested by the President, only $240,000 is projected for contracts under the newly created Autism and Behavior Research Section. To realize normal program growth, as indicated in NINCDS budgetary studies, at least $480,000 would be needed for this section.

Only $80,000 has been projected for grant-supported research on autism. At least an additional $40,000 would be needed in this area to fund more than a skeleton grant-support program for autism research.

The NINCDS grant-support program has suffered considerably because of insufficient funds. In the current fiscal

year, it is projected that only a small percentage of the grants which were approved will be able to be funded and awarded. For example, it is projected by the Institute that only 28% of the approved new and renewal competing grants will be able to be funded.

With the President's budgetary request for the coming year, the Institute estimates that only one-out-of-seven (15%) of approved research grants could be funded. Clearly, this situation could lead to a severe undermining of neurobiological research.

The National Society for Autistic Children is concerned for the future of the autism program of the NINCDS if funds for bare bones program survival only are appropriated. For our children will be served then only at the expense of others with devastating disorders.

We respectfully urge this Subcommittee to consider our concerns, as you have done in the past, and this year to appropriate at least $219 million to the total NINCDS research effort, and of those increased funds, to allocate at least $77.6 million to the Neurological Disorders Program.

For only with these increases in budget over what has been requested by the President will the Institute be able to regain normal growth of its biomedical research programs and, thus, to proceed with the research investigations which will enable man to combat the tragic disorders of autism and other neurological diseases.

EDUCATION FOR ALL HANDICAPPED CHILDREN ACT, PART B -- ASSISTANCE TO STATES (PL 94-142)

While biomedical research holds the key to the medical amelioration, cure and prevention of the autistic syndrome and other severe disorders of communication and behavior, at the present time there are no medical treatments for these childhood conditions.

There are, however, effective ways of dealing with

the autistic condition through highly specialized education programs. These programs can teach autistic children not only the traditional educational skills that all normal children are taught in the schools they are required by law to attend, but can teach autistic children the other non-academic skills which are needed to function in our society and which are necessary for making use of academic and vocational skills.

Of course for many of the severely afflicated children, the program emphasis must be on the most basic aspects of education. And for these most handicapped children highly individualized instruction with one teacher for a very small number of children is required.

Such programs are demonstrably successful; they are also expensive. Increasing numbers of states are enacting mandatory education laws, and at the same time incurring large financial obligations.

Congress recognized this situation, and passed in the autumn of 1975 the Education for All Handicapped Children Act, which provides Assistance to States. This portion of the Act has an entitlement which authorizes ten percent of the average per pupil expenditure to be allocated to the states on the basis of the number of handicapped students identified between the ages of three and twenty-one.

The entitlement in the Act, which is 10% of the average per pupil cost, based on projections for the year in which the monies will be spent (the current average per pupil cost with a ten percent inflation consideration), is equal to one hundred and fifty-three dollars ($153) per handicapped pupil.

Educational programs for handicapped children often cost considerably more than ten percent over the cost of educating a non-handicapped child. As a matter of fact, it is estimated that it costs on the average twice as much money to educate a handicapped child as it costs to educate a normal

child. Programs for autistic children can cost from approximately $6,000 for a good day school to $17,000 and more for a suitable residential school, required for certain autistic children. Thus, a ten percent grant from the Federal Government, based on the average per pupil cost, or one hundred and fifty-three dollars ($153) would not seem extravagant.

Every state will be required by September 1, 1978 to educate all children between the ages of six and seventeen. States will receive no funds under the Act, unless they provide services for all identified children. To provide less monies than the Act entitlement specifies to supplement state school district per pupil expenditures would undermine the intent of this Act.

The Education for All Handicapped Children Act indicates that there are eight million handicapped children in the United States. If close to five million of these children are identified, then at least $700 million will be needed to enable the states to receive the ten percent entitlement in the law.

The President has submitted in his budget a request for only $365 million. The National Society for Autistic Children respectfully urges along with other organizations interested in handicapped persons including the Council for Exceptional Children and National Association for Retarded Citizens, that the Assistance to the States program of PL 94-142 be increased to at least $700 million.

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

The National Society for Autistic Children also wishes to urge increases in the President's Budget for the research component of the National Institute of Mental Health (NIMH) and the Community Mental Health Centers.

While the research component of the NIMH does not have a specific autism program area, the Institute supports research which is contributing to an understanding of the basic biochemical

and behavioral processes common to mental disorders. And the Institute supports some autism research, primarily through its grant program.

Out of these investigations significant inroads have been made on the metabolic mechanisms involved in certain mental disorders, leading to effective drug and other biomedical therapies, and possibly providing a model for studying the autistic syndrome.

Investigations on the dynamics of behavior and ways of modifying abnormal behavior through operant conditioning and other behavior therapies are also yielding results. Also significant are studies on childhood behavior from a developmental perspective, against which abnormal behavior can be evaluated, and in which the progressive steps occurring in the development of normal behavior can be established. Some of the investigations in these research areas have focused on the autistic child and are providing new insights into dealing effectively with the problem.

The President has requested in his Budget $107 million, an amount no greater than the amount received by the Institute last year, an amount which does not even compensate for inflation, and will not permit, of course, any research program development.

The National Society for Autistic Children, along with the National Association for Mental Health, recommends that the research component of the NIMH budget receive $122 million. When it is considered that this amount requested by our organizations reflects less than one-half of one percent of the total cost of mental illness to Society, and that one-out-of every ten persons suffers from mental illness, affecting one out of four families, this budget request seems well justified.

We also wish to request an increase in the President's budget for the NIMH Community Mental Health Centers. The National Association for Mental Health has recommended that the Community Mental Health Centers program be increased from the President's request of $234 million to $333 million. This increase

would provide funds to permit the Community Mental Health Centers to expand their programs which last year served two million persons. While this is a substantial number, it is still considerably less than the number of persons requiring services out of the approximately 20 million who suffer from mental illness.

Since Community Mental Health Centers must serve large populations that don't have access to private services, an increase in the President's Budget for these services would seem well worth the expenditure from both a humane and economic point of view.

DEVELOPMENT DISABILITIES ACT (PL 94-103)

The National Society for Autistic Children wishes to recommend a modest increase in the President's Budget request for the Developmental Disabilities Act (DDA). DDA provides for basically four programs to be administered by the States. These program components enhance the proliferation of new and innovative programs and improve the efficiency of State programs by fostering better cooperation between various State agencies. Also, the Act provides for the training of workers in the field of developmental disabilities, and enables protection and advocacy for developmentally disabled persons.

The Act has an authorization for $109 million. The President has requested $58 million in his Budget for DDA. This sum provides no increase over the Budget of the current year. We wish to request, along with the National Association for Retarded Citizens and other organizations representing developmentally disabled persons, an increase in the President's Budget to $73 million with the following allocations:

Protection and Advocacy. We applaud the President's full funding request of $3 million for protection and advocacy. We wish to urge increases for the other three components of the DDA.

State Formula Grants. We respectfully urge an allocation of $40 million for this component. The President has

requested $30 million, the same amount that was in the Budget last year. The authorization in the Act is $60 million. The amount requested by the President will not permit the States to expand their developmental disabilities programs, nor even provide enough monies to compensate for inflation.

University Affiliated Facilities (UAF). We request an allocation of $8 million for this component of DDA. The Act authorizes $21 million. The Budget for this program last year was $5.25 million, while the President has requested only $5.5 million for next year. These programs have had only a slight increase since 1972. Since these funds are used to train personnel to provide services to developmentally disabled adults and children (personnel who cannot be trained under other UAF funding sources available for child-training health personnel, utilized primarily to train child-health personnel for the mentally retarded) the modest increase that we have requested would seem to be reasonable and justified.

Special Projects. This component provides for new and innovative programs, and for training for non-UAF programs. The authorization for these Special Projects is $25 million. The President has requested $19.6 million, slightly less money than allocated for this past year's Budget for Special Projects. We request an allocation of $22 million, an increase to compensate for inflation.

We thank the Subcommittee for its concern and urge that it consider favorably the requests made by the National Society for Autistic Children.

## NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, PEDIATRICS, AND ALLERGY AND IMMUNOLOGY

### STATEMENT OF WILLIAM E. PIERSON, M.D.

PREPARED STATEMENT

Senator SCHWEIKER. Dr. William Pierson from Seattle, Wash., is our next witness.

I understand he would like to testify on the Allergy and Infectious Diseases Institute.

Dr. PIERSON. My name is Dr. William Pierson from Seattle. I have a prepared statement I would like to be made a part of the record after I highlight the main points for you.

Senator SCHWEIKER. All right. Without objection, so ordered.

STATEMENT HIGHLIGHTED

Dr. PIERSON. I would like to try to make a couple of points.

First of all, we have heard a great deal today about research and need for basic research. Yet I think that the intent of many people in our country and the Congress in particular is to get the progress to the people.

In other words, funding for research, the infectious disease funding is about 20 percent which leaves a lot of basic important research unfunded.

What happens is that clinical research in two particular areas that I would like to talk to you about goes totally unfunded.

Roughly there are 79 million people in this country under 21 years of age. Of those, conservatively, 12 million will be allergic individuals. Of that 12 million—we are talking about people under 21 which is where my experience happens to be with pediatrics and adolescents—of those, 10 million will have a disease called allergic rhinitis or hayfever.

Senator SCHWEIKER. Called what? Allergic rhinitis?

Dr. PIERSON. Yes.

The syndrome, if you want to split hairs, is different from hayfever in that it is more seasonal, whereas, allergic rhinitis is more of a perennial problem. That means a person is hypersensitive to various factors in the environment which stuffs up his nose perennially rather than just seasonally.

With hayfever, especially in the East, when the ragweed pollinates in August, everybody gets——

Senator SCHWEIKER. What remedies are there for rhinitis?

Dr. PIERSON. I am glad you asked that. That is what we would like to know. That is exactly where we are coming from, because the problem is that there is—if we just finish the numbers, half the people with allergic rhinitis will have fluid that backs up in their ears.

The lady that talked about communicative disorders, the majority of those people—I can give you reference data for this—will have delay of speech development and the peak age is from 4 to 6 years which means that just prior to their entrance into school.

These people are not handicapped to the point where they will stand out, but they don't learn as effectively. For this reason they are to us in the field, in the trenches, if you will, there is a great need for an increased emphasis and funding for some clinical research to get to the common problem.

Senator SCHWEIKER. Are there any encouraging signs of breakthrough on the horizon?

Dr. PIERSON. Actually our understanding, first of all—there is newer technology again coming from the audiologists. There is a phenomena, a machine called a tympanometer which can measure compliance of the eardrum and detect in a newborn, certainly with reliability after age 3 months, beyond all conception—we never had any idea of the rate of intermittent disability allergic children have. It is 51 percent.

Senator SCHWEIKER. Fifty-one percent what?

Dr. PIERSON. Of the children with allergic disease under the age of 10 will have a problem of ventilating their ears which means——

Senator SCHWEICKER. Of all children now?

Dr. PIERSON. Allergic children. It is a lot of people when you weigh them against school and the fact that they are not hearing normally but their health care providers are not detecting that.

Senator SCHWEIKER. What can be done for them once it is found and diagnosed?

Dr. PIERSON. First of all, they are identified so they can get preferential seating, so they can get speech therapy and, more importantly, we think, allergic therapy in terms of things one is allergic to, the whole role of drug therapy, pharmacologic—there are studies to indicate these probably are effective, but yet when we are really pushed for hard data we are in trouble because we don't have the studies——

Senator SCHWEIKER. Does nutrition have anything to do with it?

Dr. PIERSON. It may. Nobody can say yes or no.

Vitamin C—various trials have been attempted with vitamin C to see if it makes any difference.

Here is where the problem of clinical research is a difficult one. You have a human being, and it is not like a molecular experiment that you can structure and test. There are many things to control properly so that you get a valid conclusion and that is a difficult phenomenon.

What I am here for is to say that as a practitioner I see a desperate need for increased emphasis on what is a very common problem.

That is problem one, allergic rhinitis.

Second is the problem first of all, if we run numbers again, roughly of people under 21 years of age, there are probably 3 million asthmatic patients.

Of those, 2.5 million will be made worse with exercise.

Exercised-induced asthma I think caught the national fancy at least fleetingly when Rick Demott lost his gold medals in the Munich Olympics. That was over trying to take a legitimate drug in order to compete like other people.

The whole problem of exercise-induced asthma again is one that is a very common affliction when you take 2.5 million people under 21 years of age that are afflicted with this problem but again in

terms of workdays lost, restriction of activity, et cetera, essentially nothing is being done at the research level at the NIH in this particular disease.

I have put a reference in our statement of some material that would give the committee some background of why we think this is important.

Now, essentially in deference to time, I think that NIAID has worked vigorously at basic research. I think they are now of the spirit that they see a need to translate that from basic research to clinical research, what would help our patients.

A lot of that basic research would be run.

We would like to urge the committee to do two things:

First, to emphasize in the appropriation bill that some attention be paid to these two common problems by the National Institute of Allergy and Infectious Diseases.

Second, we would like to ask funding of $178 million for 1978. Somewhat less than the coalition. In looking at the programs that would give us, especially in the area of clinical research, I think that is a conservative but reasonable estimate.

Senator SCHWEIKER. I know the Chairman is very interested in the asthma part of your work, particularly, as well as the rest of it. He is in a conference now. I am sorry he couldn't be here. I know he is interested in your work.

PREPARED STATEMENT

Thank you very much. We appreciate your coming in today. Please leave your written statement so we may include it in the record.

[The statement follows:]

STATEMENT OF WILLIAM E. PIERSON, M.D.

Mr. Chairman and Members of the committee, there are 79 million people in the United States under the age of 21. Twelve million have an allergic disease and 10 million of them have allergic rhinitis or hayfever. Six million young people have intermittent fluid in their ears as a result of their hayfever or allergic rhinitis which impairs their hearing. Three million children and adolescents have asthma and 70 percent of them will be made worse by exercise. In spite of the tremendous number of patients involved with the diseases of allergic rhinitis, hayfever, and asthma, very little has been done in the past concerning their suffering.

The National Institute of Allergy and Infectious Disease has pioneered fundamental and basic research and has more recently developed a series of 15 Asthma and Allergy Centers. The mission of these centers has been to look at basic, as well as clinical and therapuetic modalities relating to the whole spectrum of allergic diseases. There are two areas which have been largely ignored. These two are: (1) Allergic rhinitis which affects 6 million young patients and costs nearly 1 billion dollars annually in health care and, (2) Exercise induced asthma which causes physical and emotional handicaps in many ot the 3 million children and adolescents involved. However, these two areas affect such large numbers of patients that they require highest priority for new clinical research programs that will change therapy and reduce health care costs.

Therefore the organizations I represent strongly urge the committee to do two things: (1) Emphasize in the appropriation bill that the National Insititute of Allergy and Infectious Diseases initiate new clinical research programs aimed at allergic rhinitis and exercise induced asthma, the two most common problems leading to handicaps in children and increasing health care costs. (2) Increase the budget level for the National Institute of Allergy and Infectious Disease to 178 million dollars for fiscal year 1978.

Although the National Institute of Allergy and Infectious Disease has the responsibility for basic clinical research in the areas that cause one third of all physician visits,

they receive only 5 percent of the annual N.I.H. budget. This clearly is a trend that must be reversed not at the expense of critical programs in basic research and the center program but as an addition to the present programs underway.

We strongly urge the committee to increase the appropriation for fiscal 1978 to aid the National Insititue of Allergy and Infectious Diseases in accomplishing this mission. The next result will be a significant savings in health care costs and patient suffering.

## References

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2. Bierman, C. W., Pierson, W. E., Symposium on Exercise and Asthma, Pediatrics, 843–956 (Suppl.), Nov. 1975.

3. "The Asthmatic Athlete", The Committee on the Medical Aspects of Sports, American Medical Association.

## STATEMENT OF DR. HALVORSON, PRESIDENT, AMERICAN SOCIETY FOR MICROBIOLOGY

## ACCOMPANIED BY DR. C. D. COX, CHAIRMAN OF PUBLIC AFFAIRS COMMITTEE, AMERICAN SOCIETY FOR MICROBIOLOGY

### INTRODUCTION OF ASSOCIATES

Senator SCHWEIKER. Our next panel will discuss the program for the General Medical Sciences Institute.

I wonder if that panel would please come forward and introduce yourselves.

Dr. HALVORSON. I am Dr. Halverson, president of American Society for Microbiology. I have with me Dr. C. D. Cox, chairman of our Public Affairs Committee. I am director of the Medical Research Center, Brandeis University.

Senator SCHWEIKER. What about the American Institute of Biological Sciences?

Dr. HALVORSON. I don't believe they are here.

Senator SCHWEIKER. Go ahead.

### PREPARED STATEMENT

Dr. HALVORSON. You have our complete statement which I hope will be accepted for the record.

Senator SCHWEIKER. Certainly. Without objection, so ordered.

[The statement follows:]

## STATEMENT OF HARLYN O. HALVORSON, PH. D.

SUMMARY OF RECOMMENDATIONS

1. An additional $20 million is recommended for funding competing research grants in basic and special emphasis areas for the National Institute of Allergy and Infectious Diseases (NIAID), and an additional $20 million for research grants for the National Institutes of General Medical Sciences (NIGMS).
2. Research money should be sufficient to fund 40 to 55 per cent of approved competing applications. The current tendency for annual swings in the percentage of funding of approved competing grants leads to costly stop-and-go research efforts which should be avoided.
3. Broad support for basic biomedical research should not be subverted by the needs for targeted research. Both are needed.
4. An additional $6 million is recommended for the NIGMS, of which $4 million is to maintain institutional training awards and $2 million to maintain the Minorities Access to Research Careers (MARC) program. An additional $3.5 million is recommended for the NIAID, for training in areas covered by the Institute. All new institutional training awards, including the MARC program, have been eliminated in the President's proposed fiscal year 1978 budget. The 56 awards allotted NIAID from the 1,000 new individual fellowships permitted NIH should be expanded to at least 80.
5. Sufficient manpower and adequate salaries should be provided at the National Institutes of Health to ensure the recruitment and development of outstanding leaders for our National Institutes of Health. Specifically, in this instance, we recommend that the NIAID receive an additional 50 staff positions, and that NIGMS receive an additional 10 staff positions, in order to maintain and develop intra- and extramural programs.

Thank you for the opportunity to discuss with you our assessment of the needs for biomedical research and training. I am speaking as President of the American Society for Microbiology, and I have with me Dr. C. D. Cox, Chairman of our Public Affairs Committee and a medical microbiologist at the University of Massachusetts, Amherst, Massachusetts.

The American Society for Microbiology is composed of over 25,000 members who contribute to the fields of infectious diseases, clinical microbiology, industrial fermentation processes, ecological microbiology,

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and food technology, as well as to the disciplinary areas of immunology, genetics, virology, oncology, microbial physiology, environmental microbiology, mycology, and host-parasite interactions. As Director of the Rosenstiel Basic Medical Sciences Research Center at Brandeis University, I have had to deal with many of the recent events that have influenced investigators in the biomedical sciences.

Today I wish to concentrate on the appropriations for biomedical research and training in two institutes: the National Institute of Allergy and Infectious Diseases (NIAID) and the National Institute of General Medical Sciences (NIGMS).

I would like to make a plea for more stable funding for research training and for basic biomedical research, regardless of whether or not it is aimed towards application in the more targetable diseases.[1] In 1975, the latest year for which complete data are available,[2] the total outlay in the health industry was approximately $120 billion, and the total out of this spent on research and development was $4.7 billion, of which the National Institutes of Health share was only 1.5 per cent. Each fiscal year 1976 dollar awarded by NIH for research is equivalent to only 58 cents ($1/1.72) in "real" or "constant" fiscal year 1967 dollars.

Research training support has been declining since fiscal year 1974, and in fiscal year 1976 traing funds were only $123 million, dropping to the second lowest level (next to fiscal year 1973) since fiscal year 1967. The proportion for research training activities generally declined from 18 per cent of the total in fiscal year 1969 to 6.8 per cent in 1976. In terms of current dollars training activity funds declined $35 million from fiscal year 1967 to fiscal year 1976, while constant dollars reflected a drop of $87 million. This trend must be reversed if we are to ensure a manpower pool of newly trained, bright young biomedical scientists to meet national health needs in the coming years.

Among other areas, the NIAID supports research on infectious diseases which are increasingly becoming a burden to our health care delivery system. Although one-fourth of all physician visits involve infectious microbial diseases, we have been lulled into a false sense of security that antibiotics will cure them. The truth is that there is very little specific therapy

for any virus infection. The emergence of multiple antibiotic-resistant strains of many bacteria has brought us back to essentially the threshold of the pre-antibiotic era. This is especially serious for hospital-acquired infections. It should be obvious that we need more effort on basic investigations on the mechanisms of virus-host cell interactions and on the genetic basis for the emergence of antibiotic resistance.

We are now seeing the emergence of antibiotic-resistant strains of the cause of gonorrhea, the most prevalent sexually-transmitted disease. This is an ominous development. We lack any effective immunization for either gonorrhea or syphilis, and we cannot even grow the causative agent of syphilis in the laboratory. It should be apparent from this deficiency that we need more effort in basic research on the physiology and immunology of these agents. Recent years have shown the importance of opportunistic bacteria and yeast as the cause of serious illnesses and deaths, especially in the compromised patient. These are but a few examples, and there are many others that have serious consequences for society.

I feel that we have been too anxious in the past to place our money on short-term research gains. We have not adequately funded basic studies on the infectious agents or their processes, which provide us more useful, less expensive information over the long haul and in turn, permit us to respond more effectively to crises.[2]

I would like to highlight some of the facts and figures which show the impact of infectious diseases on the U. S. public and on our economy.[6]

* In 1973, there were 228,820,000 episodes of infectious disease reported in the United States. The lost man days averaged 5, for a total of more than 1 billion lost man days in 1973.

* Infectious diseases also caused approximately 50% of all days lost from work due to acute illness. The mean income for a full-time year-round worker in 1973 was $9,106, so that loss in individual income was close to $37.32 per day, or a total of nearly $6 billion for infectious diseases in 1973.

* The number of days reported lost from school due to infectious and parasitic diseases and respiratory conditions in 1973 totaled 147,372,000 days.

* Reported deaths in 1973 due to infectious diseases based on statistics for underlying causes were 107,612 deaths. The figure would be larger if contributory causes were considered. Among diseases which cause death, infections rank fourth behind heart disease, cancer, and stroke.

The NIAID also supports research in immunology, and in the fundamental areas of microbiology, such as genetics, microbial physiology, and virology.

It is also playing a leadership role in the definition of biohazards involved in recombinant DNA molecule technology. Despite the impact of these programs on the health of the nation, the 1976 budget was only increased to $127 million over the 1975 budget level of $119 million. This small increase, however, is apparent, not real, because of the decrease in the value of the dollar and the increase in indirect costs. This is shown in the 1976 budget which permits funding of only 22 per cent of the approved competing research grants, compared to 47 per cent in 1975. The current 1977 budget of $141 million dollars permits funding of only 27 per cent of approved competing awards, and the President's proposed fiscal year 1978 budget of $153 million will permit funding of only 35 per cent. Without an increase in the rate of funding of research grants, it is difficult to initiate high-priority research areas and to maintain a balanced program in fundamental research. We, therefore, recommend an additional $20 million in funding for competing basic research grants and for special emphasis areas, including immunology, sexually-transmitted diseases, recombinant DNA molecule technology, and infectious and allergic diseases. This will permit NIAID to fund an estimated 41 per cent of approved competing research awards.

NIGMS has had similar problems. This Institute has devoted significant efforts towards the elucidation of basic disease processes, the mechanism of genetic exchange and genetic disorders, drug action, and biomedical engineering. Appropriations permitted payment of 57 per cent of approved competing awards in 1976, and of only 29 per cent in 1977. We recommend adding $20 million to the President's fiscal year 1978 budget for research grants. This would permit NIGMS to again support a little over 50 per cent of approved competing grants.

The continued success of our scientific efforts in this nation is dependent in large measure upon the recruitment of bright young people. Unlike a career in the practice of medicine or law, the research scientist can anticipate only a modest salary and is required to obtain most of his or her support for research. Based on these observations, the chairmen of the medical school microbiology departments unanimously endorsed the following resolution on February 29, 1976, at their annual meeting:

> We, the chairmen of microbiology departments in the medical schools of the United States, are particularly concerned about the threatened elimination of research training support for the basic biomedical sciences in general, and microbiology in particular.
>
> Microbiology is an interdisciplinary field of knowledge that .

impinges broadly on the health of the American people. Expertise in microbiology is essential for the implementation of the national cancer program, for the control and elimination of infectious diseases, for the control of harmful factors in our environment, and very likely for the cause of diseases of uncertain etiology, such as diabetes and rheumatoid arthritis. It is also essential for progress in the agricultural, veterinary, and industrial sectors in general, for ensuring an adequate supply of food, and for the development of improved strains of microorganisms to affect biosynthetic and biodegradative processes in particular.

Acquiring the skills necessary to conduct research in these complex areas requires a minimum of 6 years on-the-job training (approximately 4 years of pre-doctoral and 2 years of post-doctoral training after the baccalaureate degree). It is our experience that young people of a caliber sufficient to perform productively will not enter this field in which remuneration is markedly less than in numerous other professions, unless they are supplemented financially during their training. Therefore, we strongly urge the implementation of a stable research training support program which will permit us to supply highly trained young microbiologists in numbers sufficient to meet the needs of the numerous program areas enumerated above.

The President's fiscal year 1978 budget essentially eliminates all new institutional training fellowship awards, including the Minorities Access to Research Careers program (MARC). If not corrected now, this cessation of institutional awards will create a serious gap in our pool of competent biomedical scientists in another ten years. This is in addition to critical shortage areas which have not yet been identified as such by the National Academy of Sciences manpower survey, but which are nevertheless apparent to the American Society for Microbiology. Unfortunately, the National Academy of Sciences manpower survey will not address several areas important to the American Society for Microbiology. We have been unsuccessful in getting these areas included in the National Academy of Sciences survey, and we are seeking funds (about $30,000) to conduct our own manpower analysis.

Quite separate from the institutional training awards is the issue of the Minorities Access to Research Careers (MARC) program which would also be eliminated in the President's fiscal year 1978 budget. This is particularly tragic because of a new initiative by NIGMS to reach into the undergraduate level at minority schools to train honor students for careers in biomedical research and teaching in the biomedical science field. We wholeheartedly support this program and deplore the removal of funding for new awards in the fiscal year 1978 budget. While 12 per cent of the population is Black, less than 0.25 per cent of persons holding a Ph. D. in science are Black. The figures are even lower for Black Ph.D's in the biomedical sciences, while the demand is very high. We therefore recommend that funds for interdisciplinary institutional training grants for fellowships

be sustained and maintained in NIGMS. This would require an appropriation of $6 million beyond the President's fiscal year 1978 budget allowance, which would include $2 million for the MARC program.

There is a need to maintain a pool of 7,500 to 8,000 investigators in the areas of science supported by NIAID. Each year, that pool loses about 400 trained investigators and requires an additional number to he added to remain level. The President's fiscal year 1978 budget will permit only about 250 individuals to enter that pool. This number must be raised by continuing the institutional fellowship awards program. Therefore, we recommend an additional $3.5 million above the President's fiscal year 1978 budget allowance for NIAID in order to replace the institutional fellowship awards. This would accommodate 231 trainees in 31 institutional awards, and 24 additional individual fellowships. NIAID, however, is limited to only 56 new individual awards out of the 1,000 total permitted NIH by the Administration. The Institute needs permission to make 80 new awards.

Sufficient manpower must be supplied at the National Institutes of Health to continue smooth functioning of the grant review processes and to permit the development of new extramural and intramural targeted programs. During the past few years there has been a reduction in the number of advisory panels at the National Institutes of Health. In addition, NIAID and NIGMS have had to assume responsibility for major problems that have arisen without appropriate funds. For example, NIGMS has had to divert 5 positions to support its assigned responsibility to maintain the NIH office of recombinant DNA activities. While it is important to economize and to prevent unwarranted expense, it is also evident that the continued success of our research programs depends on maintaining processes that ensure qualified scientists receive the national resources essential for research. The NIAID is now operating with 135 positions fewer than in 1968. We recommend an additional 50 staff positions for the development of intra- and extramural programs. We also recommend that 10 positions be added to the NIGMS budget for the same purpose. These staff positions partially replace losses that have occured from reductions in personnel caused by the relatively constant budgets of these institutes in recent years, the diversion of positions to handle newly assigned tasks without appropriate funding, and the effects of the freeze on new or replacement personnel. Our National Institutes of Health are, and should remain, a

technology resource just as important as Defense in maintaining our national leadership and security.

In conclusion, I believe that the current funds for research and training in the biomedical sciences are inadequate. A recent analysis[3] revealed that federal support for science and technology has either levelled off or has headed downward in most categories when measured in constant dollars. There is also evidence that this has affected research output. It may be important to note that the fraction of the Gross National Product that is spent on research and development appears to have declined steadily in the United States, while nations such as Japan, West Germany, and the Soviet Union have devoted substantially more funds to this sector. I realize that there are major constraints in the federal budget. Nevertheless, it is evident from past achievements that research advances have markedly decreased the costs of health care delivery for infectious diseases and have promoted technological advances.[2]

Senator Charles Mathias, in an editorial in the February 14, 1977 issue of Chemical Engineering News, stated that: "Basic research need not press for immediate, predictable results, but is central to scientific and economic progress....Investment in basic research is admittedly an act of faith, but it is a gamble that has paid off for us over and over again." I do not see how we can not afford to maintain a reasonable and adequate effort in support of biomedical research and training in this country.

References


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2 H. H. Fudenberg. The Dollar Benefits of Biomedical Research: A Cost Analysis. Journal of Laboratory and Clinical Medicine. Vol. 79: 353-363, 1972.

3. P. M. Boffey. Science Indicators: New Report Finds U. S. Performance Weakening. Science Vol. 191: 1031-1033, 1976.

4 National Institutes of Health Forward Plan FY1978-82. April 1976.

5 National Institutes of Health Extramural Trends FY1967-76. Statistics and Analysis Branch, Division of Research Grants. Jan. 1977.

6 The Killers and Cripplers - Facts on Major Diseases in the United States Today National Health Education Committee.

## CONCENTRATING ON TWO INSTITUTES

Dr. HALVERSON. We are concentrating on two Institutes of the National Institutes of Health of particular interest to ASM: the National Institute of Allergies and Infectious Diseases—NIAID—and the National Institute of General Medical Sciences—NIGMS.

In research, we are recommending an additional $20 million each for NIAID and NIGMS for competing research grants. These increases would permit both Institutes to fund at least 40 percent of approved competing grants. I should like to make a plea for more stable funding for basic biomedical research whether or not it is aimed toward application in the more targetable diseases.

One-fourth of all physicians' visits involve infectious microbial diseases. Nevertheless, we have been lulled into a false sense of security that antibiotics will take care of them. The trouble is that there is very little specific therapy for any virus infection, and the emergency of multiple antibiotic resistant strains of many bacteria has brought us back to essentially the threshold of the preantibiotic era. This is especially serious for hospital acquired infections.

It should be obvious that we need more effort on basic investigations on the mechanisms of virus-host cell interactions and on the genetic basis of emergence of antibiotic resistance.

We are now seeing the emergence of multiple antibiotic resistant strains in the cause of gonorrhea, the most prevalent sexually transmitted disease—and an ominous observation. We lack any effective immunization for either gonorrhea or syphilis, and we can't even grow the cause of syphilis in the laboratory. It should be obvious that we need more effort in basic research on the physiology and immunology of these agents. These are but examples, and others are also important.

Recent years have shown the importance of opportunistic bacteria and yeast as the cause of serious illnesses and deaths, especially in the compromised patient. I feel that we have been too anxious to place our money on the short-term research gains in the past, and have not adequately funded basic studies on these infections.

Senator Charles Mathias, in an editorial in the February 14, 1977 issue of Chemical and Engineering News stated that basic research need not press for immediate, predictable results, but is central to scientific and economic progress, and that investment in basic research is admittedly an act of faith—but that it is a gamble that has paid off for us over and over again. I do not see how we can afford to do less than adequately support basic biomedical research and training.

In training, since all new institutional fellowship awards, including the minorities access to research careers program—MARC—have been eliminated from the administration's fiscal year 1978 budget, we are recommending an additional $3.5 million for NIAID and $6 million for NIGMS, of which $2 million is for the MARC program. This will permit NIGMS to continue their interdisciplinary training grants, and will allow NIAID to continue institutional training awards in critical disciplinary and other areas pertinent to their program, as well as to increase their individual fellowship awards from 56 to 80.

However, NIAID is presently limited to 56 of the 1,000 new individual fellowships permitted NIH by the administration and NIAID would need permission to expand from 56 to 80 new awards.

In the absence of hard manpower figures and projections, one can only use their own perceptions. The NAS manpower survey has not yet identified specific shortage areas which we feel exist, but we have not been successful in getting important segments of microbiology included in their survey.

We have planned our own survey and are seeking about $30,000 to conduct it but have not yet found the funds. However, it is important to keep in mind that at least six years of postbaccalaureate training is required to be able to conduct research in the complex areas of biomedical science.

The current shortage of fellowships and training funds leads me to see only a considerable shortage of appropriately trained medical microbiologists in 5 to 10 years, when national health research problems will certainly still be with us and perhaps be even more demanding.

The relatively constant dollar support of NIAID and the freeze on new positions over recent years has led to a reduction of 135 staff personnel since 1968. NIGMS has also recently had to divert existing positions to handle the NIH office of recombinant DNA activities.

We are recommending 50 new positions for NIAID and 10 for NIGMS, which are badly needed if the intramural effort is to maintain its scientific productivity and stature, and if the extramural programs can be expected to evaluate and process research grants and programs efficiently.

We have made recommendations which are intended to correct deficiencies and we ask your serious consideration of our suggestions.

Senator SCHWEIKER. I wonder if you would just take a minute to explain why you feel the administration's decisions will eliminate the MARC program.

Dr. HALVORSON. We feel there are microbiology, areas for microbiology training which we have seen in our own Board of Education in training in our society which are needed in the minority sections as well.

Senator SCHWEIKER. You don't feel whatever has been done before, we have enough momentum to carry on at this point without some kind of Federal support, is that right?

Dr. HALVORSON. That is correct.

Dr. COX. Another point is that all new institutional awards will be eliminated from the 1978 budget as it stands including the MARC program. They are quite separate but——

Senator SCHWEIKER. I was also interested in your statement about the amount of postbaccalaureate time—how much postbaccalaureate time did you say was necessary?

Dr. HALVORSON. I think for the qualification and certification of dealing with highly infectious diseases that approximately 6 years of total training is sufficient.

Senator SCHWEIKER. Postbaccalaureate?

Dr. HALVORSON. That is correct.

Senator SCHWEIKER. All right.

Senator Brooke unfortunately has a conflict this morning, and is in a committee meeting, and he asked me to extend a greeting to you and welcome you here. He's very familiar with your work and thinks very highly of it.

Thank you very much.

## Gerontological Society

Here is a statement from the Gerontological Society to be included in the record.

[The statement follows:]

# STATEMENT OF JEROME KAPLAN, PH. D.

Senator Magnuson and Members of the Committee:

The Gerontological Society wishes to present to the members of the United States Senate budget recommendations for three principal Federal agencies which serve the elderly. These budgets are for Fiscal Year 1978 and are considered necessary at this time.

The Gerontological Society is the national organization of scientists, educators and professionals in the field of aging and in the service of older persons. The Society has been a focal point of leadership since its founding in 1945. It is this responsibility of leadership which has stimulated the following recommendations.

1. The National Institute of Mental Health, Center on Aging (NIMH)

> The NIMH Center on Aging involves itself in research, training and services. Research will focus on specific mental health problems of the aged (e.g., organic brain syndrome, depression, paranoia), on the impact of institutions on the mental health of the aged and on the relation of service delivery and family support systems to the etiology and amelioration of mental illness in aging. Training efforts include training, continuing education of professionals and scientists as well as other experimental education programs to activate and effectuate existing support systems available to the elderly. Services offered will be community services, on a demonstration basis, involving the development of different models of service delivery (primarily associated with the Community Mental Health Centers).

Over the past few years we have provided Congress with a rather comprehensive picture of the aging person and his or her mental health needs. Older persons in our country have need for care which is as great or greater than the population at large yet receives only a bare fraction of the aid which is available. For example, a National Institute on Mental Health survey has revealed that only 2% of the mental health center effort is extended to older persons.

To cite another example, the fastest growing segment of the population over 65 years of age is the group from 75 to 84 years of age. A

principal concern for this group is the maintenance of intellectual and cognitive functioning. Present efforts in this area are only miniscule yet it is precisely this area which could yield results useful to all peoples at all ages.

Congress in its wisdom has asked the Secretary of Health, Education and Welfare for a report and recommendations on these matters. At the same time, the National Institute of Mental Health has established a Center on Aging to develop a program of services, education, training and research. It should be noted, however, that this Center is in its infancy and has no Congressional appropriations for activity. In the 18 months of its existence, the Center has conducted a thorough study of the field. The result is that the Center staff are now prepared to begin a series of new activities heretofore not provided but based upon very careful, thoughtful considerations of the needs.

MR. MAGNUSON, THE GERONTOLOGICAL SOCIETY URGES THE SUBCOMMITTEE APPROPRIATE THE SPECIFIC SUM OF $15,610,000 TO THE CENTER ON AGING OF THE NATIONAL INSTITUTE OF MENTAL HEALTH. We have judged this sum to be the amount necessary. A detailed breakdown is attached as Appendix A.

2. The National Institute on Aging (NIA)

> The NIA, created under the Research on Aging Act of 1974 is responsible for basic research in the biomedical, social and behavioral sciences and for training scientists and teachers in both research and service in the field of aging.

After many years, the Federal Government has recognized the importance of understanding the processes of aging and the need to develop preventive, remedial, ameliorative and curative approaches. The characteristics of aging, with its assets and problems, is quite complex and the Federal response has been an appropriate multifaceted approach.

A cornerstone and principal focal point is the newly created National Institute on Aging, the eleventh and newest Institute of the National Institutes of Health. This agency is less than two years old yet even in that brief time has quickly risen to a point of leadership.

One clearly defined area of impact has been to stimulate the interest of many Schools of Medicine in aging -- this for the first time. For example, about two weeks ago, representatives of over three dozen medical schools assembled, out of their own interest, to hear about gerontology, the new Institute, and what needs to be done.

This Institute is now in a position to conduct research on questions of health as well as economics and issues of social concern that will yield information useful to legislators, policy makers, planners and practitioners.

The response has been overwhelming with the projections from science and practice forecasting a continuing sharp increase of interest and demand. Expectations for this Institute have been raised, the requests are now pouring in, with the consequence that this Institute must be provided with the necessary resources.

It is, therefore, essential that this Institute be provided with adequate funds and staff. The levels requested by the Administration are not at all adequate. In the opinion of the Gerontological Society, THE NATIONAL INSTITUTE ON AGING SHOULD RECEIVE A FISCAL 1978 APPROPRIATION OF $60,000,000 AND THE AUTHORIZED LEVEL OF STAFF SHOULD BE RAISED FROM 200 TO 265 PERSONS. These amounts are considered to be actual and are not an inflated figure. The manpower needs are real and are needed primarily for new levels of research being developed at the Gerontology Research Center. For example, the ongoing longitudinal health study will now begin to incorporate women, minorities and a broader representation of social and economic groups. This necessary and vital dimension to the study also requires a substantive addition of highly trained, sophisticated scientists and equipment.

Specifications for this request are described in Appendix B of this testimony.

3. Administration on Aging (AoA)

The Older Americans Act of 1965 established the Administration on Aging for the purpose of assessing the needs and characteristics of older persons, planning and services, coordinating existing programs and delivering services which are needed. This agency also has the responsibilities for research, demonstration and training of skilled personnel which can improve the quality of life of older persons.

The Administration on Aging has served as the principal Federal agency developing services to the elderly, acting as advocate and developing new information and technology to make life better. This federal effort has made some impact in the quality of life for many older persons and continues to be a much needed program. Current levels of activity must both be maintained and encouraged to grow.

Today a network of aging services has now begun to take shape and services to the aged are in the emerging stages of becoming established and effective. At the same time, education and training institutions are just beginning to produce the trained personnel that are needed. However, a planning effort is only just beginning which will assess manpower needs and develop standards and guidelines for training.

In order to further the program of service and to bring research and training into maturity, the Gerontological Society urges the SENATE APPROPRIATE TO THE ADMINISTRATION ON AGING A TOTAL BUDGET OF $536,950,000 FOR FISCAL YEAR 1978 AND AN INCREASE IN STAFF FROM THE CURRENT LEVEL OF 102 TO 140 PERSONS.

A comparative review of the Administration on Aging budget for the past five years reveals that in that time period, the budget has more than doubled yet the number of staff has decreased. One area of very critical need is an adequate number of trained staff who can develop and supervise the Title IV program of research and training. The detailed breakout of these figures is provided in Appendix C.

In summary, the Gerontological Society is recommending a moderate, carefully tailored budget with increments designed to meet real needs and to better serve Older Americans. We urge you to give these figures every consideration and to adopt them into your recommendations for the FY 1978 HEW Budget.

Recommendations For The NIMH Center on Aging Budget FY78 APPENDIX A

RESEARCH: $7.5 Million

$2.5 Million for continuations should the present supplemental go through
$2.0 Million for FY '78 New Starts
$3.0 Million: Money for matching through collaborative efforts with other parts of NIMH, HEW, and various Departments of government (e.g., HUD) to catalyze further research in the Aging and Mental Health area

Note: Given the fact that indirect costs equal on the average 50% of direct costs, only $2 million out of every $3 million really goes for new projects

TRAINING: $4.5 Million

$3.5 Million for Clinical Training
$1.5 million for "production training" (i.e., career training) for professionals and paraprofessionals
$1.0 million for R & D Training (e.g., in-service, continuing education, experimental and special efforts)
$1.0 million for post-doctoral clinical fellowships
$1.0 Million for Research Training

DEMONSTRATIONS: $2.0 Million

The Public Health Service Act PL 84-911, Title V , Section 303 has already authorized Demonstration funding. The focus here would be on:
A. Community Based Services (e.g., through Community Mental Health Centers)
B. Long-Term Care Models
C. Alternatives to Institutionalization (Deinstitutionalization)

TECHNICAL ASSISTANCE: $1.0 Million

Efforts focused on local communities, States, and DHEW Regions to improve the network and quality of Mental Health services to the elderly. This would be administered in collaboration with the 10 Regional offices.

EDUCATIONAL MATERIALS AND CONFERENCES: 0.5 Million

A. Educational materials directed to professionals and paraprofessionals (e.g., texts, guides, manuals)
B. Educational materials directed to families to help in the care and management of mentally disturbed older individuals
C. Educational conferences on such topics as widowhood, long-term care, retirement, etc.

STAFF:

3 professionals: $75,000-$80,000
2 support staff: $25,000-$30,000

1. Executive Secretary for Review Committee that would be necessary
2. Grants Clerk for Review Committee
3. Training Specialist for Center's new Training Program
4. Specialist for dissemination and utilization efforts for new Research and Demonstration Program
5. Secretary for professionals indicated in 3 and 4 above

Totals:

| | |
|---|---|
| Research: | $7.5 Million |
| Training: | $4.5 Million |
| Demonstrations: | $2.0 Million |
| Technical Assistance: | $1.0 Million |
| Educational Materials: | $0.5 Million |
| Staff: | $0.11 Million |
| | $15.61 Million |

APPENDIX B

Recommended Budget For The National Institute On Aging
FY78

APPROPRIATION

FY 1976 $19,388,000
FY 1977 $30,000,000

AUTHORIZATION

Indefinite except for Research Training

PRESIDENTS REQUEST

FY 1978 $34,500,000
(Research and Training $1,990.000)

GERONTOLOGICAL SOCIETY RECOMMENDATION

FY 1978 $60,000,000
(Research and Training $4,500,000)
Increase the authorized staff positions to 265 persons.

"It is recommended that the National Institute on Aging be appropriated a budget of $60,000,000 in Fiscal Year 1978, and be authorized 265 staff positions."

A number of specific positions are needed to carry out programs currently being planned under the mandate of the NIA act. The are as follows:

| PROGRAM | PROFESSIONAL STAFF NEEDED | SUPPORT STAFF NEEDED |
|---|---|---|
| Neurosciences | 12 | 10 |
| Pharmacology (Drugs) | 4 | 4 |
| Application of Advanced Technologies | 1 | 3 |
| Nutrition Research | 5 | 8 |
| Psychology and Sociology | 2 | 1 |

Additional staff are needed in the expanding longtudinal study; within other programs of the Gerontology Research Center in Baltimore; and in the central Institute on Aging offices in Bethesda.

APPENDIX C

Recommended Budget for Administration on Aging
FY1978

The Gerontological Society urges Congress to provide a measured increase in growth and increase in staff to better serve the older persons of America.

"It is recommended that the Administration on Aging be appropriated $536,950,000 and authorized 140 staff positions."
The following catagorical breakdown is also recommended.

| | |
|---|---|
| Title III | |
| Area plans & Services | $169,000,000 |
| State Administrator | 20,000,000 |
| Model Project: (308) | 20,000,000 |
| Title IV | |
| Education & Training | 18,000,000 |
| Research | 9,500,000 |
| Multi Disciplinary Center | 8,000,000 |
| Title V | |
| Senior Center | 40,000,000 |
| Title VII | |
| Nutrition | 250,000,000 |
| The National Clearinghouse | 2,000,000 |
| The Federal Council on Aging | 450,000 |

The need for an increment in authorized staff is graphically illustrated by comparing the budgets of recent years and staff positions available.

| Year | Fiscal Appropriation | Number of Separate Grant Programs | Staff Positions Assigned |
|---|---|---|---|
| 1973 | 200,000,000 | 5 | 122 |
| 1974 | 212,100,000 | 5 | 122 |
| 1975 | 245,000,000 | 5 | 120 |
| 1976 | 266,835,000 | 7 | 120 |
| 1977 | 401,025,000 | 7 | 102* |

There is a very critical need for an increase in staff to manage and direct research and development of multidisciplinary centers. The number of staff relative to the responsibilities is very low. Current staff, although quite competent, are seriously overworked. Consequently, additional professional and support staff are seriously needed.

Current

In Title IVB Research, there are only three (3) persons to develop and direct a budget of $8,500,000.

In Title IVC, "Multidisciplinary Centers", there is only one (1) person to develop and supervise a program of $3,800,000.

Recommended

Title IVB Research should be authorized eight (8) staff positions.

Title IVC, Multidisciplinary Centers, should be authorized three (3) staff positions.

*Under current OMB policy the figure has been recently dropped to 102.

MYOPIA INTERNATIONAL RESEARCH FOUNDATION, INC.

**STATEMENT OF A. EDWARD MAUMENEE, M.D., JOHNS HOPKINS SCHOOL OF MEDICINE**

**ACCOMPANIED BY MRS. SYLVIA RACHLIN, EXECUTIVE VICE PRESIDENT, MYOPIA INTERNATIONAL RESEARCH FOUNDATION, INC.**

PREPARED STATEMENTS

Senator SCHWEIKER. We now have two witnesses who are interested in the program for the National Eye Institute, Mrs. Rachlin and Dr. Maumenee. We will include your written statements into the record.

[The statements follow:]

## STATEMENT OF MRS. SYLVIA N. RACHLIN

Eye care, particularly among the nearsighted, continues to be one of our greatest national expenditures. A recent survey gave this annual cost as over five billion dollars. This says nothing of the traumatic costs in the disruption in the lives of individuals and their families.

After years of neglect, myopia has finally gained recognition as a valid area for research. Recently, the Report of the National Advisory Eye Council of the National Eye Institute stated:

> "There is particular need for research leading to the detection of a predisposition to develop high myopia and to the prevention of those changes that may endanger sight."

This proposal satisfies one of the annual recommendations of the MYOPIA INTERNATIONAL RESEARCH FOUNDATION. There is so much we need to know about the causes of myopia. That knowledge could revolutionize the entire practice of eye care and promote the prevention of blindness. We, therefore, recommend to this Honorable Committee that it give generous support to the National Eye Institute requests for funds for grants and research. The returns from this investment will prove most beneficial to our national health and economy.

THE MYOPIA INTERNATIONAL RESEARCH FOUNDATION renews its annual petition for a NATIONAL MYOPIA CENTER within the National Eye Institute with the following three-fold program:

1. Myopia Research Projects
2. A Myopia Service Program
3. A National Registries of Myopia Pathology

Because of budgetary stringencies, however, we shall not press for this Myopia Center at this time.

Your Honorable Committee may be interested to know that the Myopia International Research Foundation has been able to mobilize and coordinate groups of consumer-patients concerned about public health and, more particularly, eye care. These include various religious groups such as the Catholic Daughters of America, represented by Miss Elizabeth Rhoda Peircey, State Regent of the New York State Court; the Federation of Jewish Women's Organizations, Mrs. Albert Wald, President; and groups in process of formation among Protestant churchwomen. These supplement other lay groups already involved. They join in endorsing the recommendations of the Myopia International Research Foundation, Inc., to your Honorable Committee and in cooperating with you in promoting the best health interests of the American people

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 one 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 egis 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.

# STATEMENT OF A. EDWARD MAUMENEE, M.D.

A. EDWARD MAUMENEE, M.D., is Professor of Ophthalmology and Director of the Wilmer Ophthalmological Institute of the Johns Hopkins University School of Medicine and Hospital. He is Past President of the American Academy of Ophthalmology and Otolaryngology; the Section of Ophthalmology of the American Medical Association; the Association for Research in Vision and Ophthalmology; and the Pan American Association of Ophthalmology. He is founder and Past President of the Association of University Professors of Ophthalmology and serves as ophthalmic consultant to the Surgeon General of the U.S. Navy. A founding member of the Scientific Advisory Panel of Research to Prevent Blindness, Inc. (RPB), he was the 1976 recipient of the distinguished RPB Trustees Award for Outstanding Ophthalmic Achievement. Dr. Maumenee has been closely associated with the objectives of the National Eye Institute since its establishment and is currently Chairman of the National Advisory Eye Council Planning Committee

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I wish to thank the Chairman and members of the Committee for this opportunity to discuss with you the unprecedented events now taking place in vision research, and to urge your support of the National Eye Institute at a level of $118 million for Fiscal Year 1978.

Since the establishment of the Eye Institute by Congress less than a decade ago, it has been my privilege to come before you on a number of occasions to tell you of the progress made in vision research, largely as a result of that historic action. Each year we have placed before you convincing evidence of the Institute's ever-increasing capacity to do what had never been done by government before -- that is, to mobilize the enormous scientific potential of this nation in an effective program to save the sight of millions of people.

My colleagues and I are grateful for your recognition of the special circumstances under which the National Eye Institute has operated. You have been cognizant that the Institute has not had the benefit of huge sums of money. You have been mindful of the financial obstacles attending its development and growth during years of fiscal retrenchment and awesome inflation. Despite these obstacles, you have helped the Institute build a record of solid achievement. And last year, based on that record, you provided a truly sub-

stantial increase in funding. We are most grateful to you for your interest and support which has given encouragement to vision scientists everywhere.

Today it is obvious that your confidence in the vision research community and in the Eye Institute is being fully justified. Nowhere else in the health field do we see comparable immediate gains in meeting the tragedy of disease and disability. Nowhere else are there comparable opportunities for the immediate, successful application of advances in research to the needs of people. We are preserving the sight of many who a few short years ago would have faced certain blindness or severe visual impairment. We are restoring useful vision where sight already has been lost. We are solving many of the deepest mysteries of vision and the diseases which damage and destroy it. Yet, what we are doing is but a small indication of what can be done, given the plans that are now being developed, and given sufficient financial support.

This large stack of papers you see before me is the manuscript of a national program and plan for vision research. It is the work of the Eye Institute's National Advisory Eye Council and will shortly be printed as the 1977 Report of that Council. But it is far more than an annual report. It is the work of some of the most distinguished investigators in the field of vision. As members of panels covering disease areas in which they have great expertise, they have reviewed the present state of eye research. They have assessed its achievements and shortcomings in each disease category, identified the most important research objectives, analyzed present and future needs and methods of approach, and finally, they have established specific priorities, with appropriate recommendations.

This manuscript is a working blueprint of a plan to save the sight of millions of people. It is practical, it is workable, and it is possible. It is the reason why I come before you today with an urgent recommendation that you permit its implementation through your support of our request for $118 million in Fiscal Year 1978. The entire planning report is now being scheduled for printing and will be made available to every member of the Congress. I shall be happy to leave this draft copy with the Subcommittee, Mr. Chairman, should you so desire.

A review of the plan will indicate the vast areas of biomedical research that are encompassed by the term "vision research". We are not dealing with one disease, but with an incredibly large and complex array of pathological conditions.

We attempt to place them in categories -- glaucoma, cataract, retinal disease, corneal disease, sensory-motor disorders, and so forth. But within these categories and beyond them we find a still greater multiplicity of visual problems with causative factors ranging from heredity to the aging process, and from infectious agents to systemic diseases and neurological disorders. All of these represent points of opportunity in research from which may emerge advances that will save countless people from blindness. Given unlimited resources we might fruitfully pursue all of them. This being a practical world, the Planning Committee has scrupulously isolated and targeted those fundamental projects which offer highest potential for successful research, while constantly advancing their clinical application.

The recent Diabetic Retinopathy Study is an example of how available scientific knowledge may be put to work quickly, while the search continues for more conclusive answers to devastating eye problems. Such a problem is diabetic retinopathy -- a disease that is rapidly becoming the major cause of blindness in the United States. There are now more than 10 million diabetics throughout the nation. At least 300,000 of these face the threat of blindness. Diabetic blindness is most often the result of leakage in the tiny blood vessels at the back of the eye, and the unnatural growth of new, fragile blood vessels that proliferate and often bleed massively. A treatment called coagulation -- employing high-intensity light beams, such as lasers -- has been used in recent years to seal off or destroy these unwanted vessels. But many questions remained as to the effectiveness, safety and proper use of photocoagulation therapy. No conclusive determination of its validity could be established without scientific evaluation of the several processes and their effect on the vision of large numbers of patients.

With funds appropriated by the Congress, the Eye Institute organized and conducted the Diabetic Retinopathy Study -- a nationwide field trial of photocoagulation in conjunction with clinical investigators at fifteen medical centers who enrolled some 1,700 patients for the study. After less than two years of gathering and evaluating clinical data, the study has clearly demonstrated the validity of laser therapy in diabetic retinopathy and indicated the circumstances under which certain forms of treatment will be most beneficial to specific groups of patients.

The success of the Diabetic Retinopathy Study has set a pattern which will be used in demonstrating the validity of other clinically applicable research

findings as opportunities are presented. Already under way is a program of field trials for evaluation of a surgical procedure called "vitrectomy" in early diabetic retinopathy. I have described the recent development of this revolutionary operation and its instrumentation in past testimony before this Committee. In brief, vitrectomy permits the surgeon to remove the vitreous gel that fills the center of the eye if he finds that its normal clarity has been destroyed by retinal hemmorrhaging or invasion by proliferating blood vessels, as frequently occurs in diabetic retinopathy. It has been possible, through vitrectomy, to restore useful vision to some patients who have been hopelessly blind for years. But, since the procedure entails some risk, its use has been limited primarily to blind patients with no hope for spontaneous recovery of their vision.

We now find that vitrectomy may have yet another use, with hopeful implications for thousands of diabetics who are not blind, but who stand in great risk of serious visual loss. There is promising evidence that the proliferation of blood vessels into the center of the eye may not occur in the absence of the natural vitreous. Since this proliferation is a major cause of diabetic blindness, it may be possible to halt the process by removing the vitreous during the early stages of retinopathy, using the new operating technique. To evaluate this concept, the Institute has organized the Diabetic Retinopathy Victrectomy Study, which is now under way. Its principle objective is to complete the evaluation in a carefully controlled setting before this application of vitrectomy becomes widely used on the basis of uncontrolled reports. If the procedure proves effective, its broad clinical use will be speeded by many years. If it is ineffective, publication of the results will prevent much needless surgery.

The seriousness of the diabetes problem cannot be overstated. Our dependence upon surgery as a principle defense against its ocular manifestations reflects the enormous void in our fundamental knowledge of this devastating disease. In planning for the future, the vision research community must prepare to accept increasing responsibility for efforts to fill that void through basic research. The National Commission on Diabetes pointed out two years ago that the basic pathology of diabetic retinopathy involves changes in the eye's vascular structure similar to those that occur in the kidney and other organs. The Commission recommended that attention be drawn to "the specific current research opportunities to use the eye as a model in studying the basic pathogenesis of the diabetic state".

You often have heard it said that "the eye is the window to the body". Through it we can study the flow of blood through the vascular system, identify likely candidates for strokes, diagnose hidden diseases such as high blood pressure, multiple sclerosis, brain tumors, nephritis and other killing and crippling conditions. It is not incongruous to suggest that the answer to the fundamental pathology of diabetes may come through basic and clinical studies in vision research. Eye researchers already have succeeded in growing retinal capillaries in test tubes, permitting a vast range of experiments in normal and disease processes. Other recent research has produced suggestive evidence of an abnormality in the blood of diabetics that may be responsible for the capillary closure seen in retinopathy. The abnormality has been reversed in test tubes through the use of aspirin, opening up an exciting area of conjecture that some time, perhaps farther in the future than one might hope, a simple remedy will be found to reverse the destructive effects of diabetes in the living human body.

Cataract research has attracted much public attention in recent months, and with good reason. In a short period of time we have witnessed the employment of new techniques in cataract surgery, the further development of the continuous-wear soft lens and, most recently, the introduction of the intraocular lens implant into the United States. All are advances of great promise. But they have not been without problems, and possible dangers. Again, thorough scientific evaluation is in order.

Among the recommendations to be found in the Program Planning Report is the establishment of a Cooperative Cataract Research Group. Its purpose is to coordinate the activities of cataract researchers throughout the United States. One priority is the organization of large-scale clinical trials of the safety, tolerance, efficiency and visual effectiveness provided by the intra-ocular lens implant and soft contact lenses used after cataract removal. An estimated 400,000 catract operations are performed each year in the United States. It is imperative that new and better devices for maximum vision and comfort be made available to these patients as quickly as is reasonably possible. But it also is necessary to protect them from any possible harmful effects that may result from the indiscriminate use of new devices and techniques.

Less publicized, but of perhaps greater importance in our approach to cataract, are the enormous strides that have taken place in basic research. The formation of the Cooperative Cataract Research Group will give maximum impact to

these new findings. In previous testimony I have reported to you on the discovery that a particular enzyme, aldose reductase, plays a key role in the formation of sugar cataracts. The search then began to find a blocking agent that would inhibit the enzyme's activity. Two groups of investigators set about testing drugs and chemicals which might display this inhibitory characteristic in test tubes and laboratory animals. They have now found what appears to be an effective and harmless agent among a class of organic compounds called flavonoids. One of these flavonoids has impressively delayed the onset of sugar cataract formation in laboratory animals. This work has been accelerated in the hope of developing a still more potent form of the compound which can be used effectively in human beings.

The pay-off on this research may be far greater than could be hoped for. It has been further demonstrated that aldose reductase may be a factor in the damaging of retinal capillaries, opening a new line of research toward the understanding of diabetic retinopathy, and diabetes itself. It has also been said that the most important aspect of this research into the biochemistry of the lens may well be its revelation of the entire disease process of diabetic cataract formation. This in turn might well lead to the long-sought medical treatment that might avert the need for cataract surgery.

Another extremely bright development in eye research is progress in the study of antiviral drugs. The pressing need for safe but potent medications against adenovirus and herpes simplex infections of the eye is indicated by the widespread incidence of corneal disease in the United States. More than 2 million cases occur each year, accounting for 10 million office visits annually. Herpes simplex is the major cause of corneal blindness, and deep-seated herpes infections remain largely resistant to available drugs. However, promising studies are now in progress, and two valuable drugs have been put into clinical use. It is hoped that further development of a drug called Ara-AMP will provide the necessary penetrating power to overcome those infections that continue to resist treatment. Here again we see the great potential of the eye in biomedical research. The nature of the eye makes it possible to use it as a test-tube for studying the effects of antiviral drugs in man, where it is not practical to do so by introducing them systemically.

I have said that the scope of eye research is truly vast. It embraces the work of hundreds of enthusiastic scientists at medical institutions in every part of the country. It is a young discipline, employing the most advanced technology to attack an ancient problem that predates recorded history. You find in it

brilliant, dedicated men and women who are eager to explore new concepts -- people such as the young engineer at my own institution who is tracing the neural activities of the entire brain and applying his findings to the clinical problems of pitiable youngsters who cannot control the movement of their eyes. Throughout the nation's eye research laboratories we see effective new techniques and devices at work. Methods have been devised for exploring the visual pathways with cameras, lasers, ultrasound, electronics -- a host of extraordinary techniques to observe what has never been seen before. The use of fluorescein and other dyes injected into the veins of patients enables us to observe and study the microcirculation of blood through the tiny vessels of the retina at the back of the eye. Using the newly-developed specular microscope, it is now possible to examine the single layer of cells that comprise the vital endothelium of the living cornea. Through the use of holography, we can test the strength of wounds as they heal after surgery. The result of such a multitude of technical advances is the opening up of new worlds of opportunity for saving sight.

Our plans as stated in the Council's report, and as reflected in the Citizens' Budget Request, embrace those opportunities. They require financial support at a higher level than Congress has yet given. And they are justified by the pressing needs of the problems we seek to solve.

I think it appropriate to point out that the American people already have indicated their willingness to support a far greater effort to protect their vision. In the past ten years we have seen magnificent eye centers rising in every part of the country, comprehensive centers for vision research, for vision training, and for the treatment of eye diseases which today find 10,600,000 Americans with impaired vision. These modern centers are attracting the finest of basic and clinical investigators. They have been built with private funds by people who fear for their sight and look to medical science for assistance. We know from a recent Gallup survey that public fear of blindness is second only to fear of cancer. We can allay those fears only to the extent that we can reduce the crushing impact of eye disease and its effect upon human lives.

It is my urgent request that this Committee recommend approval of the appended Citizens' Budget Request of $118,648,000 for the National Eye Institute for Fiscal Year 1978. It contemplates expenditures in the following program areas: for Retinal and Choroidal Diseases, $50,342,000; for Corneal Disorders, $13,421,000; for Cataract, $10,310,000; for Glaucoma, $13,524,000; for Sensory-motor Disorders

and Rehabilitation, $18,210,000; for Intramural Laboratory and Clinical Research, $9,136,000; and for Research Management and Program Services, $3,705,000. Financial tables related to this proposed budget of $118,648,000 are appended to my statement.

I am grateful for the opportunity to present this testimony, and I welcome the questions of the Committee. Thank you.

## NATIONAL EYE INSTITUTE FINANCING

| BY ACTIVITY | Fiscal Year 1977 Appropriation | Fiscal Year 1978 President's Budget Request | Fiscal Year 1978 Citizens' Proposal |
|---|---|---|---|
| Grants: | | | |
| Research | $ 41,932,000 | $ 41,889,000 | $ 76,249,000 |
| Core Center Grants | 2,698,000 | 2,806,000 | 4,074,000 |
| Specialized Clinical Research Centers | 1,394,000 | 1,694,000 | 9,667,000 |
| Fellowships | 3,453,000 | 3,453,000 | 5,675,000 |
| Training | 1,187,000 | 690,000 | 690,000 |
| Total Grants | 50,664,000 | 50,532,000 | 96,355,000 |
| Direct Operations: | | | |
| Laboratory & Clinical Research | 6,611,000 | 7,224,000 | 8,449,000 |
| Research & Development Contracts | 3,522,000 | 3,822,000 | 9,452,000 |
| Biometry, Epidemiology & Field Services | 487,000 | 513,000 | 687,000 |
| Research Management & Program Services | 2,716,000 | 2,890,000 | 3,705,000 |
| Total Direct Operations | 13,336,000 | 14,449,000 | 22,293,000 |
| Total Obligations | $ 64,000,000 | $ 64,981,000 | $ 118,648,000 |

| BY PROGRAM | | | |
|---|---|---|---|
| Retinal & Choroidal Diseases | $ 23,125,000 | $ 22,901,000 | $ 50,342,000 a* |
| Corneal Disorders | 7,586,000 | 7,037,000 | 13,421,000 b* |
| Cataract | 5,524,000 | 5,649,000 | 10,310,000 c* |
| Glaucoma | 7,692,000 | 8,594,000 | 13,524,000 d* |
| Sensory-motor Disorders & Rehabilitation | 10,259,000 | 10,173,000 | 18,210,000 e* |
| Intramural Laboratory & Clinical Research | 7,098,000 | 7,737,000 | 9,136,000 |
| Research Management & Program Services | 2,716,000 | 2,890,000 | 3,705,000 |
| Total Obligations | $ 64,000,000 | $ 64,981,000 | $ 118,648,000 |

* Asterisked totals include the following amounts for Specialized Clinical Research Centers and Core Center Grants: a) $6,302,000; b) $1,879,000; c) $1,515,000; d) $2,105,000; e) $1,940,000. Total- $13,741,000.

NOTE: Fiscal Year 1978 begins Oct. 1, [redacted], 1977.

Senator SCHWEIKER. You have both been here before.

Mrs. RACHLIN. Thank you, Senator.

There has been a new development since last year that I am very happy to report. A consumers' movement interested in eye research and eye care has begun. As you know, until now most of the concern has been on the part of the professionals.

Miss Elizabeth Rhoda Pearcy, State regent, New York State Catholic Daughters of America, has already alerted the 25,000 Catholic daughters in New York as to the need for participation and involvement in eye research.

She has also notified every State regent in this country.

Mr. Senator, next year by this time I hope that some very active women will be able to fulfill the suggestion of the honorable members of this committee as to promoting our research through the National Eye Institute.

Tomorrow morning for the first time, the Federation of Jewish Women's Organizations in New York will make its first presentation in relation to interest in eye research and eye care. The federation includes delegates from Hadassah, American Jewish Congress, B'nai B'rith and other lay Jewish organizations.

In addition, we have presidents of temples and sisterhoods on our board. Also in various Protestant groups of women now plans are being made for active involvement and participation.

Mr. Senator, you have my annual appeal before you for the sake of more than a million American children in this country and millions around the world who do not need to go blind.

I beg you, too, to please back the entire budget requested by the National Institute.

Thank you.

Senator SCHWEIKER. Well, I thank you for your statement.

I think it is good news that you have a consumer group organized in this area. I know from my work with diabetes that it was a very significant factor in advancing the cause in the Senate. With the high competition for the research dollars, plus the fact the Government seems to be withdrawing some of its actual per capita support in this area, it takes consumer groups such as this to let the public know what is happening and to get the Congress activated.

So I think that is a very good step, an important step in the right direction. We thank you for it.

Dr. Maumenee, do you want to proceed?

Dr. MAUMENEE. Thank you very much, Senator.

I am chairman of the Department of Ophthalmology at Johns Hopkins. It is a pleasure to be allowed to present the citizens' proposed budget for the NEI to you.

We greatly appreciate the fact that less than a decade ago you established the Eye Institute, and during the past years based on the accomplishments of this Institute that you have supported us in our financing.

Last year I mentioned that the National Eye Institute and Council of the National Eye Institute prepared a vision program planning booklet we gave to you, and in that booklet it was suggested that the budget which was prepared in 1974 and 1975 should be $112 million for 1978.

At this time, sir, I would like to present material to you that has been prepared over the last year and a half by 100 of the top research scientists in the field of vision for the next 5-year program planning committee.

In preparing this material, the members of the committee were asked to look at the significance to the public of the various diseases in ophthalmology that would be involved, to the effect that the research might have on other aspects of medical problems outside of ophthalmology, to the new techniques that would be available for making breakthroughs in various research areas, to the manpower available and to the cost-benefit ratio to the public from the research that might be accomplished.

In preparing this, we also listed a number of areas we felt were adequately funded and areas that at the present time were not really applicable for breakthrough in research.

Now, in ophthalmology this is really—the problems are really a microcosm of the rest of the body. There are areas for research in physiology, chemistry, pathology, immunology, microbiology and practically every aspect of research in medicine.

Therefore, it in a way is a very challenging but also a very difficult undertaking.

In preparing this material that I would like to leave with you, sir, we have broken this up into areas of glaucoma, cataracts, retinal and corneal diseases, and central motor diseases.

I know of your interest and of Congress' interest in applying basic research work to clinical problems in medicine. So today I would just like to tell you a little bit about what we have done with diabetic retinopathy in the past few years.

There are about 9 million diabetics in this country. About 300,000 of these have visual problems from vascular disease from diabetes.

A few years back, it had been the clinical impression of some persons using the laser beam and the xenon photocoagulator that photocoagulation with destruction of the periphery of the retina, some of the retina, might be effective in preventing the total blindness that could occur from vascular disease and diabetes.

Under the direction and appropriation of Congress, we enlisted 15 medical institutions and had 1,700 patients enrolled in a study to see whether photocoagulation was really of value.

In this study, the physician doing the photocoagulation did not check the patient's vision, did not look at the—another physician did that. The statisticians received all of the material that was done in the study, and tabulated it.

This is a model of a clinical study to determine whether a drug, a surgical technique or therapy is effective.

The program was developed to go on for a period of at least 5 years, but the statisticians noted within a period of a little over 2 years that photocoagulation for diabetic retinopathy was so effective that the code had to be broken because the patients were being denied this valuable treatment for the sake of economy.

Senator SCHWEIKER. We are always glad to hear when you have got to break the code. That is a good sign.

Dr. MAUMENEE. Another program is under way now for diabetic patients and using venectomy to take the jelly-like fluid out of the eyes of patients who have been otherwise hopelessly blind.

We are now making individuals—individuals have returned some vision to them where otherwise they would be hopelessly blind.

We have a proposed study for a prophylactic removal of vitreous, and some individuals with diabetes in whom we feel that the blood vessels will begin to break through into this tissue and reduce the devastating results of retinal detachment.

Now, these surgical therapies really are primarily taking care of the problem after it has already occurred, and we are still very interested in working out the basic disease problems in diabetes.

The National Commission on Diabetes established by Congress in 1975 actually recommended that it be used to study these vascular problems because of the less complex nature of the organ as far as the blood vessels are concerned.

At the present time, we have been able to grow retinal vessels so we can check the metabolism of cells of normal individuals against those with diabetes and see if we can determine some basic problem in the cells of the diabetic patient's vessels.

There is also——

Senator SCHWEIKER. How far away is it until you expect some answer in that study?

Dr. MAUMENEE. I think any basic study—you can't just predict when you are going to make a breakthrough. As you know, all of the antibiotic and steroids and things, it just comes back.

Once you learn the basic factors and what is going on in the problem, then at any time you can get a breakthrough. Until you learn the basic problems, you are not going to be able to solve the problem.

Senator SCHWEIKER. That could well have an answer for other parts of the body, too.

Dr. MAUMENEE. That is exactly right. That is what I just mentioned, that the National Institute suggested it be used for this. Other areas along this line are the fact that it's been noted that there is platelet aggregation and red blood cell clumping in patients with diabetes more than others.

We know that the plugging up of vessels is contributory to the microaneurisms that occur in the retinal vessels.

Now a study, proposed clinical study, is under way to test the use of aspirin, long-term use of aspirin, to prevent this clumping, to see if it will have an effect on the retinopathy of diabetes.

There is some evidence that this might be true because the patients who have been on long-term aspirin who have diabetes and arthritis appear to have significantly less diabetic retinopathy than the normal public, those who don't have arthritis and haven't been on this therapy, so we think that this is another possibility for basic research.

Still further down the line, diabetic patients develop cataracts. Biochemists at the National Institute have found that there is an accumulation of aldose reductase in the patients' lenses with diabetic cataracts.

Now, in experimental animals they have found that the bioflavinoids are able to prevent these diabetic cataracts in animals. So this again gets to the basic problem of why diabetic patients develop vascular changes and cataracts.

Senator SCHWEIKER. Better get FDA to change the labeling requirement that says no nutrition value has been assigned to bioflavinoids.

Dr. MAUMENEE. There are many other areas that I would go into. For instance, you have heard something about viral research this morning and the problems of treating viral diseases. The eye is one place that we have been able to find drugs for the treatment of herpes simplex and some of the other viruses.

That is, IDU and the trineuralthymidine have been effective in treating the viral diseases on the surface of it.

Again, this is a place where you can use it as a test tube for studying topical medication that would be toxic to try in systemic viral diseases.

In the area of cataracts, we now think it is time that a study be begun to look at the use of interocular lenses which are being used quite extensively in the country.

I might also talk further about myopia, as Mrs. Rachlin mentioned, retinal degeneration, glaucoma, and some of the sensory-motor problems.

To emphasize that the public is interested in the eye problem, I just might point out that large institutes for ophthalmic research have been developed in Pennsylvania, Florida, North Carolina, Texas, Oklahoma, California, Minnesota, Massachusetts, New York, Maryland, South Carolina, and Illinois.

Several of these institutes have been funded by the general public outside of the Government up to the level of $15 million, so the public is very interested in further research in blinding eye disease.

In summary, I just would like to point out that this is the statistical evidence that we have for the budget that we are requesting at the present time, and we would like to enter it into the testimony.

Thank you, sir.

Senator SCHWEIKER. All right, Doctor. You gave a very comprehensive statement and it was very interesting in terms of diabetic repercussions.

We appreciate your work and interest and leadership in this area. Thank you.

Dr. MAUMENEE. Thank you.

PREPARED STATEMENT

Senator SCHWEIKER. On your report, we will place it in our committee files. It's too big to print the entire report in the record, but we will use it in consultation and as an educational basis for the committee. We will include your written statement in the record at this time.

Dr. MAUMENEE. Thank you, sir.

[The statement follows:]

## Statement of Friends of Eye Research, Rehabilitation and Treatment

The Friends of Eye Research, Rehabilitation and Treatment, speaking on behalf of not only the 11,000,000 citizens in the United States who currently have significant visual disabilities or blindness, but also the tens of millions of other citizens who are in the high-risk categories for visual impairment (especially the elderly), and those in this country who will lose sight through diseases about which we know today so little, hereby fully endorse a budget for the National Eye Institute of $118M for fiscal year 1978, and urge this Senate Appropriations Subcommittee on Labor; Health, Education, and Welfare, to report favorable recommendation of this amount to the full Appropriations Committee and thus to the Senate.

Our society is becoming more enlightened to the need for a quality life for people with handicaps. But this has its economic costs. We note, for instance, that in the areas of visual disability and blindness our economy, including federal programs, is spending over $5 billion each year just for the care and maintenance of these individuals. The additional economic loses due to lost income, lost revenues, and institutional maintenance raise the total economic toll to well over $7 billion each year.

But beyond just the economic costs, blindness and visual impairment take a personal toll that is almost immeasurable. By-and-large, disabilities of vision in and of themselves are not fatal — they merely leave their victim facing an entirely new, dramatically restricted life. The most obvious and significant tragedy of blindness is the loss of that sense through which a sighted person perceives 90% of the information his brain computes into knowledge. Less obvious, but of equal importance, is the psychological affront that loss of vision presents to the individual who must function in a sighted world. Loss of vision means more than just that the "lights go out." A blind or only partially sighted person, loses the mobility that a sighted individual can take for granted. They cannot hold a job without extensive rehabilitation and accommodation. Psychologists say that a person who becomes blind undergoes essentially a re-birth — a dramatic change in self-concept. There is an accompanying psychological damage which must be repaired before the person can assume any kind of function in life again. Victims

of visual impairment lose so much control over their own lives. They lose the anonymity — the identity — the personalness — of their own character. It is small wonder, then, that blindness is the most feared medical affliction throughout the world today.

While this picture of blindness is a depressing, almost ugly one, it need not stay that way. Extensive and intensive research into the causes and treatments of blinding eye diseases hold hope of overcoming the devastations of blindness. It has been only since the start of the second half of this century that any major advances have been made in the treatment of eye diseases and conditions that lead to blindness. It is to the credit of Congress that eight years ago the National Eye Institute was established as a formal commitment of our government to the battle against the scourge of blindness. Significant progress has already been made through research supported by the National Eye Institute in certain areas of eye diseases. This progress has occurred even though the basic field of eye research and treatment has lagged far behind other areas of medicine because of a lack of commitment by the public to tackle these problems.

It is important to point out some of the very real accomplishments of the National Eye Institute-supported research that were made possible recently by the $52M and $64M budgets in the past two years.

1. In the field of diabetic retinopathy, which is the disease that results in visual impairment and blindness from diabetes, and which is the leading single cause of new blindness in this country today, a major research effort was mounted, funded by the National Eye Institute, to clinically evaluate the effectiveness of treating this disease with a laser instrument. The instrumentation and basic techniques used were themselves developed over the years in N.E.I-supported research programs. This current study is the largest single clinical test even run in this country, involving several clinical centers and over 1700 patients. The early results indicate that if this treatment is applied to victims of diabetic retinopathy, under certain circumstances in two cases out of the three sight can be restored or retained. And as the treatment becomes more refined through additional

research, the success will certainly improve. While this treatment is only a stop-gap measure until the basic cause of the disease is found, it is nonetheless a reprieve from blindness which 10 million American diabetics can now look toward.

2. A dramatic new surgical technique has recently been reported for treating certain diseases of the vitreous, which is the clear jelly-like material that fills most of the inside of the eye. In certain diseases, this vitreous becomes filled with blood and membranes, thus preventing light from getting to the sensitive retina. This procedure, known as "Open-Sky Vitrectomy," has the surgeon actually opening the eye from the front in order to carefully excise and remove the damaged vitreous. This revolutionary approach has been developed over several years, extending from earlier studies in which removal of the vitreous was accomplished using a special instrument not requiring opening the eye entirely. Only recently has the open-sky approach been demonstrated as being successful in dealing with cases in which the patient would otherwise have no other recourse, and would spend the rest of his life in the restricted world of blindness. Without the support of the National Eye Institute, possibly this technique, would not have been developed, and the number of blind people in this country would be increased even further.

3. In certain cases of vitreous disease, or severe cataracts, the surgeon is uncertain whether removal of these blockages will restore sight to the patient. It is sometimes the case that the retina, the light-sensitive tissue lining the back of the inside of the eye where the visual process begins, is also damaged and will not function even if light reaches it. A new diagnostic procedure has been developed by N.E.I.-supported research which utilizes ultrasound and electrical measurements of the activity of the visual process in a technique that does not even involve looking into the eye.

The results of this diagnostic procedure can tell the doctor — and the patient — whether or not surgery to remove a blockage in the light path is

capable of restoring sight. Although this is not a technique that directly leads to prevention of blindness or improvement of vision, it does make more accurate the decision of whether or not to operate. Thus, much of the anxiety of the patient can be reduced, and needless, useless surgery can be prevented for more cost-effective health care delivery.

If significant accomplishments such as these are now being made at current budget levels, why should there be such a large increase in the budget for the National Eye Institute? The answer to that is three-fold: (1) Because the problem of visual impairment and blindness — and its concomitant economic and personal drain — is huge today, involving 11 million Americans, and growing dramatically as we develop a larger and larger population of older persons who are more frequent victims of this tragedy. (2) Because the eye and the visual process is an extremely sensitive system, the study of which will gather knowledge of not only eye diseases, but also other conditions of the body, particularly cardiovascular diseases, cancer etiology, and the aging process. (3) Finally, it is through eye research that we begin to understand the diseases that cause blindness. Therefore we have now reached a position where we can take advantage of the technologies and developments in many other biological and physical sciences — immunology, lasers, microprocessors, virology, etc.

Although the accomplishments of eye research and the efforts of the National Eye Institute up until now are impressive, it is the developments of the future that are important to the present consideration. The people of F.E.R.R.A.T. feel that the past is the basis of hope for the future. And while we cannot predict the future, and certainly do not expect the National Eye Institute to be able to either, we are aware of some breakthroughs in eye research that seem to us to be right around the corner.

The following are specific examples of some of the results that may be forthcoming in the near future:

1. A new treatment for cancer of the inside of the eye using the energy of a proton beam. Until now, the only effective treatment for choroidal melanoma — the most frequent of the eye cancers — was removal of the

eye, saving the patient's life, but destroying the vision in that eye. This new approach is harnessing the knowledge of high energy irradiation, and the technology of the cyclotron, to overcome a significant disease of the eye.

2. Although vitreous surgery has now been shown to be a valuable treatment in cases where the vitreous has become diseased, the problem has existed for many years of what to use to replace the damaged vitreous once it has been removed. Several contending materials are currently being studied, and one of them, a material called hyaluronic acid, looks as though it will be a most successful replacement. When all the results come in, and if this hyaluronic acid is as effective as it appears to be today, the surgical intervention for blinding vitreous diseases will be complete, with both the techniques and replacement material coming from N.E.I.-supported research.

3. In the area of cancer etiology, it may soon be possible to report a direct link between a cancer of the eye called retinoblastoma, which afflicts almost exclusively children under the age of 6, and a common human virus. While this relationship has been established in laboratory rodents, the final results in primates are not yet in. Such a cause and effect situation would be a first in the eye, and would be the basis on which to possibly develop a prevention program for this disease which strikes one child in every 18 thousand in this country.

Although this report has dealt primarily with those accomplishments from the N.E.I. which have direct and immediate application to patients, F.E.R.R.A.T. recognizes the need to continue to develop new knowledge and understanding of the basic functioning of the eye and the visual processes. It is necessary to learn more about the nutritional needs of the eye, the mechanisms which the brain uses in the visual processes, the growth processes of the eye, the psychological factors involved in "vision", the chemical composition of the eye structures, the processes by which the many sensitive tissues of the eye are kept healthy and working. And there are many other areas of basic understanding which either are now being investigated, or are recognized as those that should be pursued. It may well be possible with discoveries from this research to prevent some blinding eye diseases

from developing the first place, and make intervention after the fact of the disease a thing of the past.

Short of such an admittedly noble goal, increased understanding of the basic functions of the eye will make it possible to develop more effective treatments for eye diseases, based on the greater knowledge of how the treatments can utilize and interact with the eye's own natural physiology.

These things can be accomplished through an increased budget for the National Eye Institute. Obviously, the number of research project grants must be increased. There are some 400 areas which have been identified as needing study. Even with a $118 million budget, many of the grant applications expected to be submitted by the biomedical community and approved for scientific merit will not be funded.

Equally important to the research grants is the need to establish specialized centers of clinical research excellence to make possible the transfer of the laboratory information to the patients. There is much research data that is even now waiting for clinical testing. A major clinical program has been started to evaluate the effectiveness of vitreous surgery in diabetic retinopathy. A carefully controlled study should be done on the effectiveness of implanted artificial lenses to be certain we are not overlooking some long-range problems of this most promising technique. The effectiveness of certain laboratory-developed techniques for slowing the growth of diabetic cataracts should be fully evaluated clinically.

The problems of visual impairment and blindness are obviously enormous both in this country and worldwide. A major increase in the support of research, and development of clinical transfer technology, at this time can make a significant impact on these problems. In addition, as has been recognized by biological and medical scientists, study of the eye and the visual processes can now begin to impact on many areas of disease elsewhere in the body. Cardiovascular problems, nutritional disorders, genetic diseases, the functioning of the brain including mental disorders, the aging process, and connective tissue diseases are all areas to which eye research can make significant contributions. The National Eye Institute is involved in inter-institute and inter-agency programs right now to make these important links operative.

The $118 million budget which F.E.R.R.A.T. is supporting was arrived at as a result of several months of in depth study and invetsigation by a group of more than 60 doctors and scientists in the eye research and treatment community. This ad hoc committee was called by the National Advisory Eye Council to assist in preparing a comprehensive, factually-based program of development for the National Eye Institute. The formal report of this committee will be released in a very few weeks. The report projects for the next five years where funds are needed, and can most effectively be spent, to conduct productive eye research. We believe this is the first time any institute has on its own developed such a detailed projection, citing specific programs and mechanisms to address the mandate of the institute. In conducting the self-examination, the eye research and treatment community has formalized what it basically knows are the needs for improving the lot of those facing visual impairment and blindness. It has also identified the areas and mechanisms most likely to fill those needs. And in these deliberations, it has considered the scientific talent not only that is currently available but also which can most reasonably be expected to join the effort against eye diseases.

In closing, may we say F.E.R.R.A.T. feels that $54 million — less than 1% of the annual cost of blindness in this country today — when added to the current National Eye Institute budget to make the 1978 budget $118 million, seems to be an extremely cost-effective expenditure of public funds to overcome a devastating situation which our citizens face. We urge this Committee to renew the commitment of the public, first made eight years ago, to the battle against blindness.

## PRIMATE RESEARCH CENTERS PROGRAM

### STATEMENT OF DR. T. C. JONES, HARVARD MEDICAL SCHOOL

PREPARED STATEMENT

Senator SCHWEIKER. Next, I would like to call Dr. Jones who is interested in the Primate Research Centers program.

Dr. Jones, if you would please come forward. Once again, Senator Brooke asked me to extend his interest and support for your efforts.

Dr. JONES. Thank you.

Senator SCHWEIKER. You are also from Harvard Medical School.

Dr. JONES. Yes, I am.

My name is T. C. Jones. I am here in place of Dr. Hunt who asked me yesterday to come down to deliver his statement. Dr. Hunt is the director of the Primate Research Center. I have given the committee copies of Dr. Hunt's statement.

Senator SCHWEIKER. It will be included in the record.

[The statement follows:]

# STATEMENT OF RONALD D. HUNT

## SUMMARY OF RECOMMENDATIONS

Primate Research Centers Program

I am recommending that the Primate Research Centers budget be increased from the proposed $11,492,000 to $17,500,000.

This program, which is part of the Animal Resources program of the Division of Research Resources of the National Institutes of Health, was wisely created by Congress in the early 1960's, but the budget has not changed appreciably in the past 10 years, and no provision has been made for the maintenance of facilities now 15 or more years old.

The primate research centers have made significant contributions to human health through their own research programs and by serving as centralized support facilities for hundreds of N.I.H. research programs using non-human primates.

The Centers are the only National program directly studying the primate itself, an absolutely necessary corollary to using these species, many of which are currently endangered in their natural habitat.

Without the Primate Research Centers, important medical research programs from all the categorical institutes of the N.I.H. would be in jeopardy. The proposed cut in their budgets will be the first step in the realization of this potential catastrophe.

Mr. Chairman:

INTRODUCTION

I am Dr. Ronald D. Hunt, Director of the New England Regional Primate Research Center and Associate Professor of Comparative Pathology at the Harvard Medical School. It is a privilege to appear before you as the representative for the seven regional Primate Research Centers. I am requesting an additional 6.1 million dollars for this program which faces a reduction of 1 million dollars in the proposed budget.

The seven regional Primate Research Centers are

one of the most unique and valuable resources within the national program for medical research. The wisdom that Congress displayed in creating this long-term program in the 1960's showed forethought. Non-human primates are unique. There are over 250 distinct species. The Primate Centers are providing better ways to breed and maintain their health, and are conducting the needed research to ensure their conservation while simultaneously contributing to our understanding of human disease. Our knowledge of non-human primate biology is still small and what there is is mainly derived from the efforts of the Primate Centers, not from the schools of medicine or veterinary medicine where there is virtually no formal education concerning non-human primates. Non-human primates are of proven need and value as experimental animals; but without the Primate Centers' programs in conservation, they may become unavailable.

GOALS OF THE PROGRAM Each Center provides an environment for (1) human health-related research, which takes advantage of those characteristics of non-human primates that are uniquely suited for biomedical research identifiable with National needs; (2) research directed toward expanding our knowledge and understanding of non-human primates, which we identify as resources research; and (3) a resource for the biomedical community (without geographical limitations) to assist in their research which could not be conducted without such assistance.

The seven regional Primate Research Centers supported by the Division of Research Resources, of the National Institutes of Health, have made significant contributions to each of these three functions. I would like to cite examples for each, using accomplishments of the Center at Harvard Medical School.

*Human health-related basic research* at the Center is principally supported by grants or contracts from categorical institutes of the N.I.H., or private granting agencies, and as such, is appropriately reviewed by these groups. The Center's cost is minimal; we provide the environment in support of these program. I will not expand on these

studies with detail but rather cite types of programs, because health-related basic research encompasses all institutes of the N.I.H. At the New England Center, such programs include:

1. Specification of behavioral and pharmacological factors that determine how drugs alter behavior — a program which has furthered our understanding of *drug addiction*. (Dr. Roger T. Kelleher)
2. The development of the visual system and neurophysiological basis for binocular vision. These studies determine how we coordinate vision from two eyes and why in cross-eyed individuals one eye is *blind* regardless of surgical corrections. (Drs. Torsten N. Wiesel and David Hubel)
3. The migration of cells in the brain during embryonic and and fetal development; studies which help our understanding of *birth defects*. (Dr. Pascal Rakic)
4. Treatment of Schistosomiasis — an important *parasite disease of military personnel stationed in tropical countries*. (Dr. John T. Bruce)
5. Improved methods of dental prosthesis; studies designed to improve replacement of *teeth lost due to disease*. (Dr. L. B. Shulman)
6. Effect of diethylstilbesterol (D.E.S.) given during pregnancy on post-natal development. These studies should *help resolve the controversy over D.E.S. given during pregnancy* and its association with *cancer in the daughters* some 20 years later. (Dr. Arthur T. Hertig)
7. Functional anatomy of the anterior segment of the eye. These studies are furthering our understanding of the normal eye and will contribute to helping resolve such diseases as *glaucoma*. (Dr. Guiseppina Raviola)
8. Physiological mechanisms controlling behavior-induced high blood pressure. *High blood pressure* is one of the most

important diseases of man, but its cause is unknown. (Dr. J. Alan Herd)

9. Correlation of capacity to use the hand and organization of the cerebral cortex. These studies help explain *how the brain controls movement.* (Dr. Mary Carlson)
10. Chemotherapy of *leukemia.* (Drs. R.D. Hunt, J.G. Bekesi)
11. Pathogenesis of senile osteoporosis, the most important *bone disease of human beings,* but to date of unknown cause. (Drs. M.P. Anderson, H.I. Griffiths, R.D. Hunt)
12. Improved diagnostic tests for *tuberculosis.* (Dr. C.E.O. Fraser)
13. Definition of the relationship between oncogenic viruses (*cancer viruses*) and cancer cells. (Dr. B. Fleckenstein)

That is a very partial list of ongoing studies. Each is either dependent upon non-human primates or special characteristics of non-human primates make the studies more feasible and interpretable. Most could not be undertaken in the absence of the Primate Research Centers.

*Resource-related research* is a cornerstone of the primate centers program and it is this function that I will emphasize. Without the primate centers, this research would not take place and many basic research programs, no matter how important, or no matter how well funded, would be seriously jeopardized or in some cases impossible to conduct. There is no categorical institute at the N.I.H. to which application can be made to fund such questions as: how to breed owl monkeys? what are the nutritional requirements of marmosets? what viruses do non-human primates carry? what is the significance of these viruses? how can the infections be controlled? why do New World monkeys develop rickets after 2-3 years in the laboratory? why do owl monkeys die when housed with squirrel monkeys? These and similar questions are of vital importance to the use of non-human primates and to their conservation.

Let me present some examples from my Center to illustrate this type of research as well as demonstrate how resources research also leads to programs in human health-related research.

In the mid 1960's, Dr. Melendez and myself initiated studies on a fatal epidemic disease of owl monkeys and marmosets. In some colonies, hundreds of monkeys died of the infection which was shown to be caused by a herpesvirus, termed Herpesvirus T. Recognizing that neither owl monkeys nor marmosets could represent the reservoir of Herpesvirus T (in that it invariably resulted in fatality in these species), we sought the natural host for this virus. Epizootological investigations led to the squirrel monkey as the most likely candidate and the eventual isolation of the virus and demonstration of a very high incidence of serum neutralizing antibodies (immunity) in the squirrel monkeys firmly established this hypothesis as fact.

The infection in squirrel monkeys was shown to be analogous to Herpesvirus simplex infection in human beings, commonly known as "cold sores" or "fever blisters", occurring most usually on the lips but also as a venereal disease (Herpes simplex type 2). We subsequently demonstrated that owl monkeys are also susceptible to this human virus. In one colony at another institution, over 300 owl monkeys died of Herpes simplex. We have since developed vaccines for both viral infections which afford owl monkeys complete protection.

In the ensuing years, eight other distinct herpesviruses were isolated from various species of South American monkeys by this group. One was recovered from squirrel monkeys, and it was established that this species was the natural host for the agent (thus two indigenous viruses affect this species) and the virus was termed Herpesvirus saimiri.

To determine if this agent was pathogenic to other primates, marmosets and owl monkeys were injected with the new squirrel monkey virus. These species were chosen because of the previous experience with Herpesvirus T. As anticipated, the virus caused a

fatal disease in both these species, but much to our surprise, the disease was not characteristic of a herpesvirus infection but rather each monkey died of leukemia. Repeating these studies clearly established Herpesvirus saimiri as the etiologic agent causing malignancy.

This discovery represented finding:

I. The first oncogenic virus (cancer-causing) of primate origin.

II. The first mammalian oncogenic herpesvirus.

III. The first induction of leukemia in non-human primates.

Without a primate center, these studies would probably not have been conducted, to the detriment of both the owl monkey and the National Cancer Program.

Myself, Dr. F.G. Garcia, and Dr. D. Mark Hegsted resolved the major non-infectious disease problem of laboratory-housed New World primates, a malady termed "simian bone disease" or "cage paralysis". These studies demonstrated that the disease represented a form of rickets that resulted from a metabolic defect in New World primates which prevents their utilization of vitamin $D_2$ and demands receipt of vitamin $D_3$. These studies have made it possible to keep New World monkeys in the laboratory and have also evolved into a program utilizing nonhuman primates as models to study osteoporosis, the major metabolic bone disease of human beings.

Another example is the demonstration by Drs. T.C. Jones and Nancy Ma that there is variation in the number and types of chromosomes in owl monkeys. This very valuable species was known to be very difficult to breed in captivity, but Jones' and Ma's work showed that if you matched the monkeys in pairs based on similar chromosomes (karyotypes), breeding was successful.

These are but three examples of resources research which have major impact on several national research programs.

*As a resource to the biomedical community*, the primate centers (a) provide facilities for the care, management, and utilization of nonhuman primates; (b) provide professional and technical experts to assist the collaborative research program; (c) insure supply of nonhuman primates for the core staff program and the community. The supply as well as conservation of animals is one of the most important and pressing problems for the Center as well as the Nation as a whole. In addition to supply, breeding programs are necessary to make available specialized animals not obtainable from any other source. This would include species which are endangered as well as timed pregnancies, animals of known age and known geneology and animals free of certain parasites and diseases. Our objective is not directed at producing large numbers of animals, but finding out how best to produce them. Breeding and science are not separable, and our mission will be to apply the best possible science to the problem of breeding.

At the New England Center, there are currently 45 approved research programs being conducted entirely or in part at Center facilities. These involve 85 investigators from 26 institutions (see enclosed table).

In the past fiscal year, the Center has supported over 2½ million dollars of research effort. The cost of this research would easily be doubled if this Center did not exist.

BUDGET AND RECOMMENDATIONS

The *budget* of the Primate Research Center program has remained essentially static, and if official inflation rate figures are used, the budget has steadily declined. It is important to recognize that each Primate Research Center is an independent unit and its budget is not committed solely to research of one type or another, but must also meet the financial requirements of administration, heating fuel, electricity, telephone, maintenance, and all the other items usually included in indirect costs.

This means that the research budget is about one-half of the total appropriation, in other words, during this fiscal year the seven Primate Research Centers' research budget is 6.2 million dollars, not 12.4 million dollars. You can easily see that rising fuel costs directly reduce research dollars at a Primate Research Center. The physical facilities are now between 10 and 15 years old, requiring increased expenditures, further reducing available dollars for research. No provision or commitment has been made to plan for the major expenses that will occur in the very immediate future. The seven Centers are currently operating on a budget $3,713,097 below N.I.H. Council recommendation.

The budget as proposed by the previous administration would result in a reduction of over 1 million dollars for the Primate Centers (see attached chart and memorandum from N.I.H.). This would be catastrophic to the past 15-year effort. It would be impossible for the Primate Centers to absorb this reduction. Many of their own programs would be lost, and their support of approximately 20 million dollars of basic medical research would be jeopardized. Of equal importance, jobs would be lost, at a time when the Nation can ill afford increased unemployment. The loss of jobs also means the loss of uniquely trained scientists and technicians in a specialty that already suffers a shortage.

If we are to realize the "Century" of effort that Congress foresaw when they created the Centers, the proposed reduction in budget must not only be restored, but must be significantly increased, from the current $12.4 million to $17.5 million. As the Primate Centers Program budget is included in the Animal Resources Program budget, this increase must be designated for Primate Research Centers.

This is a very small investment when compared with the rewards of improved health for our Nation.

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TABLE I

Division of Research Resources

Animal Resources Program

FY 1977 and 1978 Ford Budget

| | Fiscal Year 1977 Congressional Appropriation | Fiscal Year 1978 President Ford's Budget | Request by Primate Center |
|---|---|---|---|
| Total Animal Resources Program | $22,055,000* | $20,011,000* | |
| Primate Centers | $12,492,000† | $11,492,000** | $17,500,000 |

* Total Animal Resources Program including Primate Research Centers

** Estimated Commitment to Primate Centers

† Council Recommended Budget is $16,205,097 for current fiscal year (1977)

COLLABORATIVE RESEARCH

NEW ENGLAND REGIONAL PRIMATE RESEARCH CENTER

TABLE II

| Institution | Number of Projects | | | |
|---|---|---|---|---|
| | 1973 | 1974 | 1975 | 1976 |
| Boston Biomedical Res. Inst. | | 1 | | |
| Boston University | | | | |
| School of Medicine | 1 | 1 | 3 | 3 |
| Graduate School of Dentistry | | | 1 | 2 |
| Brandeis University, Dept. of Anthropology | | | 1 | 1 |
| Brown University, Dept. of Psychology | | 1 | 1 | 1 |
| Center for Blood Res., Boston | | 1 | 1 | 2 |
| City of Boston, Dept. of Health and Hospitals | 1 | 1 | | |
| Boston City Hospital | | | | 3 |
| Harvard University | | | | |
| School of Medicine | 6 | 7 | 4 | 3 |
| School of Public Health | 1 | 2 | | |
| School of Dental Medicine | 5 | 3 | 2 | 2 |
| Harvard College | 3 | 2 | 1 | 3 |
| Affiliated Hospitals | | | | |
| Beth Israel | 1 | 1 | | |
| Boston City | | 1 | | |
| Children's Hospital Medical Center | 1 | 3 | 2 | 3 |
| Forsythe Dental Center | 2 | 3 | | 1 |
| Massachusetts General | 3 | 4 | 2 | 4 |
| New England Deaconess | 1 | 1 | | |
| Peter Bent Brigham | 2 | 3 | 1 | 4 |
| Vincent Memorial | | 1 | | 1 |

TABLE II (continued)

| Institution | Number of Projects | | | |
|---|---|---|---|---|
| | 1973 | 1974 | 1975 | 1976 |
| Liberty Mutual Res. Center | | | | 1 |
| Mass College of Optometry | | | 1 | 1 |
| Massachusetts Inst. of Technology | | | | |
| Dept. of Nutrition and Food Tech | 1 | | 1 | |
| Dept. of Psychology | 1 | 1 | 1 | 2 |
| Mount Wachusett Community College | 1 | 1 | | |
| National Institutes of Health | | | | |
| NICHHD | 1 | 1 | 1 | 1 |
| Northeastern University | | | | |
| Dept. of Psychology | 1 | | | 1 |
| Dept. of Sociology and Anthropology | | | 1 | |
| Tufts University | | | | |
| Boston VA Hospital | 1 | | | |
| School of Dental Medicine | 1 | 2 | 1 | 1 |
| School of Medicine | 2 | 4 | 2 | |
| Upstate New York Med. Center, Coll. of Med. | | | | 1 |
| University of Lowell | | | 1 | 1 |
| University of Massachusetts, Med. School | | | 2 | 2 |
| Wellesley College | 1 | 1 | | 1 |
| Worcester Foundation | 1 | 2 | 1 | 2 |
| Yale University, School of Medicine | 1 | 1 | 1 | 1 |
| | 39 | 49 | 32 | 48 |

Scientists Involved in Collaborative Research

| | 1973 | 1974 | 1975 | 1976 |
|---|---|---|---|---|
| Affiliated Scientists | 39 | 49 | 32 | 48 |
| Associated Scientists | 29 | 36 | 38 | 40 |
| Collaborative Scientists | 8 | 20 | 14 | 14 |
| Total | 76 | 105 | 84 | 102 |

UNIQUE RESEARCH PROGRAM

Dr. JONES. I would like to say something about one or two points he has made. The primate center program is a small, but unique research program which is supported by grants and administered by the Division of Research Resources of NIH. It was established by Congress as a line item in 1960. Seven centers make up the program, and our remarks are largely based on our experience with the New England center, at least one of the seven centers that makes up the national program.

Dr. Hunt describes the activities and goals of the center in three parts. I would like to refer to them very briefly. The first segment is research related to human health. Nonhuman primates, that is, monkeys and apes, are used increasingly to solve health problems in people. These studies may be supported by any categorical institute of NIH, but are often conducted in part at one of the individual primate research centers.

Example of such research projects which are supported by other NIH institutes, but are conducted at the New England center are Dr. Roger Kellehers studies of the factors that determine how drugs alter behavior, a program which is furthering the understanding of drug addiction.

The development of the visual system and basis for binocular vision are under study at the New England center.

These studies have determined how vision from both eyes is coordinated and why the crossed eye remains blind in spite of surgical correction.

Dr. Poschurokish is following the migration of brain cells during fetal development and is gaining information of great value in understanding some birth defects. High blood pressure, an important, but poorly understood disease of man is being induced in monkeys and studied by Dr. Allen Hurd.

Dr. Hunt mentioned several others.

Senator SCHWEIKER. This is by——

Dr. JONES. Behavorial condition.

Senator SCHWEIKER. Stress like that would scare a lot of Senators.

Dr. JONES. Yes. [Laughter.]

A second type of activity is source-related research. This is aimed toward expanding knowledge of the nonhuman primates to make them more available as models for the study of human disease. Some examples of this type of work at the center follow. Experiments aimed at learning the cause of two particular fatal diseases of monkeys, marmosets; Dr. Mahlendis and Dr. Hunt recovered two specific infectious agents called Herpes viruses. They are similar to the Herpes virus simplex referred to a few minutes ago that produces cold sores, occasional encephalitis in man.

Vaccine was developed against each of the—Herpes viruses and has been used with success to protect monkeys against fatal infection. It makes it more possible, more nearly possible to keep some of these sensitive animals in the laboratory when they are exposed to human carriers of Herpes simplex. In other studies, two other Herpes viruses were isolated which behaved quite differently. These both produced leukemia in susceptible animals. They were the first leu-

kemia viruses to be found in primates and the first Herpes virus known to produce this type of cancer.

These agents are now under study in many laboratories in efforts to learn more about agents which can cause leukemia in animals closely related to man. Another form, for many years a disease which caused the bones of certain South American primates to soften, enlarge and fracture spontaneously was common among animals in laboratory environments, and seriously limited the long-time study of such animals.

Doctors Hunt, Garcy, and Hagstad determined that these animals required a special type of vitamin D, $D_3$; incidentally it is the same vitamin chickens like, birds use, but the South American primates in particular.

This prevented the basic disease when supplied in the diet.

Senator SCHWEIKER. What is the name of that vitamin?

Dr. JONES. $D_3$, instead of $D_2$. $D_2$ is the one that most of us get in our diet and most animals are fed in their diet, most mammals. Certainly these South American primates required $D_3$.

Senator SCHWEIKER. When is your DES study going to be completed?

Dr. JONES. That study will probably go for several years because we have animals that were—whose mothers, while they were intrauteral, the mothers were given DES and they are being maintained. I think the oldest of these are now 2½ years old. They will reach sexual maturity about 4, so that is another year and a half at least.

Senator SCHWEIKER. I realize you didn't write this, but the statement says these studies will help resolve the controversy over DES. I have been intimately involved in that. We already know what causes it in the female offspring, second generation. I have had witnesses come before us whose child died. How will it help resolve it? We have had witnesses before us who had it and were dying and also witnesses whose children had died. What do you mean by resolve the controversy?

Dr. JONES. As I understand it, and I am not working in that field, but as I understand it, the question is, is it clearly, definitely, related to the administration of the DES to the mother while the infant was intrauteral. That seems to be accepted by many people. Dr. Hurd is studying several thousand patients, but Dr. Herps who is not mentioned is also trying to reproduce it in primates. If it can be produced in monkeys, then the whole problem would be much clearer and evidence would be stronger.

Senator SCHWEIKER. Well, we have human beings, a study now in New York as I recall, pretty clearly labeling it statistically as a very real problem.

Dr. JONES. Well, I think it could be reproduced, it would strengthen that statistical——

Senator SCHWEIKER. I will tell you maybe you could have Dr. Hunt mention whatever he has on that study.

Dr. JONES. Very good.

Senator SCHWEIKER. Anything else?

Dr. JONES. I wanted to mention on this bone disease that studies growing out of that are now being applied to the problem of osteoporosis in people.

The third activity described in Dr. Hunt's statement involves providing a resource for the medical research community. Investigators bring their own research ideas to the center, utilize the center's facilities and collaborate with the center staff. The center provides facilities for the care, management, production, and utilization of the primates, provides professional and technical experts to assist in therapy research and insures the supply of nonhuman primates for research programs at the center, particularly important is the development of technical knowledge on maintaining health and reproduction of monkeys in the laboratory.

Senator SCHWEIKER. All right. I appreciate your substituting for Dr. Hunt very much, and I think the specific identification up here of the studies is very helpful.

We would appreciate getting that DES information. It will be very helpful to us in our Health Committee work.

Dr. JONES. OK, sir. He, I think, describes the budget there and what he recommends. I would have gone into that had we had more time.

## GORGAS MEMORIAL INSTITUTE

### STATEMENT OF JACK W. MILLAR, M.D., PRESIDENT, GORGAS MEMORIAL INSTITUTE.

#### $1.4 MILLION APPROPRIATION SUPPORTED

Senator SCHWEIKER. All right, thank you.

Our next witness, Dr. Millar, president of the Gorgas Memorial Institute funded through NIH.

Dr. MILLAR. Thank you, Mr. Chairman. I have a brief written statement I would like to read.

I appreciate the opportunity of appearing before you today as president of the Gorgas Memorial Institute of Tropical and Preventive Medicine, Inc., to support a $1.4 million appropriation in fiscal year 1978, for the maintenance and operation of the Gorgas Memorial Laboratory as provided by Public Law 70–350, an act authorizing a permanent annual appropriation for such a purpose. Said amount is being requested for the Gorgas Memorial Institute by the Fogarty International Center, National Institutes of Health.

I believe it is important at this point to restate the nature of our organization. The Gorgas Memorial Institute—GMI—is a private, nonprofit corporation which operates the Gorgas Memorial Laboratory—GML—in Panama with resources made available by the Government of the United States and Panama, and by other agencies. The Laboratory is dedicated to the prevention and control of diseases of the tropics, and is an early disease warning center for Central and North America. Its physical plant consists of a major facility in Panama City: A four-building complex situated on the original site ceded by the Republic of Panama, adjacent to the Santo Tomas Hospital; a virology research laboratory housed in a leased Canal Zone building within the Gorgas Hospital complex; and two permanent field stations, the most important being a recently man-made island in the Bayano area, Panama—earmarked to become a biological reserve station—and the second one, Juan Mina, in the Canal Zone.

After a period of serious financial difficulties, Gorgas has regained sound base fiscal support. I would like to record again the sincere appreciation which our board of directors, officers and executive committee, as well as the scientific community feel toward the Congressional authorization and Appropriations Committees for their reasonable judgment and timely action in providing the level of core funding commensurate with the laboratory's operating needs.

The return to fiscal solvency late in fiscal year 1976 and the assurance, for the immediate future, of adequate core funding in line with Gorgas' legislative authority have directed our attention and efforts to rebuilding, reorienting and strengthening GML's research and training program. Top priority was given to the recruitment of highly skilled professionals.

The board of directors, through its executive committee, carefully considered potential candidates and has selected the best qualified to continue important ongoing programs and to institute new ones. Abram S. Benenson, M.D., has been designated director of the Gorgas Memorial Laboratory and will assume his duties next month. A former chairman and professor of the Department of Community Medicine at the University of Kentucky College of Medicine, Lexington, and director of the Pakistan-SEATO Cholera Research Laboratory in Dacca, Dr. Benenson is a world authority on infectious diseases; he brings to the Gorgas scientific community professional prestige and more than two decades of scientific accomplishment, particularly in epidemiology, clinical investigation, and immunology.

Five additional well-trained and seasoned U.S. investigators have been recruited in virology, epidemiology, immunology, insect vector genetics, and entomology. Also, a qualified Panamanian engineer has filled the vacant position of administrator. Early in fiscal year 1978 the GML professional staff will have increased to 19: 12 United States and 7 Panamanian scientists, all at the doctoral level. In addition, there will be the five current visiting scientists: Two U.S. Naval officers, two senior scientists from the Pan American Health Organization, and one from California State University.

A proposed fiscal year 1978 operating budget is attached, and I would like to have it in the record, showing anticipated sources and levels of revenue and operating expenditures; actual figures for fiscal year 1976 and the transition quarter, as well as revised estimates for fiscal year 1977, are furnished for comparison.

The U.S. contribution of $1.4 million for GML's core support allocated for fiscal year 1978 represents 77 percent of our total proposed budget, the remainder to come from grants and contracts as now known to us. Funds which may be supplied for specific new short-term projects, but which are still under negotiation, are now included.

GML received a $120,000 contract award from the Government of Panama, through its Institute of Hydroelectric Resources and Electrification—IRHE—in calendar year 1976, for an environmental impact study of a La Fortuna hydroelectric area in western Panama. The project has been satisfactorily completed and the final report is about to be printed. It appears that GML may again be called on to conduct similar environmental assessments. Such projects give GML scientists a sound base for identifying areas of future research

and for planning new programs on disease problems characteristic of but not confined to the tropics. Hydroelectricity—an energy potential in countries rich in water resources—seems to be in greater demand to offset energy shortages and assist developing farmland areas. Dam construction projects, however, may ultimately expose human communities to disease risks, such as malaria, yellow fever, Venezuelan equine encephalitis, et cetera.

The World Health Organization reports that malaria is one of the most widespread diseases in the world, affecting some 200 million people. In some regions malaria transmission is so intense that present efforts toward mosquito control and disease treatment are hopelessly inadequate; at least 1 million children die of the disease every year. In places such as El Salvador and the Darien area of eastern Panama where malaria had formerly regressed, it is now resurgent.

Gorgas' malaria research will now consist of intensive efforts towards revealing immunological and other phenomena associated with transmission and disease-prevention. Our skilled scientific staff, backed by this year's adequate funding is committed to this special, comprehensive program for evaluating new approaches, planning specific lines of research and carrying them out.

Pursuing earlier discussions, Gorgas signed a 3-year agreement with the Pan American Health Organization—PAHO—which provides the basis for coliaborative research projects at GML, in malaria and other parasitic diseases. As a result, PAHO has now assigned to GML, as the base of operation, two of their senior scientists—a medical officer and a parasitologist—along with adequate funding to support their collaborative research activities. GML scientists also continue to act as consultants, in various disciplines, to PAHO and the countries it serves.

In further support of the GML research programs, the Fogarty International Center—FIC—sponsored a site visit team which reviewed, last October, the scientific program and the operations of the Gorgas Memorial Laboratory. Findings and recommendations contained in the team's report will furnish helpful guidance toward the immediate goal of strengthening our scientific research and training capabilities.

We respectfully request your favorable consideration of and affirmative action on a $1.4 million appropriation as essential for optimum functioning in fiscal year 1978 of the Gorgas Memorial Laboratory, an indispensable outpost against tropical diseases in the Western Hemisphere.

PROPOSED OPERATING BUDGET

In conclusion, Mr. Chairman, I would like to submit for the record an attachment with the proposed operating budget for fiscal year 1978, actual figures for fiscal year 1976 and the transition quarter, and revised estimates for fiscal year 1977, for comparison.

[The information follows:]

GORGAS MEMORIAL INSTITUTE OF TROPICAL
AND PREVENTIVE MEDICINE, INCORPORATED

OPERATING BUDGET (IN THOUSANDS OF DOLLARS)
FOR FISCAL PERIODS 1976 through 1978

| | 1976 ACTUAL | TRANSITION QUARTER ACTUAL | 1977 REVISED ESTIMATE | 1978 ESTIMATE |
|---|---|---|---|---|
| REVENUES: | | | | |
| U.S. Government Contribution | $1,360 | $ 250 | $1,400 | $1,400 |
| Research Grants and Contracts: | | | | |
| National Institutes of Health | | | | |
| NIAID: Leishmaniasis | 1 | - | - | - |
| NIAID: Ecology of Vector Borne Viruses | 120 | 25 | 119 | 167 |
| NIAID: Microclimate of Vector Borne Diseases | 17 | 7 | 35 | 39 |
| NIAID: Epizootic Venezuelan Equine Encephalitis | - | 16 | 34 | 36 |
| Total NIAID | $ 138 | $ 48 | $ 188 | $ 233 |
| Division of Research Resources | | | | |
| General Research Support | 37 | - | - | - |
| TOTAL NIH | $ 175 | $ 48 | $ 188 | $ 233 |
| U.S. ARMY | | | | |
| Monkeys as Hosts of Human Malaria | $ 29 | $ - | $ - | $ - |
| Biohazards of Blackfly | 57 | - | - | - |
| Army Unit/ Building 265, Canal Zone | 119 | - | - | - |
| Drug Evaluation (Aotus Model) | - | 32 | 98 | 114 |
| Total U.S. ARMY | $ 205 | $ 32 | $ 98 | $ 114 |
| U.S. NAVY | | | | |
| Training (Medicine in the Tropics) | $ 25 | $ 6 | $ 25 | $ 25 |
| Chagas Immunity | 9 | - | - | - |
| Total U.S. NAVY | $ 34 | $ 6 | $ 25 | $ 25 |
| AID - Yellow Fever | $ 5 | $ - | $ - | $ - |
| New England Regional Primate Research Center | $ 4 | $ 1 | $ - | $ - |
| Pan American Health Organization | | | | |
| Malaria and other Parasitic Diseases | $ 4 | $ - | $ 35 | $ 38 |
| Republic of Panama: Environmental Impact Studies | $ 59 | $ 52 | $ 13 | $ - |
| TOTAL GRANTS AND CONTRACTS | $ 486 | $ 139 | $ 359 | $ 410 |
| Other Miscellaneous Income | $ 3 | $ 3 | $ 3 | $ 3 |
| | $1,849 | $ 392 | $1,762 | $1,813 |
| Non Current Funds (See note) | - | 423 | 348 | 346 |
| TOTAL REVENUES | $1,849 | $ 815 | $2,110 | $2,159 |

GORGAS MEMORIAL INSTITUTE OF TROPICAL
AND PREVENTIVE MEDICINE, INCORPORATED

OPERATING BUDGET (IN THOUSANDS OF DOLLARS)
FOR FISCAL PERIODS 1976 through 1978

| | 1976 ACTUAL | TRANSITION QUARTER ACTUAL | 1977 REVISED ESTIMATE | 1978 ESTIMATE |
|---|---|---|---|---|
| OPERATING EXPENDITURES: | | | | |
| 1. Biomedical Educational Resources | | | | |
| Medical Library | $ 37 | $ 12 | $ 40 | $ 45 |
| Data Processing | - | 2 | 19 | 26 |
| Educational Center | 8 | 5 | 30 | 34 |
| Total | $ 45 | $ 19 | $ 89 | $ 105 |
| 2. Primate Studies | | | | |
| Reproductive Studies | $ - | $ - | $ - | $ 10 |
| Simian Diseases | - | - | - | 22 |
| Experimental Models | 145 | 50 | 150 | 190 |
| Total | $ 145 | $ 50 | $ 150 | $ 222 |
| 3. Infectious Diseases Programs | | | | |
| Bacterial Diseases | $ 60 | $ 15 | $ 67 | $ 74 |
| Parasitic Diseases | 72 | 14 | 68 | 103 |
| Virus Diseases | 224 | 62 | 300 | 334 |
| Zoonosis | 19 | 6 | 25 | 29 |
| Total | $ 375 | $ 97 | $ 460 | $ 540 |
| 4. Ecology and Epidemiology Programs | | | | |
| Ecology | $ 249 | $ 87 | $ 195 | $ 234 |
| Epidemiology | - | - | 25 | 43 |
| Vector Biology | - | 1 | 64 | 82 |
| Total | $ 249 | $ 88 | $ 284 | $ 359 |
| 5. Clinical Investigations | | | | |
| Immunopathology | $ - | $ 12 | $ 23 | $ 61 |
| Clinical Services | 106 | 16 | 73 | 81 |
| Total | $ 106 | $ 28 | $ 96 | $ 142 |
| 6. Administration | | | | |
| Washington, D.C. | $ 84 | $ 16 | $ 99 | $ 107 |
| Panama and Canal Zone | 147 | 45 | 218 | 238 |
| Total | $ 231 | $ 61 | $ 317 | $ 345 |
| 7. Plant and Equipment Maintenance | | | | |
| Panama | $ 114 | $ 78 | $ 241 | $ 173 |
| Canal Zone | 161 | 43 | 100 | 161 |
| Total | $ 275 | $ 121 | $ 341 | $ 334 |
| 8. Seniority Premium | $ - | $ - | $ 24 | $ 26 |
| TOTAL EXPENDITURES | $1,426 | $ 464 | $1,761 | $2,073 |
| BALANCE OF OPERATING FUNDS (See note) | $ 423 | $ 351 | $ 349 | $ 86 |

NOTE:

This amount represents a carry over from prior periods of earmarked but unexpended funds to cover potential liabilities for which funds have not been appropriated. The Panamanian Labor Code provides that an indemnity be paid to all employees with service of 3 months or more if such employees are terminated without "justifiable cause" (severance indemnity). Due to the contingent nature of this severance indemnity, the Institute has adopted the policy of recording a liability only when it is incurred. At June 30, 1976, the total contingent liability for severance indemnity benefits was approximately $499,000.

Senator SCHWEIKER. Let me ask this.

Your primary mission is malaria research as I understand it.

Dr. MILLAR. Our primary mission is to study the diseases of the tropics. I picked malaria as one example.

Senator SCHWEIKER. What progress are we making on malaria? What can you tell us about what we have done, what we have invested?

Dr. MILLAR. Malaria was pretty well controlled in the 1950's. However, there has been a resurgence in the 1970's in areas such as Sri Lanka and El Salvador. So there is a need for a new look in malaria prevention and control measures. In El Salvador the mosquito vector is resistant to DDT and to most other insecticides which are safe and inexpensive. What is needed, therefore, is to look at other control methods.

We have at Gorgas a nonhuman primate monkey model infected with human malaria for testing new antimalarial drugs. As indicated in my statement, a comprehensive team consisting of an immunologist, an epidemiologist, parasitologists, et cetera will intensify efforts towards revealing immunological and other phenomena associated with transmission and disease-prevention.

Senator SCHWEIKER. What is the $84,000 administration expense in Washington?

Dr. MILLAR. Such amount represents 6 percent of the total operating budget. It covers the operation of the Gorgas Memorial Institute office with its small administrative staff. The Institute is governed by a 47-member board of directors which meets annually in Washington to determine the policies of the Institute, review the managerial and fiscal operation and serve as liasion with United States and Panamanian agencies, international organizations such as PAHO, et cetera. Between meetings, its functions are delegated to the 9-member executive committee which meets monthly at the Washington office.

Senator SCHWEIKER. The Pan American Health Organization is located where?

Dr. MILLAR. Yes, sir. In Washington, D.C. We have just signed a letter of agreement establishing collaborative projects in parasitic diseases. As a result, PAHO has assigned to GML two senior scientists—a parasitologist and a physician clinical malariologist.

Senator SCHWEIKER. All right.

Well, our time is running out. Do you have anything else in summary you would like to say, Doctor? We will put your whole statement in the record.

Dr. MILLAR. Because of research at Gorgas, we predicted an outbreak of Venezuelan equine encephalitis in the United States in the early 1970's. It did break out within a short period of time, and it cost the United States in hard money, $17 million to irradicate and control this epidemic.

Senator SCHWEIKER. All right, and if there is anything else you want to submit for the record we would be glad to have it.

Dr. MILLAR. Fine.

Senator SCHWEIKER. Thank you.

Dr. MILLAR. Concerning administrative costs—it is 6 percent for the Washington office as previously noted and 12 percent for the laboratory in Panama, making an overall total of 18 percent.

Senator SCHWEIKER. Yes, I wasn't arguing so much about the overall because I think that is reasonably low. I just wondered why the two areas were needed for administration.

Dr. MILLAR. The officers of the Institute serve without compensation. I am a professor of epidimiology and environmental health at the George Washington University, School of Medicine.

Senator SCHWEIKER. We can't criticize that, Doctor, that is for sure. Your argument is that because of the Panama connection here, the organization of Pan American states, you have to have some liaison.

Dr. MILLAR. Well, this is very important.

Senator SCHWEIKER. What I suggest you do, your statement is a good analysis of the operation but I think it would be helpful if you would summarize and send to us a list of some of the accomplishments of your group over the last several years.

This is sort of a functional and cost breakdown and we are glad to have it, but you just told me some things that weren't in your statement.

You ought to give us a list of some of these.

Dr. MILLAR. I will be very pleased to do so. For the record, I would like to add that in compliance with our legislative authority we submit to Congress an annual report of our research accomplishments; also, we are audited by GAO every other year.

Senator SCHWEIKER. Where is the status of that present report now?

Dr. MILLAR. The fiscal year 1976 report was submitted to the Congress in January. I can see that you have one within 2 hours, sir.

Senator SCHWEIKER. Good enough. All right, can't ask for more than that, could I?

[CLERK'S NOTE.—"Gorgas Memorial Laboratory, 48th annual report, fiscal year 1976" (H.Doc. 95–39) has been received for the subcommittee files.]

Dr. MILLAR. The report is a full record of the research and training activities

Senator SCHWEIKER. Good. I would put a little more of that into this.

Dr. MILLAR. We were complying with the 10-minute allowed each witness.

Senator SCHWEIKER. No, but I mean in the annual statement. This is a good financial breakdown and a lot of groups don't have this. We appreciate that. I think because our interest is specifically in the health accomplishment area you really ought to put in your statement to our appropriations committee some of the specific things that probably you are putting in your research report. Somehow the two aren't put together for us.

Dr. MILLAR. All right. If we may provide supplemental material——

Senator SCHWEIKER. We will give you one. I suggest you take some highlights from that in the future and put it in your statement. I think it will help your case.

Dr. MILLAR. Thank you.

[The information follows:]

RESEARCH AND TRAINING

The Gorgas Memorial Laboratory, in its program of epidemiological surveillance of explosive viral diseases—such as yellow fever, St. Louis, Eastern and Venezuelan equine encephalitis—continues to serve the Central American Isthmus and the United States as an early warning center of dangerous epidemics. Earlier testimony has related and documented the importance of virus diseases, especially those causing encephalitis with the potential complication of brain damage. By identifying a buildup of virus infection in both animal and bird populations, as well as identifying human cases, we can alert Central and North America to start immediate preventive and control measures for the specific disease concerned. Gorgas Memorial Laboratory remains the only laboratory, clinical or research, in Central America that is capable of virus isolation and diagnosis.

A breakthrough occurred this year in the rabies virus studies initiated last year. Many rabies death in cattle may be a severe threat to human nutrition. Since most mammals, particularly cattle and horses, appear not to live through a rabies virus infection, there is—as recognized for some time—an unidentified factor in the rabies virus' natural survival in the wild; the unknown link would explain where the reservoir of the virus is maintained.

Both bloodsucking and insectivorous bats have been implicated in the natural history of rabies. It appears that passive-active immunization occurs in bats; that is, the immune mother transmits her antibodies to her offspring, so that when the latter are exposed to airborne respiratory viruses in caves, the rabies infections in these mammals do not mean death but chronic infection.

The concept of passive-active immunization without clinical disease, within a rabies virus infected animal, is new and leads us to an interesting system where rabies virus can live without producing harm to the host. It is recognized, of course, that significant research is still required in order to document and explain natural-occurring rabies.

Human leishmaniasis is an insect born disease that is active in Panama as well as many areas in Latin America. The current frontiers of economic development interface with the jungle, creating the situation where leishmaniasis is most prevalent. There is much disfigurement and disability as part of this disease for which there is no known cure, of effective prevention. Gorgas Memorial Laboratory is seeking new leads and better methods of prevention and control.

Another important function of GML is carried out in its training and collaborative research programs. During 1976, 35 university, government and research institutions collaborated in GML research and/or training programs at pre-doctoral, doctoral, and post-doctoral levels. The unique array of clinical and field studies of diseases of the tropics allows GML to function as an on-site training facility.

Senator SCHWEIKER. We are going to declare about a 3 minute recess here.

[A brief recess was taken.]

## NATIONAL DIABETES ADVISORY BOARD

### STATEMENT OF DAVID K. KIPNIS, CHAIRMAN, NATIONAL DIABETES ADVISORY BOARD

PREPARED STATEMENTS

Senator SCHWEIKER. The subcommittee will reconvene.

We will start out with Dr. Kipnis, who is the newly elected chairman of the National Diabetes Advisory Board.

We want to congratulate you, Doctor. I was pleased to be at the opening meeting before the balloting took place. I heard a lot of favorable comments about your selection, so I want to congratulate you and welcome you here today in that capacity because I did request at that meeting that the National Diabetes Advisory Board make a presentation here. Let us have all the written statements from the diabetes panel so they may be included in the record.

[The statements follow:]

# STATEMENT OF DAVID M. KIPNIS, M.D.

I am Dr. David M. Kipnis, Professor and Chairman of the Department of Medicine at Washington University School of Medicine and Physician-in-Chief at Barnes Hospital in St. Louis. I am here today as Chairman of the National Diabetes Advisory Board which was established by Congress to review and evaluate the implementation of the long-range plan formulated by the National Commission on Diabetes and to advise and recommend to Congress, the Secretary of Health, Education and Welfare and the heads of other appropriate agencies with respect to guidelines, policies and procedures of federal programs relating to diabetes. Board members were selected early this year and the Board held its first meeting on March 11, 1977. At that meeting, representatives of the various federal agencies participating in the Diabetes Program presented progress reports of their activities since passage of the Diabetes Act. In addition, the Board received the current Administration's budget for the Diabetes Program, its proposed allocation between the various agencies and the programmatic developments anticipated for the coming year.

Since our Board has just begun its work, it has not had sufficient time to evaluate in-depth the initial efforts to implement the recommendations of the National Commission on Diabetes. However, during the past three weeks, a subcommittee has been involved - as mandated by P.L. 94-562 - in "analyzing expenditures made by the federal government for diabetes-related activities" during the past year and attempting to assess the impact of proposed fiscal 1978 expenditures on the Diabetes Program developed by the National Commission on Diabetes. This assessment has been greatly facilitated by the 1976 Updated Interim Report submitted to Congress four months ago by the National Commission on Diabetes which assumed the responsibility for annual review until legislation authorizing the formation of the current Board had been enacted.

My comments and recommendations will deal with five areas:

I. Diabetes Research Programs
II. Manpower Development
III. Diabetes Research and Training Centers
IV. Health Care Activities
V. Management of the Diabetes Program in the NIAMDD and the NIH at-large

I. Diabetes Research Programs

Fiscal year 1977 is the first full year for implementation of the Long-Range Plan for Diabetes. The funds appropriated by Congress for diabetes research represented an increase in diabetes research support for the NIH of 78 per cent. Current funding is at the level of approximately $74.1 million with the major share allocated to the NIAMDD ($39.83 million ) -- the institute with principal responsibility for diabetes. The funding level recommended by the Administration for diabetes research and associated activities of the NIH in aggregate for fiscal year 1978 is actually less than available in fiscal 1977.

A. NIAMDD

The proposed diabetes budget for this institute is approximately $2.0 million less than fiscal 1977. Funding of research grants and contracts is reduced in excess of 11.5% in absolute dollars or 17% if one accepts an inflation rate of 7%/annum. If existing research commitments are to be honored, the opportunity to support new research grant initiatives in the coming year by investigators new to diabetes or by young medical researchers would be severely compromised. It is our estimate that the institute will be able to fund less than 30 per cent (probably in the range of 20 per cent) of competing approved applications - a situation which the Board feels clearly thwarts the intent of Congress and the National Diabetes Commission to provide an innovative and expanded research program in Diabetes. New initiatives to be supported through the contract mechanism such as 1) a cooperative clinical trial for defining the relationship between treatment and the development of diabetes complications, 2) studies of pancreatic transplantation, 3) the development of artifical devices for the control of blood glucose, and 4) the development of experimental animal models of obesity and diabetes would have to be completely abandoned. The increased funds for research support made available during fiscal 1977 appear adequate to fund new research grant proposals submitted in response to a RFA (Request for Applications) announced to the scientific community by the institute at the end of 1976. Well over three hundred applications have been received thus far and the current budget

should permit funding of approximately 40-50 per cent of approved requests.

The Board recommends that the fiscal 1978 budget be maintained at a level which permits funding of approximately 40-50 per cent of approved grants. To accomplish this, an increase of approximately $12.5 million over the currently proposed fiscal 1978 budget is recommended.

B. NHLBI

Budgetary requests for research support are equivalent to those recommended by the Commission for fiscal 1978. The Board has been gratified by the response of the biomedical community to two RFAs for research dealing with the relationship of diabetes to heart and vessel disease. At the present time, the budget of this institute permits funding of approximately 40 per cent of approved grants in diabetes-related research.

C. NEI

The proposed 1978 budget has been maintained at the current 1977 level. As a consequence, two meritorious and innovative intramural research programs dealing with cataract formation and retinal vessel tissue culture models cannot be expanded. Furthermore, several extremely promising cooperative studies dealing with the effects of aspirin and photocoagulation on pre-proliferative retinopathy and the effectiveness of vitrectomy on hemorrhagic retinopathy cannot be initiated. The Board also estimates that less than 25 per cent of investigator initiated research grant applications on eye disease and diabetes will be funded under the proposed 1978 budget. The Board recommends that the research budget of this institute be increased $2.0 million in accord with the recommendation of the National Commission on Diabetes.

The Board has not had sufficient time to thoroughly assess the consequences of the current budget for the research programs of the NICHHD, NINCDS, NIDR and DRR. However, previous review by the National Diabetes Commission recommended budget levels for the NICHHD and NINCDS which are $1.4 million and $0.3 million greater than proposed. The current Board wishes to endorse these budgetary recommendations.

II. Manpower Development

The Board is distressed to find that the Administration's 1978 budget does not address itself in a constructive or meaningful fashion to this critical issue. For example, the NEI has absolutely no funds earmarked in 1978 for new training activities in diabetes and the NIAMDD budget provides for remarkably little expansion, particularly if one takes into consideration the 11.5 per cent decrease in research grants and contracts proposed for fiscal 1978 which includes funds for clinical investigators and research career development awards. In the NHLBI, training support has been decreased over 30 per cent during the past four years, and the proposed 1978 budget affords no relief. These severe reductions over the past 3-4 years have had a particularly adverse effect on the research and teaching community, since alternative sources for supporting the training of biomedical investigators and teachers -- in contrast to clinical subspecialty practitioners - have not been available. Consequently, the influx of new individuals into biomedical investigation has been severely curtailed. When one recognizes the adverse effects of such additional factors as instability of long-term research funding and the financial rewards and security of private practice, the dramatic decrease in young people committing themselves to academic and investigative careers becomes readily understandable. The National Diabetes Commission recognized the critical importance of increasing both the number and scope of biomedical research training opportunities for young individuals as well as the retraining of presently existing research personnel who could be profitably involved in diabetes-related research. These opportunities should encompass the broad range of academic positions extending from new postdoctoral fellowship opportunities to clinical investigatorships and research career development awards. It is also important to stabilize the fiscal support for uniquely talented biomedical researchers in the form of Distinguished Scientist Awards.

The Board, therefore, recommends that additional manpower development funds in the amount of $5.0 million be budgeted to the NIH with final allocation to be made by the Associate Director for Diabetes after consultation with the Directors of the various institutes involved and the National Diabetes Advisory Board.

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III. Diabetes Research and Training Centers

Approximately $6 million were appropriated by Congress in fiscal 1977 to establish these centers which are charged with three principal functions:

1) Performance of research into the courses, treatment, and management of diabetes.

2) Training of professional personnel both for research in diabetes and for management of the diabetic patient.

3) Translation of advances in the field of research and methods of improved care for the diabetic patient.

At the present time, fourteen completed applications have been received and are under review. It is estimated that approximately 4-5 Centers will be funded by the end of fiscal 1977. It is likely that these initial Centers will probably be at institutions which already have major personnel resources in the areas of diabetes research and training and have been able to mobilize these talents into a coordinated program allowing expansion and development of new initiatives in diabetes biomedical research and health care delivery systems. However, the fiscal 1978 budget allows for no further Centers to be established and consequently, the development of new multi-faceted Centers of excellence in research, training and education would be thwarted. The creation of Diabetes and Research Training Centers was an extremely important element in the Long-Range Program developed by the National Commission on Diabetes and if it is to be viable to all, adequate funds must be made available.

The Board recommends that the National Commission's recommendation be accepted and that $12.0 million be budgeted in fiscal 1978 for this purpose.

IV. Health Care, Education and Control Program Activities

Since a cure for diabetes mellitus does not appear to be imminent, it was deemed important in the National Commission's report that efforts be increased in the area of prevention and treatment of this disease. Of utmost importance in these efforts was implementation of the Center for Disease Control (CDC) Diabetes Control Program. This program involved the development of a co-ordinated system for providing ongoing surveillance of therapeutic effectiveness in diabetes, public education in diabetes and other issues important in

assuring maximal effectiveness of health care delivery as related to diabetes mellitus. Unfortunately, relatively little progress has been made in this area. Initial review by the Board attributed this lack of accomplishment to two factors: 1) the reluctance of the CDC to initiate a program involving multiple states and geographical regions when long-term funding for the positions involved appears to be quite tenuous and the initial monies allocated were significantly less than those recommended, and 2) the failure of the CDC to develop an in-depth analysis of the personnel resources and administrative structure needed to accomplish the goals recommended by the National Commission. The Administration's fiscal 1978 budget reinforces the reluctance of the CDC to proceed with implementing the program since the budget is reduced to $500,000 and is to be utilized for an ill-defined goal of "health education." Consequently, funds are not available to maintain even the modest programmatic development which has occurred this year.

The Board recommends that the fiscal 1978 budget for the CDC Diabetes Control Program be established at the level recommended by the National Commission ($6.1 million) and that the CDC develop a detailed analysis of the manpower needs and administrative organization required to implement this program.

V. Management of the Diabetes Program in the NIAMDD and the NIH at-large

The Board wishes to reaffirm the policy recommended previously that the Associate Director for Diabetes be the principle program official responsible for planning, budgeting and allocation of funds in diabetes activities in the NIAMDD and that this individual be consulted in all matters concerning this portion of the NIAMDD program. The Board was distressed to learn that the proposed fiscal 1978 diabetes budget for NIAMDD was developed without extensive consultation or involvement with the Associate Director for Diabetes.

At its initial meeting, the Board was pleased to hear from Dr. Donald Fredrickson - Director of the NIH - that a NIH Diabetes Mellitus Coordinating Committee was being developed with the Associate Director for Diabetes as chairman, to facilitate programmatic developments, increase intra-institute collaborative research activities, avoid duplication of efforts, and co-ordinate budgetary planning. The Board commends this action and urges its early implementation.

STATEMENT OF DONNELL D. ETZWILER, M.D.

Mr. Chairman and Members of the Subcommittee:

I am Donnell Etzwiler, M.D., President of the American Diabetes Association. I also served as a member of the National Commission on Diabetes, whose Report to the Congress, in December 1975, laid the foundation for much of the subsequent action of the Congress which has meant so much to diabetics throughout the country. I want to take this opportunity to express the gratitude of the ADA and the diabetes community for the effort of this Subcommittee in passing the FY 1977 Appropriations Bill.

That bill began the implementation of the Long Range Plan developed by the Commission to combat diabetes. The expenditures for diabetes authorized by that bill amounted to about $75 million, an increase of about $32 million above the prior year. Under the FY 1977 bill, 6 Diabetes Research and Training Centers will be established; some $125 million in new research grants will be awarded, exploring areas dealing with diabetes and nutrition, obesity, transplantation, retinopathy, cardiovascular disease; and some 6 to 10 community-based diabetes control programs will be established by the Center for Disease Control. Also, in FY 1977 a National Diabetes Advisory Board was created to oversee future implementation of the Diabetes Long Range Plan and this Board is now operative.

But, we have only begun to implement this Diabetes Plan, so well documented by the National Commission on Diabetes. That Plan established a well integrated five year program, of which FY 1977 was only the first year. Substantial increases are necessary for FY 1978 over and above this year's level of effort to accomplish the second year of the program laid out by the scientific, consumer and NIH experts on the National Commission. Unfortunately, the Carter Administration

budget for FY 1978 made no increases over FY 1977 for diabetes research or service programs, and therefore substantial increases over the Carter budget are likewise necessary. The chart set forth on the last page of this testimony shows our request and the recommendation of the National Commission for FY 1978 and compares it to the FY 1977 level and the Carter Administration FY 1978 budget. We are requesting a total increase of about $42 million over the Carter Administration's FY 1978 budget.

The need for this type of increase and for a total program level of about $116 million is easy to document. First, the National Commission Plan is only in its first year. We are therefore still faced with the horrible mortality and morbidity facts regarding diabetes. While some improvements in treatment have occurred, such as the laser treatment for diabetic retinopathy, no solution to the basic biochemical cause of the problem has been developed. The diabetes caseload continues to grow each year and the complications from it are as severe as ever.

I need not cite mortality and morbidity statistics in detail for you know them well; yet no budget justification is complete without some indication of the parameters of need in this area:

> Some 10 million American are estimated to have this disease and it is probably the third leading cause of death. Its incidence is disproportionately high for the poor and minority groups. Diabetes is the major cause of blindness and a major cause of heart disease--the diabetic being 25 times more prone to blindness, 17 times more prone to kidney disease, and twice as prone to heart attacks as the non-diabetic population. Disability days represent even more staggering data. Among the non-institutionalized population, no chronic disease causes more bed days than diabetes.

Second, while major increases in funds were provided in FY 1977, those funds provided for the beginning of major programs only. The six Diabetes Research and Training Centers represent fewer than half those recommended for the nation by the National Commission. The five new Centers recommended for FY 1978 will necessitate an additional $6 million over the Carter Administration budget. Manpower training funds to encourage the entry into diabetes research of vigorous young scientific minds are a necessity. The present level of training support in NIAMDD, for example, is about $1.6 million only; whereas, research grants are $30 million. Thus, training represents about 5% of research funding in NIAMDD; whereas, the National Commission recommended that it represent 20% of research funding in each Institute. Other Institutes have the same problem. Research grant activity, long dormant, needs to continue its growth in all of the relevant Institutes: NIAMDD, Heart, Eye, Child Health, Stroke, and Dental. The projected cost for these increases is about $20 million. The CDC control program should be expanded substantially to support the full recommendation of the Commission and the CDC's own plan of 20 model community projects and the necessary staff. This will cost a total of $6 million above the Carter Administration's budget. Finally, new programs are recommended this year for NIMH, and for three program areas in HSA - emergency care, Indian health, and community health centers - costing $1 million and $2.5 million, respectively.

Mr. Chairman, we have come far with your help and the help of this Subcommittee. But we have only gotten the programs to a walking condition. For a disease of such dramatic consequences, whose programs were literally in a crippled state until the recent year, we must now move the programs forward at a faster pace. The Diabetes Plan of the National Commission is a coherent, well integrated five year approach whose second year needs full support to complement the important beginning year. We recommend that full support.

Thank you very much.

## APPROPRIATIONS POSITION*

| | FY 1977 | Carter FY 1978 | Diabetes Groups 1978 Request (Commission, ADA) | '78 Request for New Positions |
|---|---|---|---|---|
| A. NIH | | | | |
| NIAMDD | $39.8<br>Centers (6)<br>Research (32.2)<br>Training (1.6) | $37.9<br>Centers (6)<br>Research (30.3)<br>Training (1.6) | $64.4<br>Centers (12)<br>Research (46.5)<br>Training (5.5)<br>Clearinghouse & Data Group (.5) | 40 |
| | ($39.8) | | ($64.4) | |
| Eye | 9 | 9 | 11.5 | 13 |
| Heart | 11.9 | 12.4 | 12.3 | 4 |
| NICHHD | 4.6 | 4.7 | 6.1 | 5 |
| Stroke | 1.8 | 2 | 2.4 | 3 |
| Dental | .600 | .660 | 1.4 | 6 |
| Research Resources | 6.3 | 7.3 | 9.1 | 0 |
| NIH SUBTOTAL | $74.1 | $74.2 | $107.2 | 71 |
| B. NIMH<br>Research | 0 | 0 | 1 | |
| C. CDC<br>Prevention & Health Education | 1.5 | 0 | 6 | 20 |
| D. HSA | 0 | 0 | 2.5<br>EMS (.850)<br>IHS (.925)<br>Community Health (.700)<br>$ 2.5 | |
| TOTAL HEW---------- | $75.6 | $74.2 | $116.7 | 91 |

*In Millions

Add on over Carter base budget: NIH - $33 million ($31 if DRR not included); Other HEW - $9.5 million (CDC, NIMH, HSA). Total Add On: $42.5 Million

STATEMENT OF MRS. ERWIN J. LURIE

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THIS COMMITTEE, I AM CAROLINE LURIE, NATIONAL PRESIDENT OF THE JUVENILE DIABETES FOUNDATION. I AM ALSO THE PARENT OF A 21 YEAR OLD SON WHO HAS HAD DIABETES FOR ALMOST ELEVEN YEARS. JDF IS A NATIONAL VOLUNTARY HEALTH ORGANIZATION THREE AND A HALF YEARS OLD, DEDICATED TO SUPPORTING AND FURTHERING RESEARCH AND EDUCATION IN THE FIELD OF DIABETES. TODAY I APPEAR BEFORE YOU ON BEHALF OF OUR BOARD OF DIRECTORS AND OUR MORE THAN 500,000 MEMBERS AND THEIR FAMILIES IN OUR EIGHTY-FIVE CHAPTERS THROUGHOUT THE UNITED STATES. INCIDENTLY, WE ALSO HAVE AFFILIATED CHAPTERS IN CANADA AND ONE IN ISRAEL. AS YOU MAY KNOW, WE ARE A VERY DETERMINED AND VITAL ORGANIZATION WHICH WILL NOT BE DETERRED FROM AN OVERRIDING GOAL, THE PREVENTION AND CURE OF DIABETES AND ITS DEVASTATING COMPLICATIONS.

WITH REGARD TO JDF, YOU MAY BE INTERESTED TO KNOW THAT THE LATEST NATIONAL INFORMATION BUREAU REPORT LISTS THE JUVENILE DIABETES FOUNDATION AS THE LEADER OF ALL VOLUNTARY HEALTH ORGANIZATIONS IN THE PERCENTAGE OF TOTAL RECEIVED FUNDS GIVEN TO RESEARCH (81%). WE ARE PROUD TO SAY THAT IN A SHORT PERIOD OF TIME WE HAVE BEEN ABLE TO ESTABLISH A HUMAN CHAIN OF VOLUNTEERS, DIABETICS AND THEIR FAMILIES, DEVOTED TO HELPING ONE ANOTHER AND TO RAISING FUNDS FOR DIABETES RESEARCH IN ORDER TO SOME DAY FIND THE CAUSE OF AND THE CURE FOR DIABETES.

THREE YEARS AGO LEE DUCAT, OUR FOUNDER AND FIRST PRESIDENT, TESTIFIED BEFORE OTHER CONGRESSIONAL COMMITTEES ON PENDING LEGISLATION TO ESTABLISH A NATIONAL DIABETES COMMISSION. TODAY, THREE AND A HALF YEARS LATER, I AM THANKFUL AND GRATEFUL TO SAY THAT THROUGH THE LEADERSHIP OF CHAIRMAN SENATOR MAGNUSON, SENATOR BROOKE, AND SENATOR SCHWEIKER OF THIS COMMITTEE AND MANY OTHER MEMBERS OF THE CONGRESS, THE SEEDS WERE PLANTED FOR A FULL SCALE ATTACK ON THE DEBILITATING DISEASE OF DIABETES. THE GROUNDWORK WAS LAID BY THE ESTABLISHMENT OF THE CONGRESSIONALLY CREATED NATIONAL COMMISION ON DIABETES. THE NINETY-FOURTH CONGRESS THEN ESTABLISHED THE NATIONAL DIABETES ADVISORY BOARD AS A MAJOR COMPONENT IN THE COMMISSION'S LONG RANGE PLAN. THE NATIONAL DIABETES ADVISORY

BOARD, I AM HAPPY TO SAY, BECAME A FUNCTIONING ONE WITH ITS FIRST MEETING ON MARCH 11, 1977.

WE HAVE A MOST UNIQUE VEHICLE IN THE NDAB. IT IS THE FIRST TIME THE CONSUMER, THE GOVERNMENT, AND THE MEDICAL PROFESSION HAVE ALL SERVED TOGETHER ON ONE BOARD, CHARGED WITH THE IMPLEMENTATION AND CARRYING OUT OF A LONG RANGE PLAN ON DIABETES AS FORMULATED BY THE NATIONAL COMMISSION ON DIABETES.

ANOTHER MAJOR COMPONENT OF THE COMMISSION'S LONG RANGE PLAN WAS A SUBSTANTIAL INCREASE IN DOLLARS FOR FISCAL YEAR 1977. THIS MADE UP IN PART FOR A DECADE AND MORE OF SERIOUS UNDERFUNDING FOR DIABETES.

YES, THE SEEDS HAVE NOW BEEN PLANTED. I AM HERE TODAY TO ASK FOR YOUR CONTINUED ASSISTANCE AND SUPPORT TO NURTURE AND HARVEST AND PLANT MORE OF THESE SEEDS.

PREVIOUS CONGRESSES, AS EVIDENCED BY THEIR APPROPRIATIONS, HAVE RECOGNIZED DIABETES AS THE DEVESTATING DISEASE THAT IT IS.

-- DIABETES IS THE 3RD LEADING CAUSE OF DEATH IN THE UNITED STATES WITH SOME 300,000 DEATHS ATTRIBUTED TO IT YEARLY.
-- DIABETES IS THE LEADING CAUSE OF NEW BLINDNESS
-- DIABETES IS A LEADING CAUSE OF HEART DISEASE, KIDNEY DISEASE AND GANGRENE.
-- OVER 10 MILLION AMERICANS HAVE DIABETES
-- THERE ARE 600,000 NEW CASES A YEAR, OVER 2,000 NEW CASES EACH DAY.
-- DIABETES IS ACCELERATING IN INCIDENCE IN THE BLACK POPULATION; AMONG THE AMERICAN INDIANS AND AMONG THE CHICANO POPULATION.
-- DIABETES IS ACCELERATING IN INCIDENCE IN THE FEMALE POPULATION.
-- DIABETES AFFECTS ALL STRATAS OF OUR POPULATION EQUALLY KNOWING NO RACIAL, ETHNIC CLASS OR GEOGRAPHIC BARRIERS.

IN THE PREPARATION OF MY TESTIMONY BEFORE YOU TODAY, I SPENT MANY HOURS RE-READING THE NATIONAL COMMISSION ON DIABETES LONG

RANGE PLAN TO COMBAT DIABETES AS WELL AS THE 1976 UPDATE OF THE COMMISSION. THE UPDATED FACTS THEREIN PRESENTED REINFORCE THE IMPERATIVE NEEDS YET TO BE MET. THE MAGNITUDE OF THE PROBLEM REMAINS AS GREAT, BUT THE NEED FOR ACTION AND FURTHER IMPLEMENTATION MUST TAKE ON INCREASED VELOCITY.

WHY THIS NEED FOR INCREASED VELOCITY OF IMPLEMENTATION AND EFFORT? GENTLEMEN, THIS PAST YEAR SINCE WE LAST APPEARED BEFORE YOU HAS PROVEN TO US THAT THERE ARE A NUMBER OF APPROACHES THAT HAVE NOT BEEN FOLLOWED, THAT HAVE NOT BEEN FUNDED, AND, THEREFORE, HAVE DETERRED THE IMPLEMENTATION OF THE LONG RANGE PLAN ADOPTED BY CONGRESS.

EARLIER READING OF THE COMMISSION'S REPORT AND EARLIER TESTIMONY BEFORE CONGRESS INDICATED THAT FUNDS SHOULD BE CONSERVATIVELY APPROPRIATED BECAUSE THERE WAS A CONCERN THAT THERE WAS A LACK OF RESEARCHERS TO ADEQUATELY UTILIZE THE FUNDS RECOMMENDED.

THIS PAST YEAR HAS PROVEN OTHERWISE. NOT ONLY ARE THERE RESEARCHERS AVAILABLE BUT THEY ARE SERIOUSLY SEEKING FUNDS FOR DIABETES RESEARCH PROJECTS, A FACT KNOWN AND STATED BY THE JUVENILE DIABETES FOUNDATION OVER THE YEARS.

THIS YEAR THE JUVENILE DIABETES FOUNDATION HAS RECEIVED OVER 40% MORE REQUESTS FOR GRANT FUNDING OVER THE LAST YEAR. AS PERSONALLY RELATED TO ME, NIAMDD DURING THE PAST YEAR HAS RECEIVED OVER 900 GRANT APPLICATION REQUESTS -- SEVERAL TIMES THE AMOUNTS EVER RECEIVED IN RELATION TO DIABETES FUNDING. TO QUOTE DR. ROBERT LEVY OF THE NATIONAL INSTITUTE OF HEART, LUNG AND BLOOD IN A STATEMENT TO THE NATIONAL INSTITUTES OF HEALTH: "DIABETES, ANOTHER DISEASE WHICH MAY START IN EARLY CHILDHOOD CLEARLY IS AN INDEPENDENT RISK FACTOR FOR CORONARY HEART DISEASE, SUDDEN DEATH, CONGESTIVE HEART FAILURE, STROKE, AND PERIPHERAL VASCULAR DISEASE IN ADULT LIFE. ... BECAUSE OF THE ENORMOUS INVESTIGATOR INTEREST...A SECOND PROGRAM FOCUSING ON DIABETIC CARDIO MYOPATHY WILL BE INITIATED THIS YEAR" END OF QUOTE.

THEREFORE THERE IS ONLY ONE CONCLUSION AND HINDSIGHT THAT HAS NOW PROVEN IT TO US ALL. THE AMOUNT OF RESEARCH FUNDING RECOMMENDED BY THE ADMINISTRATION FOR FISCAL YEAR 1978 IS GROSSLY INSUFFICIENT

AND INADEQUATE. THERE ARE RESEARCHERS WAITING FOR FUNDING. THERE ARE EXCELLENT RESEARCHERS AND INSTITUTIONS SEEKING FUNDING FOR EXCELLENT DIABETES PROJECTS NOW. SADLY, ADEQUATE FUNDING IS NOT AVAILABLE FROM THE NATIONAL INSTITUTES OF HEALTH. YOUR SUBCOMMITTEE MUST REMEDY THIS SITUATION.

THE COMMISSION REPORT PRESENTS AN ACCURATE, ALARMING PICTURE OF DIABETES IN THIS COUNTRY. HOWEVER, WE BELIEVE THAT THE ADMINISTRATION HAS FAILED TO REQUEST SUFFICIENT FUNDS TO CARRY OUT ADEQUATE RESEARCH THRUSTS BASED ON THE NEEDS OF DIABETES RESEARCH IN 1978, AND THE RESEARCH BUDGET IS FAR TOO CONSERVATIVE AND NOT BROAD ENOUGH. WE ARE FACED WITH THIS CONTINUING CRISIS, A POLYGLOT OF A DISEASE AND UNLESS THE CONGRESS AND PARTICULARLY THIS COMMITTEE STEPS IN ONCE AGAIN TO SAVE THE DAY, THIS CRISIS WILL ULTIMATELY TURN INTO A DISASTER. I SUBMIT TO YOU THAT WE WILL NOT GET A STEPPED UP, "CATCH-UP" RESEARCH EFFORT UNLESS ADEQUATE FUNDS ARE ONCE AGAIN INFUSED INTO FEDERAL AGENCIES CAPABLE OF EXPANDING THE DIABETES RESEARCH EFFORT.

THE RECOMMENDATIONS OF THE JUVENILE DIABETES FOUNDATION SUPPORT, IN ESSENCE, THE NATIONAL COMMISSION ON DIABETES. HOWEVER, THE ADMINISTRATION'S BUDGET IS COMPLETELY UNSATISFACTORY AND A DETERRENT TO PROGRESS IN RELATION TO THE DIABETES PROGRAM. THE BUDGET MUST BE BASED ON THE PREMISE THAT GREATER FUNDING IN ALL INSTITUTIONS WILL SERVE AS A STIMULATOR AND THAT IF SUFFICIENT FUNDS ARE AVAILABLE IN TRAINING GRANTS AND RETRAINING GRANTS, RESEARCHERS WILL ENTER THE FIELD AND TRAINED RESEARCHERS IN OTHER FIELDS COULD BE RETRAINED TO DO DIABETES RESEARCH -- IN AREAS OF PRIME VOIDS, SUCH AS VASCULAR COMPLICATIONS, EYE, STROKE, DENTAL PROBLEMS, NEUROPATHY AND EMOTIONAL RESEARCH.

WE ARE RECOMMENDING INCREASED APPROPRIATIONS FOR FISCAL YEAR 1978 BASED ON VERY SMALL PERCENTAGES OF TOTAL FISCAL YEAR 1977 INSTITUTE APPROPRIATIONS; FROM 1 TO 10% IN MOST INSTITUTIONS, EXCEPT FOR THE NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES AND THE NATIONAL EYE INSTITUTE. OF THE RECOMMENDATIONS BEFORE YOU, OURS IS THE SINGLE MOST COMPREHENSIVE AND VITAL TO THE DIABETES EFFORT. FUNDS FOR RESEARCH ON EMOTIONAL PROBLEMS CONNECTED WITH DIABETES, GROWTH PROBLEMS, MATURATION PROBLEMS, FERTILITY PROBLEMS,

INFECTIONS, SKIN DISEASES, HEALING PROBLEMS, GANGRENE AND KIDNEY DISEASE ARE COVERED BY THE THE ENLARGED RECOMMENDED TOTALS FOR THE VARIOUS INSTITUTES. DIABETES MUST BE ENCIRCLED FROM EVERY AVAILABLE VANTAGE POINT AND EVERY AVAILABLE RESOURSE FROM THE NATIONAL INSTITUTES OF HEALTH TO THE VETERANS ADMINISTRATION TO THE DEPARTMENT OF AGRICULTURE TO THE CENTER FOR DISEASE CONTROL.

* TOP PRIORITY MUST BE GIVEN TO METHODS TO ARREST THE MANY COMPLICATIONS OF DIABETES. RESEARCH MUST FIND WAYS TO PREVENT DETERIORATING DIABETIC COMPLICATIONS. SUPPORT TO RESEARCH IN CARDIOVASCULAR PROBLEMS, EYE RESEARCH, KIDNEY RESEARCH AND NEUROPATHY ARE HIGH PRIORITY.

* TOP PRIORITY MUST BE GIVEN TO PREVENTIVE RESEARCH. THERE IS VIRTUALLY NO PREVENTIVE RESEARCH AT PRESENT. SUPPORT MUST BE GIVEN TO RESEARCH INTO GENETICS, THE VIRUS THEORY OF CAUSATION, NUTRITIONAL CAUSATION OF DIABETES AND OBESITY.

* TOP PRIORITY MUST BE GIVEN TO AREAS WHICH MIGHT RESULT IN A "QUICK PAY-OFF" OR CURE. RESEARCH SUPPORT MUST BE GIVEN TO PANCREAS TRANSPLANTATION, BETA CELL TRANSPLANTS AND THE ARTICIAL PANCREAS.

I MUST TAKE A MOMENT TO FOCUS IN ON A FEW OF THE PARTICULAR INSTITUTIONS THAT THE JUVENILE DIABETES FOUNDATION FEELS MUST HAVE A GREATER INFUSION OF FUNDS. OUR "ADD-ON" BUDGET INCLUDES:

NATIONAL HEART, LUNG AND BLOOD INSTITUTE

IN YOUR FISCAL YEAR 1977 APPROPRIATIONS REPORT, YOU HAILED NHLBI FOR ITS RESEARCH EFFORTS IN DIABETES-RELATED CARDIOVASCULAR PROBLEMS AND ENCOURAGED THE INSTITUTE TO MOVE AHEAD IN THE AREA AND TO SIGNIFICANTLY EXPAND RESEARCH ON THE CONSEQUENCES AND COMPLICATIONS OF DIABETES AS AN INDEPENDENT RISK FACTOR FOR CORONARY HEART DISEASE, SUDDEN DEATH, HEART FAILURE AND STROKE. AS PARENTS OF DIABETIC CHILDREN, WE ARE ALSO CONCERNED THAT ADEQUATE RESOURCES BE MADE AVAILABLE FOR THE JOINT NHLBI - NIAMDD EXAMINATION OF THE FEASIBILITY AND IMPLEMENTATION OF A CLINICAL TRIAL OF DEGREES OF CONTROL IN THE CARDIOVASCULAR PROGNOSIS OF JUVENILE DIABETES. NIH'S PLANNED ALLOCATION FOR FISCAL YEAR 1978 DIABETES-RELATED ACTIVITIES FOR THE NATIONAL HEART, LUNG AND BLOOD INSTITUTE IS APPROXIMATELY $12,350,000. WE BELIEVE THAT IN ORDER TO ACCOMPLISH THE

AFOREMENTIONED OBJECTIVES, THE FISCAL YEAR 1978 APPROPRIATION FOR NHLBI SHOULD AT LEAST BE $496 MILLION OF WHICH 10% SHOULD BE DEVOTED TO DIABETES AND RELATED RESEARCH.

INCLUDED IN THIS FIGURE IS $5 MILLION FOR NEW INSTITUTIONAL FELLOWSHIP AWARDS IN CARDIO-VASCULAR DISEASE. TODAY DIABETES IS ACKNOWLEDGED AS ONE OF THE FOUR MAJOR CAUSES OF HEART ATTACKS, THUS WE ARE NOT SATISFIED WITH THE EFFORTS MADE TO DATE. HOWEVER, WE DO UNDERSTAND THAT THE INSTITUTE'S EFFORTS HAVE BEEN HAMPERED BY LACK OF SUFFICIENT FUNDING.

AN EFFECTIVE INSTITUTIONAL TRAINING PROGRAM MUST CONTINUE TO MOVE FORWARD WITHIN THE HEART, LUNG AND BLOOD INSTITUTE AND THIS CANNOT BE ACCOMPLISHED WITHOUT YOUR SPECIFIC SUPPORT.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

WE ARE ENCOURAGED THAT THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT HAS INITIATED NEW PROGRAMS, BUT AS AN ORGANIZATION REPRESENTING THE NEEDS OF CHILDREN AND YOUNG ADULTS WITH DIABETES IT IS OUR BELIEF THAT THE APPROPRIATION AMOUNT REQUESTED BY THE ADMINISTRATION IS TOTALLY INADEQUATE TO INSURE SOME BREAKTHROUGH IN THE DIAGNOSIS, CURE AND TREATMENT OF JUVENILE DIABETES. IT IS OUR RECOMMENDATION THAT THE NICHHD BUDGET BE INCREASED TO APPROXIMATELY $16 MILLION, WHICH IS JUST OVER 10% OF THE INSTITUTE'S TOTAL BUDGET TO EMPHASIZE RESEARCH INTO DIABETES-CAUSED EMOTIONAL, ADOLESCENT, GROWTH AND MATURATION PROBLEMS AS WELL AS IMPOTENCY AND FERTILITY PROBLEMS CAUSED BY DIABETES. WE ALSO BELIEVE THAT, PURSUANT TO YOUR COMMITTEE'S REPORT LANGUAGE:

" THE NICHHD SHOULD EXPAND RESEARCH INTO ENFANT FEEDING AS IT LEADS TO OBESITY AND DIABETES, PREGNANCY AND DIABETES, THE CHILDREN OF DIABETIC MOTHERS AND THE RELATIONSHIPS BETWEEN ORAL CONTRACEPTIVES AND DIABETES."

JDF SUPPORTS INCREASED FUNDING FOR RESEARCH MANPOWER TRAINING IN THESE IMPORTANT AREAS.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

EXPANSION OF RESEARCH AT THE NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE WITH RESEARCH INTO:

-- NEUROPATHY DUE TO DIABETES

-- TREATMENT OF NEUROPATHY CAUSED BY DIABETES

-- RESEARCH INTO STROKE CAUSED BY DIABETES

-- RESEARCH INTO HIGH BLOOD PRESSURE CAUSED BY DIABETES

-- RESEARCH INTO PITUITARY COMPLICATIONS CAUSED BY DIABETES.

OUR "ADD-ON" BUDGET IS JUST OVER $7 MILLION.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

WE RECOMMEND EXPANSION OF RESEARCH WITH INFUSED FUNDING IN THE NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES. THIS INSTITUTE MUST TAKE A GIANT STEP FORWARD WITH EMPHASIS PLACED INTO THE VIRAL CAUSES OF DIABETES; RESEARCH INTO DEVELOPMENT OF A VACCINE FOR PREVENTION; RESEARCH INTO INFECTIONS DUE TO DIABETES AND TREATMENT OF THESE INFECTIONS. THE JUVENILE DIABETES FOUNDATION RECOMMENDS AN "ADD-ON" BUDGET OF APPROXIMATELY $14 MILLION INTO DIABETES AND RELATED RESEARCH AND MANPOWER TRAINING.

NATIONAL INSTITUTE FOR THE AGING

NEW EXPANSION FOR THE INSTITUTE FOR THE AGING BUDGET MUST BE ACCOMPLISHED THIS YEAR. DIABETES TODAY IS ONE OF THE MAJOR PROBLEMS OF OUR ELDERLY POPULATION. RESEARCH, MANPOWER AND TRAINING IN THIS CATAGORY IS TOTALLY INADEQUATE AND WE RECOMMEND AN "ADD-ON" BUDGET OF $4.5 MILLION FOR RESEARCH AND TRAINING.

THE JUVENILE DIABETES FOUNDATION'S RECOMMENDATIONS OF DETAILED FUNDING FOR THE OTHER INSTITUTIONS AND AGENCIES ARE ATTACHED TO THIS STATEMENT.

LOOKING AHEAD, PERHAPS ONE OF THE GREATEST CONCERNS, CONSTANTLY REAPPEARING IN ALL TESTIMONIES AND REPORTS IS TO THE DIRE NEED FOR RESEARCH TRAINING IN DIABETES FOR THE FUTURE. A CONTINUOUS IMPUT OF YOUNG AND VIGOROUS SCIENTIFIC MINDS IS OF ABSOLUTE NECESSITY IN EXPANDING RESEARCH EFFORT AND IMPLEMENTING THE DIABETES LONG RANGE PLAN.

THE SHORTAGE OF SUPPORT OF RESEARCH MANPOWER TRAINING, INTO THE AREAS OF PREVENTION AND COMPLICATION AND CURE CAN EMASCULATE THE GROWTH OF ALL RESEARCH EFFORT IN DIABETES. TO TAKE CARE OF

TODAY AND GIVE NO THOUGHT TO TOMORROW IS A DISASTEROUS PATH TO FOLLOW.

I CAN ALSO REPORT TO YOU THAT THE JUVENILE DIABETES FOUNDATION HAS RECEIVED OVER A 200% INCREASE IN REQUESTS FOR RESEARCH TRAINING FELLOWSHIPS DURING THE PAST YEAR. CONGRESS MUST POINTEDLY AUTHORIZE LEGISLATION FOR INCREASED FUNDING OF TRAINING OF NEW YOUNG SCIENTISTS AND FOR INSTITUTIONAL TRAINING GRANTS AND A CROSS-FERTILIZATION OF SCIENTISTS IN AREAS RELATING TO DIABETES.

THIS MUST BE A CONGRESSIONAL MANDATE AS THE NEEDS ARE TOO GREAT FOR THE PRIVATE SECTOR ALONE TO ACCOMPLISH. OUR CHILDREN'S FUTURES LIE IN THE HANDS OF NOT ONLY THE RESEARCHERS OF TODAY, BUT IN THE NEW YOUNG DEVELOPING RESEARCHERS OF TOMORROW.

DEVELOPING A LONG RANGE PLAN TO COMBAT DIABETES IN 1975 WAS A GREAT FORWARD STEP TAKEN BY CONGRESS IN ITS WISDOM. IMPLEMENTING THE PLAN WITH ADEQUATE FUNDING FOR THE FIRST YEAR WAS ADDING HIGH POWERED FUEL TO A NEW VEHICLE.

DEVELOPING NEW MANPOWER TO TECHNICALLY SERVICE THIS HIGH POWERED VEHICLE, IS NOW A NECESSITY, AND NOW WE COME TO ANOTHER CRUCIAL POINT: HOW CAN WE MOVE THIS ENTIRE CONCEPT FORWARD WITHOUT THE ARMS AND LEGS AND CARING AND SPECIFIC POSITIONS NECESSARY TO MANAGE AND STAFF AND COORDINATE THIS GREAT EFFORT?

PERHAPS ONE OF THE MAJOR DEFICIENCIES IN ALL OUR EFFORTS HAS BEEN THE LACK OF DIRECT CONGRESSIONAL AUTHORIZATION FOR PROGRAM STAFFING TO IMPLEMENT ALL GOVERNMENTAL DIABETES ACTIVITIES.

WE THOROUGHLY CONCUR WITH THE NATIONAL COMMISSION ON DIABETES' RECOMMENDATION TO CONGRESS AND THE ADMINISTRATION, THAT THE NUMBER OF POSITIONS NEEDED TO IMPLEMENT THE DIABETES PROGRAM BE SPECIFICALLY AND SUBSTANTIALLY INCREASED BY CONGRESSIONAL AND EXECUTIVE MANDATE. WE IMPLORE YOU TO DO THIS. FOR OUR ANALYSIS OF THE TOTAL NATIONAL INSTITUTES OF HEALTH IN HOUSE MANPOWER NEEDS WE BELIEVE THEY SHOULD HAVE A CEILING OF AT LEAST 11,500 PEOPLE WITH AS MUCH DESCRETION AS POSSIBLE IN THE HANDS OF THE DIRECTOR OF THE NATIONAL INSTITUTES OF HEALTH.

ALL THE COMPONENTS FOR A POTENTIALLY SUCCESSFUL ATTACK ON DIABETES CAN BE MADE AVAILABLE. IF THE CORRECT IMPUT OF DOLLARS ARE ADDED INTO THE CORRECT INSTITUTES, AS THE JDF STRONGLY RECOMMENDS, THERE WILL BE A RETURN BENEFITING ALL OF THE DIABETES COMMUNITY AND THE NATION AT LARGE.

THEREFORE, WE BELIEVE IT IS INCUMBENT ON THIS CONGRESS TO CARRY THE LONG RANGE PLAN FOR DIABETES FORWARD FROM ITS BEGINNING TO ITS HOPEFUL END.

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THIS COMMITTEE, DIABETES IS A RUTHLESS KILLER, THE THIRD LEADING CAUSE OF DEATH BY DISEASE KNOWN TO MAN THAT AFFECTS OVER 10 MILLION PEOPLE. IT IS WITHIN OUR POWER TO STOP THIS KILLER, TO SAVE LIVES, TO ALLEVIATE THE COMPLICATIONS, TO IMPROVE THE QUALITY OF LIFE FOR OUR CHILDREN AND ALL DIABETICS, TO INCREASE THEIR PRODUCTIVITY. IT SEEMS TO ME THAT WE HAVE NO CHOICE -- WE HAVE A MORAL IMPERATIVE, IF YOU WILL, TO DO WHAT MUST BE DONE, AND TO DO IT NOW.

DIABETES TODAY IS A BLAZING FIRE BURNING OUT OF CONTROL. ONE SINGLE STREAM OF PRESSURE CAN NEVER PUT IT OUT. BUT STREAMS OF RESEARCH FOCUSED IN FROM EVERY AVAILABLE ENCIRCLING POSITION CAN GET TO THAT FLAME UNTIL IT EXISTS NO MORE. WE HAVE A FIRE TO PUT OUT -- A DISEASE TO ELIMINATE. IT IS NOW UP TO YOU TO PROVIDE THE PRESSURE AND THE POWER.

GENTLEMEN, THANK YOU SO MUCH FOR YOUR COURTESY, YOUR ENCOURAGMENT AND YOUR DEEP CONCERN AND CARING.

84-877 (Pt. 4) O - 77 - 48

JDF APPROPRIATIONS RECOMMENDATIONS
RE: MANPOWER TRAINING AND RESEARCH
FOR THE
NATIONAL INSTITUTES OF HEALTH
DIABETES AND RESEARCH TRAINING CENTERS
CENTER FOR DISEASE CONTROL

NATIONAL INSTITUTE OF ARTHRITIS, METABOLIC AND DIGESTIVE DISEASES

Total Institute Budget -- Fiscal Year 1977.....$209,000,000

| YEAR | PERCENTAGE OF INCREASE OF TOTAL BUDGET FY'77 TO DIABETES & RELATED RESEARCH | | NUMBER OF FELLOWSHIPS | TOTAL COST | TOTAL ADD-ON |
|---|---|---|---|---|---|
| Budget for 1 year: | | | | | |
| FY '78 | 30% | $62,700,000 | 400 | $6,000,000 | $68,700,000 |

NATIONAL EYE INSTITUTE

Total Institute Budget -- Fiscal Year 1977.....$64,000,000
Diabetes Related Research: Wheras diabetic retinopathy/diabetic cartaracts is the leading cause of new blindness -- the effort is to be expanded

| | | | | | |
|---|---|---|---|---|---|
| Budget for 1 year: | | | | | |
| FY '78 | 20% | 12,800,000 | 200 | 3,000,000 | 15,800,000 |

NATIONAL HEART AND LUNG INSTITUTE

Total Institute Budget -- Fiscal Year 1977.....$396,661,000
Diabetes Related Research

| | | | | | |
|---|---|---|---|---|---|
| Budget for 1 year: | | | | | |
| FY '78 | 10% | 39,666,100 | 300 | 5,000,000 | 44,661,000 |

| YEAR | PERCENTAGE OF INCREASE OF TOTAL BUDGET FY '76 TO DIABETES & RELATED RESEARCH | | NUMBER OF FELLOWSHIPS | TOTAL COST | TOTAL ADD-ON |
|---|---|---|---|---|---|
| NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT | | | | | |
| Total Institute Budget -- Fiscal Year 1977.....$145,543,000<br>Diabetes Related Research | | | | | |
| Budget for 1 year: | | | | | |
| FY '78 | 10% | $14,554,300 | 100 | $1,500,000 | $16,054,300 |
| NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS & STROKE | | | | | |
| Total Institute Budget -- Fiscal Year 1977.....155,500,000<br>Diabetes Related Research | | | | | |
| Budget for 1 year: | | | | | |
| FY '78 | 5% | 7,775,000 | 200 | 1,500,000 | 9,275,000 |
| NATIONAL INSTITUTE OF DENTAL RESEARCH | | | | | |
| Total Institute Budget -- Fiscal Year 1977.....55,573,000<br>Diabetes Related Research | | | | | |
| Budget for 1 year: | | | | | |
| FY '78 | 5% | 2,778,650 | 100 | 1,000,000 | 3,778,650 |

| YEAR | PERCENTAGE OF INCREASE OF TOTAL BUDGET FY '76 TO DIABETES & RELATED RESEARCH | | NUMBER OF FELLOWSHIPS | TOTAL COST | TOTAL ADD-ON |
|---|---|---|---|---|---|
| INSTITUTES TO BE INCLUDED IN THE DIABETES PLAN: | | | | | |
| NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES | | | | | |
| Total Institute Budget -- Fiscal Year 1977.....$205,000,000<br>Diabetes Related Research | | | | | |
| Budget for 1 year: | | | | | |
| FY '78 | 5% | $10,250,000 | 100 | $1,500,000 | $11,525,000 |
| NATIONAL INSTITUTE ON AGING (Cell aging, arteriosclerosis) | | | | | |
| Total Institute Budget -- Fiscal Year 1977.....30,000,000<br>Diabetes Related Research | | | | | |
| Budget for 1 year: | | | | | |
| FY '78 | 10% | 3,000,000 | 100 | 1,500,000 | 4,500,000 |
| NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES | | | | | |
| Total Institute Budget -- Fiscal Year 1977<br>Diabetes Related Research | | | 141,000,000 | | |
| Budget for 1 year: | | | | | |
| FY '78 | 10% | 14,100,000 | 50 | 750,000 | 14,750,000 |

TOTALS NIH "ADD-ON" BUDGET

| YEAR | TOTAL RESEARCH | TOTAL MANPOWER | TOTAL DIABETES ADD-ON |
|---|---|---|---|
| FY '78 | $167,624,050 | $21,750,000 | $189,374,000 |
| DIABETES RESEARCH AND TRAINING CENTERS | | | 12,000,000 |
| CENTER FOR DISEASE CONTROL | | | 3,600,000 |
| DIABETES RESEARCH -- TOTAL | | | $204,974,050 |

JDF APPROPRIATIONS RECOMMENDATIONS
RE: MANPOWER TRAINING AND RESEARCH
FOR THE
NATIONAL INSTITUTES OF HEALTH
DIABETES AND RESEARCH TRAINING CENTERS
CENTER FOR DISEASE CONTROL

The recommended increases for the budgets for the Institutes at NIH reflect the overwhelming need for further research into possible areas of prevention and treatment of diabetes and its many complications. As you will note from the wide range our fiscal recommendations and the many Institutes that are included in the recommendations, we are not only talking about a disease which itself aflicts over 10 million Americans but we are also talking about the complications of this disease which run the gamit from heart problems to blindness to loss of limbs. Therefore, we respectfully request that this distinguished Committee view our budgetary recommendation in the context of requests for increased support for research on diabetes as well as its multitude of complications.

In designating our recommendation budget, we have taken a conservative approach in that we have been cautious not to exceed amounts for which there are qualified researchers waiting to work on meritorious projects. They are only lacking sufficient funds.

NATIONAL INSTITUTE FOR ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES

The Commission, in its 1976 Update, stressed that NIAMDD has, within the confines of its budget limitations, expanded diabetes-related activities. We have every reason to believe that given adequate appropriations and your mandate in the form of strong and supportive Report language, this Institute will continue to remain the bastion of federally funded diabetes research. Moreover, the Institute is also in the process of

expanding its vehicles for research manpower development, in the form of the Clinical Investigator Award and the Academic Career Award. While we are pleased with NIAMDD's increased efforts in diabetes research, we believe that its budget should be expanded to include an augmented emphasis on research into kidney disease due to diabetes, hormonal factors of diabetes and nutrition and obesity as regards to "prevention." As such, we recommend an FY 1978 appropriation of approximately $68 million for the Institute for Diabetes and Related Research.

NATIONAL EYE INSTITUTE

In your Fiscal Year 1977 Appropriations Report, your Committee directed the National Eye Institute to "increase its support for research on the causes and treatment of diabetic retinopathy so that this tragic complication of diabetes can be prevented or cured." We recommend an FY 1978 appropriation of $15,800,000 for diabetes and related research, with a directive from your Committee that NEI increase its emphasis on research into cataracts due to diabetes, treatment of cataracts, glaucoma due to diabetes, treatment of glaucoma, research into sight saving lenses, expansion of research manpower, and increased training and retraining grants.

NATIONAL HEART, LUNG AND BLOOD INSTITUTE

In your Fiscal Year 1977 Appropriations Report, you hailed NILBI for its research efforts in diabetes-related cardiovascular problems and encouraged the institute to move ahead in the area and to significantly expand research on the consequences and complications of diabetes as an independent risk factor for coronary heart disease, sudden death, heart failure and stroke. As parents of diabetic children, we are also concerned that adequate resources be made available for the joint NHLBI - NIAMDD examination of the feasibility and implementation of a clinical trial of degrees of control in the cardiovascular prognosis of Juvenile Diabetes. NIH's

planned allocation for Fiscal Year 1978 diabetes-related activities for the National Heart, Lung and Blood Institute is approximately $12,350,000. We believe that in order to accomplish the aforementioned objectives, the Fiscal Year 1978 appropriation for MHLBI should at least be $496 million of which 10% should be devoted to diabetes and related research.

Included in this figure is $5 million for new institutional fellowship awards in cardio-vascular disease. Today Diabetes is acknowledged as one of the four major causes of heart attacks, thus we are not satisfied with the efforts made to date. However, we do understand that the Institute's efforts have been hampered by lack of sufficient funding.

An effective institutional training program must continue to move forward within the Heart, Lung and Blood Institute and this cannot be accomplished without your specific support.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

We are encouraged that the National Institute of Child Health and Human Development has initiated new programs, but as an organization representing the needs of children and young adults with diabetes it is our belief that the appropriation amount requested by the administration is totally inadequate to insure some breakthrough in the diagnosis, cure and treatment of Juvenile Diabetes. It is our recommendation that the NICHHD budget be increased to approximately $16 million for diabetes and related research, which is just over 10% of the Institute's total budget to emphasize research into diabetes-caused emotional, adolescent, growth and maturation problems as well as impotency and fertility problems as caused by diabetes. We also believe that, pursuant to your committee's Report language:

> "The NICHHD should expand research into enfant feeding as it leads to obesity and diabetes, pregnancy and diabetes, the children of diabetic mothers and the relationships between oral contraceptives and diabetes."

JDF supports increased funding for research manpower training in these important areas.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

Expansion of research at the National Institute of Neurological and Communicative Disorders and Stroke with research into:

-- Neuropathy due to Diabetes
-- Treatment of Neuropathy caused by Diabetes
-- Research into Stroke caused by Diabetes
-- Research into High Blood Pressure caused by Diabetes
-- Research into Pituitary complications caused by Diabetes.

Our "Add-On" Budget is just over $7 million for diabetes and related research.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASE

We recommend expansion of research with infused funding in the National Institute of Allergy and Infectious Diseases. This Institute must take a giant step forward with emphasis placed into the viral causes of Diabetes; research into development of a vaccine for prevention; research into infections due to Diabetes and treatment of these infections. The Juvenile Diabetes Foundation recommends an "Add-on" Budget of approximately $14 million into Diabetes and related research and manpower training.

NATIONAL INSTITUTE FOR THE AGING

New expansion for the Institute for the Aging budget must be accomplished this year. Diabetes today is one of the major problems of our elderly population. Research, manpower and training in this catagory is totally inadequate and we recommend an "Add-On" Budget of $4.5 million for research and training into diabetes and related research.

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

The increase of funding for establishment of diabetic cell collection for tissue culture, and research relating to genetics of Diabetes.

Expansion of Research manpower.

The Juvenile Diabetes Foundation recommendation of approximentally $11 million for Diabetes and related research.

NATIONAL DENTAL INSTITUTE

Expansion of the National Dental Institute's budget for emphasis on:

-- Preiodontal disease due to Diabetes

-- Tooth loss and bone loss

-- Basal membrane research

-- Expansion of research manpower.

The Juvenile Diabetes Foundation recommends an increase of $3,778,650 for diabetes and related research.

DIABETES RESEARCH AND TRAINING CENTERS

This Committee, in its FY 1977 Appropriations Report, stated that these diabetes research and training centers "will significantly enhance research, training, education and exchange of vital information on diabetes." We agree wholeheartedly and are pleased to report that several of these centers may be initiated during FY 1977. However, to insure that the directive that 15 centers be established is met and to insure that those established are funded so as to function effectively as centers for "applied research", we recommend that the Committee provide an appropriation of $12 million. This is vital to the Diabetes Program.

CENTER FOR DISEASE CONTROL

Section 4 of P. L. 93-354 in amending Section 317 of the

Public Health Service Act, broadened the responsibilities of the Center for Disease Control to include authority for programs in "communicable and other diseases," thereby providing the Center for Disease Control with the responsibility to establish Diabetes Control initiatives. Yet, in the absence of adequate appropriations, the National Commission on Diabetes in its 1976 Update reports that only a small effort has been possible. For FY 1978, we recommend an additional $3.6 million for CDC in order to implement a Diabetes Prevention and Control Program. Such an add-on would also provide for improved coordination and communications of agencies at the national, state and local level in efforts to evaluate and improve the delivery of health services to the patient with diabetes and his family.

VETERANS ADMINISTRATION

We are most distressed to learn of the lack of initiative at the Veterans Administration level. With the Veterans Administration lies a built in vehicle for clinical study and research into Diabetes.

A recommendation must be made by your Committee to expand Diabetes in the Veterans Administration.

## STATEMENT OF MR. AND MRS. J. GILPIN ALLEN

We represent almost the total long term complications inherent in juvenile-onset and mature-type diabetes mellitus.

My wife is a juvenile-onset diabetic; diagnosis was made 44 years ago on her eighth birthday. For 33 years, with insulin and diet, she maintained a comfortable life. During the last eleven years, per presence as a normal human being has deteriorated to almost zero. She is totally blind, with a serious heart condition and a host of neuropathies and other lethal complications. Current clinical expertise offers no hope.

Nine years ago, I was diagnosed a mature-type diabetic. During the last year, neuropathy in my feet has so encroached on my being as to make me unemployable. Within the context of what is known, I risk heart disease, hypertension, stroke and amputation. For my neuropathy and each of these complications, there are no durable therapies.

Our social and economic life is plagued with insecurity, frustration, social rejection, boredom, daily medical needs, psychological and physical problems that breed tension and confrontation--but worst of all is the sense of hopelessness.

From upper middle class citizens, we are reduced to unemployable, non-productive, non-taxpaying citizens who can survive only by the charity of our government, which we do not want.

We are two people who are a microcosm of what is happening or can happen to millions of diabetics. Our problem--their problems are vascular and neurologic. Therefore, we urge you to direct adequate new money to the Heart Institute and Neurology Institute where authoritative knowledge and leadership capabilities exist.

Mr. Chairman:

I am J. Gilpin Allen. My wife's name is Marian Allen. My age is 54 years; my wife's age is 52 years. Our residence for 16 years is 330 Castlewood Drive, Devon, Pennsylvania.

Until one year ago, I was an able-bodied male, capable of supporting and providing for the well-being of my family, contributing to gross national product, paying my share of federal, state and local taxes. One year later, I am unemployable.

Marian, my wife, is a multiple-handicapped, insulin-dependent, juvenile-onset diabetic. Her diabetes was diagnosed at the age of 8. Insulin and diet allowed her to live the next 33 years of her life in reasonable comfort. Then she lost her God-given human right to go where she wants to go; to see for whom she is voting; to work where she wants to work; to speak to whom she wants to speak. In eleven years, all these essentials to being a whole person were reduced to nothing by diabetes.

She is totally blind. She has a serious heart condition. She has neuropathy in the bowels, bladder, small intestine, colon and stomach. During the course of her progression toward blindness, she developed glaucoma and cataracts due to diabetes. Both can cause blindness. She had her cataracts removed with surgery. She was told there is no remedy for diabetic glaucoma.

As a result of her bowel and bladder neuropathies, she has continuing urinary infections, which we are afraid can lead to kidney disease. She retains significant quantities of fluid, which weakens the bladder walls and requires treatment with strong drugs. The neuropathy in her hips makes it clumsy to balance and walk steadily. The neuropathy in her hands makes it arduous to grip and feel. The diminished sense of touch in her hands makes it difficult for her to learn braille. Neuropathies in the intestines and stomach impede proper digestion. We fear this could progress to total failure to digest food and can lead to malnutrition and death.

From a simple blister, Marian developed a diabetic ulcer on her foot. For a year, she did not know if her foot or leg would require amputation or could be saved. Her doctor told her it is almost impossible to predict what will happen in the future.

As for me, nine years ago I was diagnosed a mature-type diabetic. Oral sugar reducing pills, diet and exercise are my daily prescription. I have diabetic neuropathy; my type causes severe pain in the bottom of my feet. Besides the diabetes, I am undergoing chemotherapy for two kinds of cancer. Having both diseases complicates suitable treatment for either. I'm unable to work because pain caused by neuropathy is unpredictable; the only relief is to elevate my feet and remove my shoes and socks. How can I hold a steady job with that demand?

Now, I am unable to support my family; stripped of my earning capability; unable to fulfill my role as a citizen and pay taxes; am potentially dependent on the charity of my government--which I do not want. The dignity of my wife and me has been shot to hell.

I live with the high risk of arteriosclerosis, blindness, amputation, hypertension and stroke.

I have been told....for the whole complex of complications, there are no dependable therapies. And what is worse--is waiting for the next domino to fall. Which will it be...kidney poisoning...hypertension... stroke...amputation???

What has this meant to our marriage? We were married in 1951, and led a fairly normal life except for my wife's diabetes control; that is, until 1962, when she lost the sight of her right eye. She continued working until 1968, when she started losing the sight of her left eye.

The knowledge of her impending total blindness, the loss of her job, and the diagnosis of my diabetes at this point was a triple blow. Over the next nine years, there was a series of medical crises due to the diabetes.

My wife's diabetes definitely influenced our consideration of having children. To begin with, the chances of her conceiving a child were poor, much less carrying it full term. As it happened, she had two miscarriages. This would seem fortunate in retrospect, since we both are diabetic and now know the consequences. We would not want to bring another diabetic child into this world.

The financial effect has lowered our income considerably. Marian receives Social Security benefits because of blindness, plus a small pension. I'm unable to work and too young to collect Social Security; therefore, I have no income.

From a social standpoint, it's hard to plan ahead, not knowing how either of us will feel. We've had to cancel many social engagements, or leave early because of intense pain. My wife's blindness and our diet complications make some of our friends uncomfortable.

All these factors create a terrific emotional strain on both of us, which, in turn, aggravates the diabetes. For example:

(1) the feelings of insecurity and frustration over our inability to work;

(2) the boredom that comes from inactivity;

(3) the daily grind is aggravating--the inescapable necessity of attending to our medical needs;

(4) the inability to support each other in the face of our overwhelming psychological and physical problems due to diabetes, and the resultant tension of our relationship; and

(5) the worst thing about all of this is the sense of hopelessness.

At least if we knew there was a stopping point that we could adjust to, we would not be so depressed. But...we know it is only going to get worse.

Mr. Chairman....While I speak for the need for expanded diabetes research in relation to my wife and me, I must identify with the multi-million people who are afflicted with a spectrum of unrelenting disease problems. My wife and I represent a microcosm of what is happening to or can happen to millions of diabetics.

Two people with private problems are unimportant. Ten million diabetics and the millions of heart patients with asymptomatic diabetes are very important to this country. They represent a blot on the God-given human right to live a decent life.

Mr. Chairman....under the strong leadership of Senator Richard Schweiker of Pennsylvania and this Committee on Appropriations, funds for diabetes research were increased during 1977 to a very significant $39 million in the National Institute for Arthritis. Small sums--like $3 million for vascular research in the Heart Institute--were added to the other Institutes whose expertise represents the long-term frightening complications.

For this beginning....I say "thank God."

The question today is not how much money Congress appropriates. Rather, it is how is this money spent? Will you appropriate new money in proportion to priority needs which, in our experience, are the complications?

I pray you will use your considerable office to establish the beginning of real hope for all of us by addressing reasonable...but important...new money to innovative vascular and neurologic research in the Heart Institute and the Neurology Institute.

STATEMENT SUMMARIZED

Dr. KIPNIS. Thank you.

Let me introduce myself, professor and chairman of the department of medicine at Washington University and physician-in-chief at Barnes Hospital at St. Louis, but I am here today as chairman of the National Diabetes Advisory Board.

I appreciate the time constraints under which you're operating and the other panelists who wish to participate, and I will try to keep my comments brief and paraphrase the report we submitted.

As you know, we had our first meeting on March 11. We had presentations at that time by representatives of the various agencies to give us an interim report as to what had happened between the time that the National Diabetes Commission had submitted its interim report to you at the end of November and the time of that meeting. Subsequently, for the past several weeks, various subcommittees have been working rather intensively in terms of developing their own committee substructure and also developing information we could provide you concerning the impact of the proposed budget on the long-range diabetes program.

It is in that area that I would like to confine my comments, primarily in the area of diabetes research programs, manpower development with diabetes research and training centers, health-care activities and management.

The National Institute of Arthritis, Metabolism, and Digestive Diseases is the major institute responsible for diabetes. This is reflected in the fact that nearly $40 million of the total diabetes program resides in that institute.

We have been very pleased that Dr. Salans has been selected——

Senator SCHWEIKER. I want to say I am very pleased with the work and job he's done. I know he's from my State, and I want him to know we do appreciate his work. I think he's dug in very well there and I have heard very fine comments about his work within the Institute and outside, and that isn't always easy.

Dr. KIPNIS. I think that is a critically important appointment. Irrespective of desires, individuals still are going to make or break most of these activities.

When we analyzed the budget for next year, the Board noted that actually the budget requested about 11½ percent decrease in the funding for research grants and contracts. That is in absolute dollars.

During the course of the initial year of operation, requests for applications were submitted and we were pleased that well over 300 applications were received by investigator initiated grant request covering a wide variety of areas from fundamental studies on the etiology of diabetes including genetics, viruses, to the very important yet pragmatic questions of diabetic complications extending from very sophisticated biochemical and physiological studies to more clinical oriented studies covering a very broad segment of the diabetes problem.

The current budgets would permit funding of somewhere between 40 to 50 percent of these new grant applications. However, next year's recommended budgets would permit funding close to about 20 percent of new projects.

Senator SCHWEIKER. 20 percent?

Dr. KIPNIS. Yes. This has been an analysis that has been carried out for us by Dr. Salans' office. This reflects a fact that a significant amount of the money involved in the current allocation has been used to quite correctly fund diabetes-related research that was already ongoing in the Institute. I think, therefore, this has had a catalytic effect not only on the diabetes program, but has acted synergistically with other major activities that we fund.

However, the decrease in grant request and contract request budgets actually creates a major problem for pursuing contract mechanisms in four major areas that have been identified by the National Diabetes Commission and which the Board fully concurs; namely, a cooperative study on the relationship between treatment and the development of diabetes complications, studies of pancreatic transplantation, the development of artificial devices for the control of blood sugar and development of experimental animal models for obesity and diabetes.

The lack of adequate funds may well prevent any significant contracts being let in any of these four areas. The Board, therefore, would like to recommend that the funding initially requested in the National Diabetes Commission report be maintained and that the research budgets, that is, research grants and contracts, be increased by $12½ million over the current proposed fiscal budget.

Now, the National Heart/Lung and Blood Institute request is in accord with the Commission's report. We would like to report to you that two requests for applications were submitted to the general scientific public. The initial request generated over 165 applications. About 61 of these were approved and approximately 45 percent funded.

At the present time, the second RFA is being reviewed. The National Eye Institute's proposed budget is maintained at its current 1977 level. As a consequence of this, two very meritorious programs cannot be expanded. They deal with cataract formation and retinal vessel tissue culture.

This is particularly disturbing because they had been identified by the review group several years ago that these two projects were two of the most innovative and potentially satisfying and productive ones currently in the diabetes field that are supported by NEI activities.

In addition, two major clinical trials, one of which was referred to by a previous panelist—namely the effectiveness of vitrectomy on hemorrhagic retinopathy—either will not be initiated or will be restricted by the request.

We have also been informed that the current budget request will be able to fund less than 25 percent of the approved grants in the field of diabetes.

Therefore, we support the recommendation of the National Commission on Diabetes that this fund be increased by $2 million. The Board hasn't had sufficient time to review in detail the requests of the other institutes, but we would support $1.4 million for NICHHD and $0.3 million for NINCDS.

Now on manpower, the Board is, frankly, distressed that the current budget does not address itself in either a constructive or meaningful fashion to the issue.

Senator SCHWEIKER. Let me ask you a question going back to your statement that the funding level would drop from——

Dr. KIPNIS. 39.8 to 37.9.

Senator SCHWEIKER. 20 percent I thought. The Institute will be able to fund less than 30 percent, probably in the range of 20 percent of new grant applications.

Dr. KIPNIS. That's right. What that speaks to is that research grants and contracts currently have $28.6 million budgeted for it, but will have next year $25.3, a $3.3 million decrease.

Senator SCHWEIKER. You're talking about the whole Institute now, right?

All right, go ahead.

Dr. KIPNIS. The actual budgeted amount for research grants and contracts is reduced $3.3 million, so if one takes into consideration current levels of application plus renewal requests, it is estimated that only about 20 percent of new grant, competing grant requests will be funded.

Senator SCHWEIKER. In the justification book it shows grants dropping from 278 to 83 which is what you are saying.

Do you want to say anything, Dr. Salans, to clear it up? I am trying to find out exactly why we have this dropoff. I realize the chairman of the board is in a new position. I am trying to find out why such a steep dropoff is expected from, what was the funding level you mentioned, 39 percent?

Dr. KIPNIS. Currently we are probably funding around 40 percent.

Senator SCHWEIKER. 40 percent to 20 percent, a dropoff in funding level of grants for diabetes?

Dr. SALANS. I think the reason is that having committed dollars this year to research grants and contracts that permits dollars for, as you know, in general at least 3 to 5 years——

Senator SCHWEIKER. I see.

These are multiyear contracts.

Dr. SALANS. Grants that have been previously awarded are now terminating. So these are now going into the competing type applications along with new research grants for individuals never funded.

Having committed all of this money, in this year, we will, therefore, be much less able to support new research, new competing research.

Senator SCHWEIKER. OK, I think you have answered my question. Go ahead.

Dr. KIPNIS. I would like to focus on the issue of manpower. It is a generic issue affecting basically the entire biomedical research and teaching community, but becomes rather evident in diabetes as a prototype of the more generalized problem.

For example, in the budget as proposed the National Institute has absolutely no funds earmarked in 1978 for new training activities in diabetes. NIAMDD budget which provides for a modest increase, one must recognize that even that modest increase is even more modest when a significant amount of clinical investigatorships and research career development awards are funded off of the research funding rather than off the training funding.

We were informed by the National Heart/Lung and Blood Institute, for example, that over the past 4 years there has been a 30-percent decrease in training funding and the proposed 1978 budget affords no relief for this.

These severe reductions over the past 3 to 4 years were, I think, evolved as an effort to decrease the training of clinical subspecialty

practitioners. It is interesting, though, that alternative sources of these funds have been generated, but for the research and teaching community alternative sources of funds have not been generated.

Consequently, the influx of new people into the field has been markedly diminished. When one recognizes adverse effects of such things as instability of research funding and security and financial rewards of private practice, one can readily account for the dramatic decrease in young people entering biomedical and teaching careers.

We feel that we would support the National Diabetes Commission's recognition, how critically important the availability of skilled individuals will be to, in essence, maintain and fulfill the long-term goals of the long-planned program they submitted.

For this reason, we recommend that $5 million be budgeted to the entire NIH with four manpower development, with final allocation to be made by the Associate Director for Diabetes after consultation and involvement with the directors of the various institutes involved and the National Diabetes Advisory Board.

That sum of money is consistent with the total funds requested in the National Diabetes Commission report. When it comes to training centers, I think this was an extraordinary approach to both the lay groups involved as well as to congressional review in that these centers were to have a tripartite function of research, training, and translating into health-care delivery—$6 million was allocated for this role.

To date, 14 applications have been received and are now under review. It is estimated that four or five centers will be funded by the end of 1977. It is estimated they will be institutions which already have major personnel, physical resources and training programs and have been able to coordinate them and mobilize them into an effective training center and research center.

However, the 1978 fiscal budget allows for no further centers to be established. Consequently, the development of new multifaceted centers of excellence in research training and education would be thwarted. Now, it seems to the Board that if the Diabetes and Research Training Centers is an important element, and we think it is an extremely important element, and if both the lay, as well as congressional support for these activities is justified, then either a decision should be made—either the program exists or is not available at all. For next year, there are no funds for such centers.

The Board, therefore, recommends that the National Commission's recommendation that $6 million additional be allocated, a total budget of $12 million be budgeted for this——

Senator SCHWEIKER. Wait, $6 million is for manpower. What is the other?

Dr. KIPNIS. $6 million was for diabetes centers. That is in the current budget but nothing is allocated in addition to that in the next year's budget. That means no further centers will be developed.

Senator SCHWEIKER. How much for manpower?

Dr. KIPNIS. $5 million.

Senator SCHWEIKER. That is separate from the $12 million. All right.

Dr. KIPNIS. Health care, education and control program activities have not been actively developed over the years and I think for

a number of justifiable reasons. One is it is an area where there is considerable ignorance although great demand. However, the Board would like to focus its comments on the CDC program. The CDC representative reported to the Board and the Board came up with the following two factors which we think have contributed to the failure to develop that program very well.

Senator SCHWEIKER. I was trying to find out from the hearing we had with CDC what happened to that program.

Dr. KIPNIS. Not very much. One is the reluctance of the CDC to initiate a program which involves multiple States and geographical regions when long-term funding for the positions is involved, about 50 or 60, appears to be rather tenuous and the initial moneys allocated were significantly less than recommended. The desire to set up intimate interactions with a variety of State agencies and involving people on a commitment which may be rather tenuous has been used by the CDC to explain part of what we detect as inertia in the developing program.

There is also a failure within the CDC itself to develop an in-depth analysis of the structure needed to accomplish the goals defined by the National Commission. It is also, however, pertinent to point out that the concern and skepticism of the CDC seems to be justified in that the current budget allocates only $500,000 to the total program, which is $1 million less than last year for what, as far as the Board can conceive right now, is a rather ill-defined area called health education.

Now, the Board, therefore, is in the position of wishing to support the National Commission's recommendations although we recognize that the Board also has a great deal of work to do in the coming year to really review in detail what is involved in accomplishing some of the goals that have been established.

I think that the circumstances today, whether or not the program should continue at all or be phased out, if it is continued at all, and I think it is a very important program, it is one that the National Commission and its consultant groups place great emphasis, then I think funding should be established at a viable level.

We have recommended acceptance of the National Diabetes Commission reports which is $6 million on that basis.

The last comment I would like to direct to you is the concern about management of the diabetes program at the NIAMDD and NIH at large.

On numerous previous occasions the Commission recommended that the policy be accepted that the associate director for diabetes be the principal program official responsible for planning, budgeting, and allocation of funds in the NIAMDD, and that this individual be consulted in all matters concerning this portion of the program.

The Board was disappointed to learn that the proposed fiscal budget for NIAMDD was developed without extensive consultation or involvement with the Diabetes Board. We think this leads to internal stresses that need not be present, recognizing and, I think that I should point out to you personally, that the NIAMDD is an institute with an extraordinarily broad scope of responsibilities. One has to be a Solomon to be able to wisely deal with such vast numbers of justifiable demands.

It does seem to me that consultation should be of assistance. At its initial meeting you attended the Board was pleased to hear from Dr. Donald Fredrickson that at NIH a Diabetes Coordinating Committee was being developed with the associated Director for Diabetes as its chairman to facilitate programmatic developments, increase institute collaborative research, avoid duplication of efforts and coordinate budgetary planning.

The Board commends this action and urges its early action.

Senator SCHWEIKER. All right. I think that is a very comprehensive statement.

I did let you go over the time limit because this is your first appearance and because I know you are speaking on behalf of an official group established by the Congress. You gave us, I think, some valuable insight into what we ought to be thinking about in terms of funding and where some of our problems lie.

So we certainly appreciate your well-structured and well-articulated statement.

Dr. KIPNIS. Thank you.

Senator SCHWEIKER. THANK YOU.

## AMERICAN DIABETES ASSOCIATION

## STATEMENT OF DONNELL D. ETZWILER, PRESIDENT

### DIABETES STILL MAJOR PROBLEM

Senator SCHWEIKER. Next, we will call the American Diabetes Association. Dr. Etzwiler.

Dr. ETZWILER. It is a pleasure to be here again.

I am a practicing pediatrician that handles between 400 and 500 juvenile cases at the University of Minnesota. I am national president, also former chairman of the National Commission.

Senator SCHWEIKER. That is right. You did a fine job with it, too, I might say.

Dr. ETZWILER. I would first thank you for your efforts on behalf of diabetes. The problem we have all faced is that we have really not had recognition of diabetes as the major problem it was. Probably after the discovery in 1921 everybody sort of anticipated that diabetes was a disease in whch one took insulin and lived happily ever after.

We found that problem certainly at voluntary health agencies, soliciting funds and so forth were very difficult. Probably the greatest function the Commission did was provide us with the realization of what a major problem it is.

You are well familiar with the scope of the severity and deaths and so forth.

The Commission report was really submitted as a 5-year, long-range plan at the request of the Congress and what we did was to really look at what were the needs around the country, what kind of resources were there, and then develop that plan, much of which was embodied in S. 2910, which you certainly championed and worked closely with that effort.

The Commission report was developed by some 300 consultants. Many were scientists; many were heard at national hearings around the country.

There were groups or individuals who felt at times that our requests were very minor, that we really should make larger requests. We felt the Commission was very honest in terms of what the needs were and scaled into an area in which we could achieve, recognized the area for, the needs for manpower, that it could not be developed overnight, but looked at it as a long-range plan and hoped in the acceptance of that by the Congress that they would gear it accordingly.

Last year, obviously for appropriations for 1977 we were very pleased with the appropriations at that time.

We are now looking at the 1978 appropriations. The last page of our submitted proposal states what those figures are. We are concerned, as Dr. Kipnis very nicely pointed out in detail on all of this, of the decreased funding of the NIAMDD, which drops the—the current proposal drops from 39.8 to 37.9. One of the areas we were very concerned about was generation of interest in manpower and interest in projects to be developed in diabetes at appropriate times, and some of the figures that Dr. Salans has presented us with are very indicative of the needs.

For instance, the Heart-Lung, when they put out their RFA, had some 163 applicants, of which 68 were approved, 31 funded. NIAMDD had 800 letters come in when they first announced in November. Of that, 300 applications were submitted, and those are under review.

Obviously, only a small portion of these are going to be able to be funded this year.

The centers' applications were very similar in need; 40 applications came in. These were reviewed, and some 40 centers are now chosen, at a level of dollars of funding, and the probability is that four or five of the centers will be accepted.

Dr. Kipnis pointed out that next year the Presidential budget does not call for increasing that, and we have asked they go from $6 million to $12 million for next year's to be maintained.

If it were to be maintained, obviously, at the recommended level by the Carter budget, it would mean the present centers would have to decrease their activities next year.

The other areas we are concerned about in the present proposed administrative budget are the total lack of support under NIAMH of CDC Health Services Administration. In those areas nothing is being proposed at that point. The Commission has suggested the figures of $1 million at NIMH and $6 million in CDC, some $2.5 million going into the HSAs.

The area of how we deliver health care cost has been grossly overlooked. One of the main areas is how we implement it at the research levels. At a time when we are being looked at for national health insurance, with so little research in the area of how to deliver this, is practically unbelievable.

We are concerned again about manpower training, as Dr. Kipnis recorded in that point, and we are also concerned in the areas of funding for the National Advisory Board. They have additional funds under the Assistant Secretary.

In general, we would like to point out we well know the requests of the National Commission last year were met very well by the

Congress. We are concerned about next year's funding, that this continue to be increased, and with the Commission report, is really a 5-year program.

Diabetes has not been conquered. It continues to increase in our population at the present time. We urge your continued support in these efforts.

Senator SCHWEIKER. All right, Doctor.

I was just seeing if I understand all the requests you have mentioned in your statement. In terms of the different programs mentioned here, would you care to give us any ranking of importance in terms of the moneys available?

Dr. ETZWILER. I think most people would certainly concur that research is imperative for a cure on the disease.

On the other hand, I do not think we can totally neglect the concept of health care delivery and how to get those advances in research out. That is a field where the health care system at the present time is grossly neglected, as to how do we move those things out of the research lab and implement them.

Senator SCHWEIKER. Will you give me a rough ranking, say, between basic research, training centers, CDC program, which obviously would take more funding—and the manpower. How would you rank those?

Mr. ETZWILER. Certainly I think research is definitely, and development of manpower to carry out the research, is imperative. The centers are very important. They begin to say research is important. We are looking at training and going into that area.

Finally, four you talked about—what other areas need—are important at the present time, but I think in some areas lack structure in which directions we ought to go.

Senator SCHWEIKER. All right. Well, thank you very much. We appreciate your presentation.

## JUVENILE DIABETES FOUNDATION

### STATEMENT OF MRS. ERWIN J. LURIE, PRESIDENT

#### CONTINUED SUPPORT REQUESTED

Senator SCHWEIKER. Now we will call on the Juvenile Diabetes Foundation.

Mrs. LURIE. I think you know us as a national voluntary health agency. I think you know our background and history.

In deference to time, I will submit, of course, my whole report in but there are certain things I have to point out. The seeds were planted in the diabetes effort, and we are back again asking for continued support, but we need to plant more seeds for a very good reason.

It is a year later, and I think we have learned an awful lot. When the commission submitted its report, it did it on a bare-bones budget. It was conservative thinking as to research.

As JDF has said for many a year, we felt the researchers were out there. Therefore, we are going to recommend larger funds into diabetes research and the whole long-range plan.

I think it is important to state that we have a disease which reaches out like an octopus. It reaches not only the Heart and Lung Institute,

and not only child development—which it hasn't touched enough, it goes into other areas that need support and much greater support.

We are talking about the Institute of Stroke, the Institute of Neurology. It is a whole circle.

I believe very sincerely that if the entire National Institutes of Health are funded with the infused funds into the proper Institutes, you will be getting back a lot more than anyone ever realized.

You have got to work for cure, you have to work for prevention, but above all, you must work for the alleviation of the complications. Research must find ways to prevent deteriorating diabetes complications.

Support has to go into cardiovascular problems, eye research, kidney research, they are all high priority items.

There is virtually no preventive research, and support must be given to genetics, nutritional causation of diabetes and obesity—of course, one day, that cure.

Diabetes must be encircled from every available vantage point at every available resource from the NIH to the Veterans' Administration, to the Department of Agriculture, to the Center for Disease Control.

Heart and Lung must have—they are the first ones really that stepped on the bandwagon. As I say, I will submit it all because I have very definitive strong suggestions, recommendations, which I know time is of the essence at this point.

Senator SCHWEIKER. I wonder, Carol, if you would give us an opinion on a question I asked the doctor.

Looking at three or four different elements here, how would you rank them in terms of consumers' need in the diabetic field: research, training centers, CDC, epidemiology programs, manpower?

How would you rank them, because we are going to have to take a hard look at where we are going to put the money.

Mrs. LURIE. Good, basic research, and with that has to go manpower because you can take care of today and pour in this money or infusion of funds into institutes, and if you are not also putting in manpower for the future, you are, aren't you, really emasculating the whole program as it continues and goes on?

So I consider basic research, manpower, diabetes centers, research training centers and care delivery. I think—I don't know how you can talk about research today without thinking about research tomorrow. I think they walk hand in hand.

Senator SCHWEIKER. What about the CDC program?

Mrs. LURIE. I think it is imperative. It is very, very important. Nothing has happened so far.

You hear excuses and reasons from all ends, but there has been no real forward movement at this point. I think there must be—put in figures forcing CDC.

I am also concerned with one other thing terribly, the lack of staffing and position to push the—how do you get that vehicle moving now? I don't understand how you actually—how Congress can say here are the funds, put it into diabetes at long last. The leading cause of death by disease, growing at the rate of 6 percent per year, and you give it no arms or legs at the staffing level as you put it together.

This seems incongruous as far as we are concerned. We completely agree with the long-range plan. I think it almost has to be a mandate.

If I can sum up all the opponents for—a potentially successful attack on diabetes can be made available if the correct input of dollars are added to the correct institutes as the JDF strongly recommends.

There will be a return benefiting all the diabetic communities and nations at large. So it almost becomes incumbent on the Congress, in my opinion—you start a program, with the work and effort that went into it, then when you start to think that some of the funds could be cut back—and that is just one institute.

It has to be a program that if Congress believes in what they did, you have to go forward on this.

I spent a lot of time going over the Commission report. I took a long time putting the testimony together. At about the end of the fifth day, I moved from my desk to a living room chair and said, "I think my brain's on fire at this point."

I came up with the feeling that what we have got here in diabetes is a blazing fire burning out of control. Only one single pressure can put it out, streams of pressure focused in can put out that flame until it exists no more.

We have a disease to eliminate and it's up to you, the committee and the Congress, to provide us with the pressure and power.

Thank you.

Senator SCHWEIKER. Thank you very much.

Your organization has been very diligent and innovative and very active in the field.

Mrs. LURIE. I promise you we will continue to be.

Senator SCHWEIKER. That makes our job easier in the long run.

## PENNSYLVANIA DIABETES INSTITUTE

### STATEMENT OF CARL STENZLER, PRESIDENT

### ACCOMPANIED BY MRS. MARIAN S. ALLEN

#### ORAL STATEMENT

Senator SCHWEIKER. Now we will call on Carl Stenzler and Mrs. Allen.

Please come forward.

Senator SCHWEIKER. Carl, I know you have some other people with you. Did you want them to come sit at the table with you?

Mr. STENZLER. This would coordinate as Terry had recommended. These were three individual requests. Each has a different piece.

Mrs. Allen is the problem and Dr. Behrendt will tell you what the problem is and where to go and Mrs. Hyde has the wrap-up.

I am going to read Mrs. Allen's statement since she is blind.

Senator SCHWEIKER. All right, go ahead. Another Pennsylvanian. This is an all-Pennsylvania day, right?

Mr. STENZLER. If you realize the enormous impact Pennsylvania has had on the international disease called diabetes, it is almost unbelievable, including its two Senators are the most interested Senators in the United States.

Senator SCHWEIKER. Thank you.

Mr. STENZLER. It runs all the way down the line. Senator Schweiker: You were one of those who got me interested initially back when I was a Congressman, so you can take a lot of credit for that.

Thank you.

Senator SCHWEIKER. All right.

Mr. STENZLER. Mr. Allen is ill, and is unable to read his paper.

Mr. Chairman, I am J. Gilpin Allen. Our residence for 16 years is 330 Castlewood Drive, Devon, Pa.

Nine years ago I was diagnosed a mature-type diabetic. Only 12 months ago I was an able-bodied male capable of supporting and providing for the well-being of my family, contributing to gross national product and paying my share of Federal, State, and local taxes.

Today I am unemployable. Marian, my wife, is a multiple-handicapped, insulin-dependent, juvenile-onset diabetic. Her diabetes was diagnosed at the age of 8

Insulin and diet allowed her to live the next 33 years of her life in reasonable comfort. Then she lost her God-given human right to go where she wants to go, to see for whom she is voting, to work where she wants to work, to speak to whom she wants to speak.

In 11 years all these essentials of being a whole person were reduced to nothing by diabetes. She is totally blind with a serious heart condition and neuropathy in the bowels, bladder, small intestine, colon, and stomach.

During the course of her progress toward blindness she develped glaucoma and cataracts. Her bowel and bladder neuropathies underly continuing urinary infections which can lead to kidney disease.

She retains significant quantities of fluid which weakens bladder walls and requires treatment with strong drugs. The neuropathy in her hips makes it difficult to balance and walk steadily; in her hands, makes it arduous to grip and feel.

The diminished sense of touch in her hands preludes properly learning braille. Neuropathies in the intestines and stomach impede proper digestion, a possible prelude to total failure to digest food and subsequent malnutrition and death.

A simple blister on her foot became a diabetic ulcer. For a year she did not know if her foot or leg would require amputation or could be saved.

As for me, I have diabetic neuropathy which causes severe pain in the bottoms of my feet. Besides the diabetes I am undergoing chemotherapy for two kinds of cancer. Having both diseases complicates suitable treatment for either.

I am unable to work because intense pain caused by neuropathy is unpredictable. The only relief is to elevate my feet and remove my shoes and socks. How can I hold a steady job with that demand?

I live with the high risk of arteriosclerosis, blindness, amputation, hypertension, and stroke. What does all this do to Mrs. Allen and me as human beings?

From upper-class citizens we are reduced to unemployable nontax-paying citizens who can survive only by the charity of our Government, which we do not want.

Insecurity, frustration, social rejections, boredom, daily medical needs, psychological and physical problems that breed tension and confrontation are aggravating.

The worst thing about all of this is the sense of hopelessness. At least if we knew there was a stopping point that we could adjust to we would not be so depressed. We know it is only going to get worse.

My wife and I represent a microcosm of what is happening, or can happen, to millions of diabetics. Two people are unimportant; 10 million diabetics are very important.

Mr. Chairman, under your strong leadership and the cooperation of this committee on appropriations, funds for diabetes research were increased during 1977 to a very signficant $39 million in the National Institute of Arthritis.

Small sums like $3 million for vascular research in the Heart Institute were added to other national institutes whose expertise represents the long-term frightening complications.

For this beginning I say thank God.

The question today is not how much money Congress appropriates. Rather it is, how is this money spent?

Will you appropriate in proportion to priority need which in our experience are the complications?

I pray you will use your office to establish the beginning of real hope for all of us by investing reasonable, but important new money to innovative vascular research in the Heart Institute, the Neuropathy Institute and the Eye Institute.

If you wish to ask Mrs. Allen any questions, she is prepared to answer.

Senator SCHWEIKER. First I want to thank you, Carl, for reading her husband's statement. I just wish that 99 other Senators would be here to hear it. You are talking to the wrong Senator.

It is like a preacher giving a sermon at church. All the people there hear it. The people who need it aren't there and don't hear. That is one of the problems we have with this disease.

Mr. STENZLER. Hopefully we can gain a direction. The vascular problem is so enormous and so little known and the neurologic problem is almost unknown.

This is the, really, heart of Mrs. Allen's statement. All of the diabetics fail from vascular problems. All the diabetics fail from neurology and neurologic problems. Other problems are not nearly so consistent with the great numbers involved.

Senator SCHWEIKER. Mrs. Allen, let me ask you this.

Would the new technique of photocoagulation, had it been known sooner, been of help to you back in earlier days with your sight condition, or is that a difficult question to know?

Mrs. ALLEN. I do think it is difficult to answer that because each case is individual and even though the long-range term, for each one of us, maybe in that area, hopefully it might have.

Yet you know I do think there have been people that would have had a lot of help with that. There were others of us who were not.

I was in a class of nine diabetics and out of them we were all blind. Some were helped with the laser.

Senator SCHWEIKER. Your husband mentioned in the statement about children. What did the doctors tell you about, if you did have children, what kind of chances would there be that they would have severe diabetic conditions?

Mrs. ALLEN. I came from an era where no one leveled with me. I didn't even know I could go blind from diabetes at the point I had it when I would have conceived.

Thank God we didn't have them. I wouldn't want to bring a diabetic child into this world under the conditions in which we are living. It is an insidious disease and my husband feels very strongly on this, too.

Senator SCHWEIKER. Is that a laser cane you have?

Mrs. ALLEN. Yes, it is.

Senator SCHWEIKER. How do you like it?

Mrs. ALLEN. I wouldn't be walking independently without it.

Senator SCHWEIKER. How does that compare to, say, a shepherd?

Mrs. ALLEN. Only less than 10 percent of the blind get dogs. There are a lot of reasons for that. With the additional complications of diabetes which is the neuropathy it has—this has been a saving grace.

I could not keep the pace of 4 miles an hour which is required to have a dog, with my neuropathy I could not maintain that pace and that is what you have to have to use a dog correctly because the dog gets distracted if it goes less than that.

So for us that do have neuropathy and complications, there are some that can use dogs and—but many of us can't. So it has been a godsend in getting around.

Senator SCHWEIKER. All right. Is there anything else you would like to say? I realize this is very comprehensive but perhaps you have something else?

Mrs. ALLEN. Hopefully you will see better, those of us who don't make it, with all the complications and there are potentially many more, that little is being addressed to this part of it, the complications.

Senator SCHWEIKER. All right.

We will call our next witness, then.

Thank you very much, Mrs. Allen, Carl Stenzler. Dr. Behrendt.

JEFFERSON MEDICAL COLLEGE OF THOMAS JEFFERSON UNIVERSITY, PHILADELPHIA, PA.

## STATEMENT OF THOMAS BEHRENDT, PROFESSOR OF OPTHALMOLOGY

### PREPARED STATEMENT

Dr. BEHRENDT. Good afternoon, Mr. Chairman.

My name is Thomas Behrendt. I am a professor of opthalmology at the Jefferson Medical College of Thomas Jefferson University in Philadelphia, Pa.

In the interest of brevity may I be permitted to make only some short remarks and introduce my full testimony into the record?

Senator SCHWEIKER. Without objection, we will put your full testimony in the record.

[The statement follows:]

## STATEMENT OF THOMAS BEHRENDT, M.D.

### SUMMARY

The impact of diabetes to date is mainly due to to the complications. Insulin regimes can be satisfied. Many diabetics do not need insulin. Actually by current concepts of diabetes there are many more diabetics that do not require insulin than those that do. All diabetics are at risk of "late" complications involving heart, eye, kidney, nervous system, small vessels throughout the body.

Based on the present status of the disease it is recommended that research scope in diabetes is expanded to include fundamental and clinical research in vascular and neurological involvement of diabetes. It is strongly recommended that new monies are made available to research in vascular and neurological problems in diabetes by necessary appropriations to the Institutes that have the expertise and leadership to conduct research in these areas, namely: the National Eye Institute, the National Institute of Neurology, Communicable Diseases and Stroke, and, the National Heart, Lung and Blood Institute.

Mr. Chairman, my name is Thomas Behrendt. I am a Professor of Ophthalmology at the Jefferson Medical College of Thomas Jefferson University in Philadelphia, Pa. Diabetes has been a special interest of mine since my medical school days. I wish to call your attention to the Allen couple who represent a dramatic example of the risk that all diabetics are exposed to.
It is, of course, always possible to present a dramatic, moving case of any disease entity regardless of how rare

or common. By themselves, the Allens would be just another case.

But the Allens are not by themselves; far from being alone, they represent the typical pattern of the disease of tens of thousands of juvenile diabetics, some ten million maturity onset diabetics and a huge, yet to be counted number of diabetics whose only sugar metabolism abnormality consists of some misbehavior of their glucose tolerance test curve. It may be argued that a person that every day has to take an exact amount of insulin critically related to activity and diet in order to fend off coma and death, does not suffer from the same ailment than a person that merely spills some sugar in the urine after an unusually large intake of carbohydrates This question is of considerable clinical interest but has detracted attention from the real pivotal question of diabetes, an enigmatic health care problem affecting hugh segments of our population. The critical issue with these patients today is not how or whether to control their sugar, but to determine what to do about the frightful late complications that threaten them. The crucial point is that the insulin dependent diabetic, the diet controllable one, the person with a glucose tolerance abnormality and the one on pills, all share the common danger of developing problems in their vascular and nervous systems. The consequences are as varied as they are catastrophic,as these two systems permeate the whole body and are indispensable to function and survival of all its parts. Some of the more common consequences, many of them so vividly demonstrated by the Allens, are heart disease, kidney

failure, blindness, loss of limbs, neuropathies disseminated in any or all parts of the body, and stroke. The neuropathy, leading to insensibility, pain and dysfunction opens a Pandora's box of tragic, self perpetuating problems. In it, is the blind diabetic that cannot learn Braille as he does not have enough sensation left in his fingers; the diabetic that does not notice a stone in his shoe and loses his leg due to the infection of the blister created by this stone; the diabetic that lost coordination to the point of no longer being able to take care of even trivial personal problems.

We are yet to measure fully the profound and long lasting social economic impact of these complications. The loss of quality of the life that these many millions of diabetics face does not come from the fact that a small minority of them, less than 1%, has to take care of their sugar metabolism problems in a painstaking and somewhat inconvenient way. Their tragedy is the host of impending or actual complications against which little or nothing can be done. It is important to stress that these complications occur in diabetics with all forms of sugar metabolism involvement. The vascular involvement in its early stages is extremely difficult to detect and study as compared to the study of the sugar metabolism problem in which rather simple laboratory tests will yield the key data. Consequently very little to nothing is known of the early stages of these complications and still less of their cause. We are here today to ask you to insure that this ignorance will not endure indefinately by making sure that there will be adequate resources available to investigate the question

ailments typified by the Allens.

It cannot be overstated that although we deal daily with the final stages of the diabetic complications, there is only the slightest knowledge of the early stages of such complications and still less of what sets the stage for their appearance. We are still living in the euphoria of the discovery of internal secretion glands, hormones, the isolation and clinical availability of insulin. All of this, however, is over half a century old. Bitter clinical experience, shared by everybody dealing with the long term diabetic complications, shows that there is little correlation between the occurance of the late diabetic complication and the forms of control possible in actual practice. There is no doubt that those diabetics that have marked sugar imbalances depending on insulin or strict diet control and pills will initially lead a better everyday life if they adhere to their recommended procedures to keep themselves under control. However, the traditional text book recommendation of keeping every diabetic under control of his blood sugar failed to fulfill the promise of avoiding the complications. Far less, it does not even seem to make a significant difference in their appearance, severity or incidence. It can, of course, be argued that all the diabetics showing complications merely failed to follow the recommendations leading to control and are now paying for their lack of compliance. Such argument lacks any supportive evidence showing that diabetes under better control fare better than those under poor control. It is extremely unfair to those for which control was a question

and does not consider at all the majority of the victims for whom the sugar metabolism presents no problem.

The Allens demonstrate dramatically the maiming impact of these complications. Blindness, in the diabetic, occurs basically either from the retinopathy with all its complications or from neo-vascular glaucoma. Contrary to the common chronic (open angle) glaucoma that can be controlled over long periods of time by rather acceptable therapies, neovascular glaucoma is practically uncontrollable leading rapidly to total blindness. Another visual problem facing large number of diabetics is cataracts, be it of diabetic origin or not. The surgery of cataract in diabetic is fraught with complications making it a far riskier procedure than the cataract extraction procedure in the non diabetic. Of these blinding complications facing the diabetic, at least the retinopathy and the neo-vascular glaucoma are clearly vascular complications and based on current knowledge are not related to control of diabetes, that is to sugar metabolism.

As an ophthalmologist, I am less authoritative in making statements in other areas of medicine. However, as an ophthalmologist I am in the unique position of being able to observe routinely the only representative vascular bed available to inspection without invasive techniques. The correlation of the status of these small vessels and vascular systems elsewhere in the body is the subject of long standing clinical investigation and a particular interest of mine. The appreciation of the basic similarities in the vascular involvement in the various systems and the impact that this represents on the patient brings me in front of you today.

The totality of the vascular involvement is beyond the possible scope of this testimony. Some of the highlights, however, should be mentioned. Arteriosclerosis has long been identified as one of the leading killers in our society. Diabetes has recently been identified as one of the leading factors in arteriosclerosis. Death from heart disease, kidney failure or stroke usually strikes in the decade after blindness from retinopathy occurs. The neuropathies so vividly exemplified by both the Allens are often associated with involvement of the vessels nourishing the nerves involved, although other factors may very well pay a significant role. It seems unquestionable that diabetes is more than an insulin substitution regime, a pill, a diet, an exercise plan. If the neuropathies and the vascular involvement could be conquered, the lot of the diabetics would be definitely ameliorated. There has been long standing, profound, and meritorious efforts investigating sugar imbalance questions. It is essential that we broaden our research efforts to cover the areas of vascular involvement and neuropathies. It is clear due to the far larger complexity of the problems that results may be slow in coming in. However, if we want to avoid innumerable repetitions of catastrophies like the Allens, we must be willing to change the scope of our investigations.

Mr. Chairman, would you please use the authority of your position to insure that adequate new monies are made available to research in vascular and neurological problems in diabetes by the necessary appropriations to the Institutes that have the expertise and leadership to conduct research in these areas, namely: the National Eye Institute, the National Institute of Neurology, Communicable Diseases and Stroke, and, the National Heart, Lung and Blood Institute.

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ABSTRACT OF STATEMENT

Dr. BEHRENDT. Thank you.

Every medical self-interest group is able to bring forth a pathetic case of the disease they are interested in. The question really is not how pathetic is such a case but how representative it is of problems that may afflict large segments of our population. The Allens represent millions at risk.

We do not know what diabetes is. It is customary to hide this ignorance in classifications based on the sugar metabolism problems of the patient. Thus, we speak of a juvenile onset diabetic desperately dependent on insulin, and there are some 80,000 to 90,000 of them.

We speak of maturity onset diabetics requiring some insulin, and there are some 80,000 to 90,000 of them. We speak of maturity onset diabetics requiring some insulin, diet or pills: There are some 10 million of these. We speak of chemical diabetics who only show some changes in glucose tolerance curves; we never managed to count those. Those three apparently desperate groups, however, are all at risk of the late complications involving among others, heart, eyes, kidneys, brain peripheral nerves and vessels. The Allens exemplify vividly some of these problems. By and large, these problems are resultant from the involvement of the vessels and nerves in the affected areas.

Mr. Chairman, it is time that we admit publicly what every doctor working with diabetic complications knows the promise held by insulin, the traditional statement of the texts, that insulin would present a substitution therapy which if properly administered would make the diabetic a normal human being, is not true. At least the clinical feasible control of the diabetic does not avoid the complications. We do not have any data that better control may do so. It is unsubstantiated by facts and actually cruel to consider that people like the Allens are now paying for their noncompliance with regimes under which they were placed. Further such concepts do not explain the complications in those that do not suffer from overt imbalance.

What happened to the Allens? She is blind; what her retinopathy did not destroy was destroyed by the uncontrollable vascular glaucoma. What caused all this? Basically a vascular involvement. She has problems moving around due to neuropathy in her feet and hips. Her husband cannot work due to similar neuropathy. You heard how neuropathy transverses her system like a red thread.

What causes neuropathy? We don't know. It is often related with vascular involvement of the affected nerves. What else does the vascular involvement do? It creates heart disease, kidney failure and strokes. It leads to loss of limbs. Diabetes has recently been identified as one of the leading factors in arteriosclerosis, a major killer in our society.

What have we done about all this? There has been a long-standing meritorious research effort along the lines of sugar metabolism. Research in early vascular changes and early neuropathy is, by its nature much harder. However, if we want to avoid the perpetuation of catastrophes like the Allens we must accept this challenge.

We must realize that the progress will be slow, but we are faced with the plight of this large segment of our population.

Mr. Chairman, let me leave you with the plea to use your position to insure that adequate funds will become available for research in vascular involvement and neuropathies by allocating adequate amounts of new moneys to research in vascular and neurological problems in diabetes by the necessary appropriations to the institutes that have the expertise and leadership to conduct research in these areas; namely, the National Eye Institute, the National Institute of Neurology, Communicable Diseases and Stroke, and the National Heart, Lung and Blood Institute.

Thank you.

Senator SCHWEIKER. Thank you, Doctor.

As you can see, the chairman of our subcommittee has come. He is about to take over in a second shift and conduct another series of hearings after I complete.

Before we do that, with his indulgence we will hear from Mrs. Hyde.

Mrs.Hyde.

PENNSYLVANIA DIABETES INSTITUTE

## STATEMENT OF MRS. FLOYD H. HYDE, PENNSYLVANIA DIABETES INSTITUTE

### INTRODUCTORY REMARKS

Mrs. HYDE. Mr. Chairman, I am Mrs. Floyd H. Hyde, vice-president of Floyd H. Hyde associates, a team concerned with comprehensive health service and health care delivery service in our cities.

I am speaking today on behalf of the Pennsylvania Diabetes Institute, an organization which represents a consortium of doctors from all the medical disciplines impacted by or impacting on diabetes mellitus.

In the past few years, PDI is proud to have worked with members of this distinguished subcommittee and others who have spoken here today to achieve greater public awareness of the seriousness of diabetes to obtain more Federal funds for basic medical research into the cause, cure, and preventive and arrest therapies, none of which is definitely known, of this disease, which affects so many Americans.

We have worked with Members of Congress on the development of legislation which creates the first congressional mandated organization designed to specifically address the needs of diabetics. As a caveat, we do wish to commend the subcommittee for its foresight in developing language in its reports and legislation which has enabled such advisory groups and for taking the lead in generating national consciousness to the allocation of funds for research in therapy as to the seriousness of diabetes.

### PREPARED STATEMENTS

However, at this point I will digress and ask the whole context be entered.

Senator SCHWEIKER. So ordered without objection.

[The statements follow:]

STATEMENT OF MRS. FLOYD H. HYDE

Mr. Chairman, members of this distinguished Subcommittee: I am Mrs. Floyd H. Hyde, speaking on behalf of the Pennsylvania Diabetes Institute. This organization represents a consortium of doctors from all the medical disciplines impacted by, or impacting on diabetes mellitus. Its primary charge, issued by Governor Shapp of Pennsylvania in 1972, is to evaluate and recommend change for increased efficiency and effectiveness in national health policies and programs relating to diabetes. Functioning primarily as a catalyst for change, the Institute has been instrumental in bringing together a "coalition of concern" among the various public and private national interest groups concerned with diabetes mellitus, members of the National Administration, and member of Congress. The Institute neither participates in nor benefits directly from its recommendations at any time.

In the past few years, PDI is proud to have worked with members of this distinguished Subcommittee and this panel to achieve a greater public awareness of the seriousness of diabetes; to obtain more Federal funds for basic bio-medical research into the cause, cure, and preventive and arrest therapies (none of which is definitely known) of this disease which affects so many Americans; to focus on the development of legislation which created the first National commission addressed specifically to the concerns of diabetics and charged to develop a long-range plan to combat the disease in the future—the National Commission on Diabetes; and to have helped increase the range of focus of this Commission's successor, the National Diabetes Advisory Board, whose broad membership truly relects the multi-disciplined nature of the diabetes mellitus syndrome.

We wish to commend this Subcommittee for its foresight in developing language in its report that enabled such advisory groups to evolve; and for taking the lead in attempting to generate a national consciousness through the allocation of funds for research and therapy as to the seriousness of diabetes. As other members of this panel have testified, as we ourselves have testified in the past (a copy of our testimony of May, 1975, before the House Subcommittee on Appropriations, is appended for reference), the deleterious and often lethal impact of the complications of this disease affect all parts of the human body. According to statistics accumulated by the American Diabetes Association, one out of every four persons in America today is a carrier of this disease.

Therefore, given the quality and quantity of the seriousness of the problem, PDI feels a moral responsibility to urge this Subcommittee's careful review of proposed funding levels of the various National Insititues of Health, and HEW in general.

We acknowledge that, today, everyone is clamoring for more funds, both as a result of inflated costs that prevent existing monies from being used with maximum effect, and because of increased human need. But, we must urge this committee, in its deliberations by appropriate funding levels for each of the Institutes, to consider the following:

(a) The loss of potential incoming revenues from income producing persons, and the high, ever-increasing expenditures from the national treasury in health maintenance costs if adequate funds for preventive research and arrest therapies for ongoing complications are not made available.

The combined loss to the GNP of billions in tax revenues and productivity loss and of millions in increasing expenditures for demand services in the form of federal health care and health maintenance, create an intolerable taxpayer burden of hundreds of billions of dollars. This can be expected to reoccur with a 10 to 20 percent increase during each coming year.

(b) The multi-disciplined nature of the disease is such that no one Institute of the NIH should be favored with increased sums of money.

Increased attention is necessary in all Institutes if some surcease is to be achieved. Additionally, Federal attention must be devoted not only to people who have suffered, but to prevent others from suffering in the future. Currently, this is not being adequately addressed.

Additionally, as a nation, we have failed to rationalize and adequately fund health and social support service delivery within HEW in a way that the services are complementary, and more beneficial to recipients. The various elements of HEW are so fragmented and torn within their own interest areas that no competent national health policy exists. Rather, there is constant competition and conflict of goals and objectives among all HEW programs, and especially within NIH. Such activity only further negates the limited effectiveness which the small pot of money designed to deal with so vast a problem as our Nation's health can have, and must be rationalized and harmonized. This need is especially great for diabetics, who, because of the systemic impact of the disease throughout their bodies, require so many of the related support services. (As a caveat, we note with an element of hope the efforts of the Current Administration, to reconcile this confusion.)

(c) The lack of adequate health data for establishment of objective criteria for determination of health expenditure priorities and the allocation of limited national resources for health service delivery.

No disease index yet exists which gives any disease, or parts of a disease as in diabetes mellitus, any measurable dimension by which the extent and seriousness of the problem can either be determined or be evaluated for priority against the impact of other diseases, or parts of the disease as in diabetes, in our population. Neither does such data exist to determine criteria for allocation of funds for research care and therapy based on priority of need.

In light of these points, PDI makes the following observations and recommendations:

(1) We urge this Subcommittee to carefully review and reconsider the proposed budget which maintains, at best, given the inflation and need factors, the current budget levels.

Because of the multi-faceted nature of the disease, we are in basic agreement with the proposals for the need for increased funds within all NIH Institutes set forth here today. However, we wish to stress that recent medical evidence suggests that, as regards diabetes mellitus, additional funds be allocated to other Institutes, in addition to the NIAMDD, than are proposed by the ADA and the JDF, because of the direct relation between the diseases which they study and diabetes. We respectfully urge this Subcommittee to particularly review recent data on the importance of heart disease, neuropathy and blindness in the diabetes mellitus syndrome; and to consider recommendations within the Committee Report that any discretionary monies available within the individual Institutes be, at least, partially directed toward additional research on this linkage. The more quickly this is done, the more rapidly our national health costs and the net loss to the GNP can be reduced.

(2) We urge the Subcommittee to give attention to the inter-relationship between the services provided within NIH and the more consumer-oriented services within HEW as a whole, and to recommend that such coordination be carried out in its Report.

Allocation of additional funds for such services as the Emergency Medical Service, and Health maintenance organizations, given the need for more doctors and the high costs of maintaining chronic illness; pre-natal, genetic, maternal, and family crisis counseling; job counseling and training for handicapped individuals; and efficient health crisis detection centers is essential. These services are of especial benefit to Diabetics: but also, service the communities in which they live. Adequate funds are essential to insure effective service delivery and the ultimate integration of Diabetics into our total society.

It is our belief that better coordination might help, although surely not eliminate, the negative impact on our work force and unemployment statistics, as well as reduce gross costs for the numbers of people requiring demand services. Clearly, the constantly escalating costs which the Nation has witnessed in these areas in recent years can no longer be tolerated. Neither, even more important, can the human costs. We believe this Subcommittee can recommend ways in which linkage could be achieved, and, since the total outcome is one beneficial to both our national physical and fiscal health, might well consider recommending the allocating of discretionary funds to achieve this end.

(3) We urge this Subcommittee to recommend in its Report appropriation of discretionary monies to the full amount authorized for the National Diabetes Advisory Board.

As you know, this Board is charged to evaluate current research and programs first, and to make recommendations for change to both the Secretary of Health, Education and Welfare and to the Congress as such changes may be beneficial.

Membership composition is significant in that it comprises a Board which, for the first time, reflects the true multi-faceted aspects of diabetes and which could provide an interdisciplinary forum for further discussion among the many medical disciplines negatively affected by the disease, and to address the broader questions we have already commented upon. In our opinion, this Board is crucial to achieving the success in the resolution of any of the above noted problems.

Only through such monitoring and evaluation of ongoing health policy, research and programs as it may undertake, can there be true assessment of health needs and establishment of national health priorities, and an end to "the disease of the month" syndrome. Only then can limited financial and manpower resources be allocated most efficiently and effectively. Only then will we be able to fully determine the inter-relationship between the different Insititutes of NIH which must be achieved in future research efforts. And only then will we be able to adequately assess what facilities, policies, programs, and legislative tools are already available within HEW and other branches of government to provide the necessary social and health support services for those afflicted with diabetes mellitus.

In closing, let me thank this Subcommittee for this time to speak and, more importantly, for its foresight in recognizing the terrible need for addressing the problem of the millions of diabetics and potential diabetics in our country today. It is our hope that you will continue to take the lead in developing legislation and innovation in this field; that you will make not only your concern available to the public at large, but the necessary funds as well. As a Nation, we must commit ourselves to developing new, broadened strategies and methods for confronting a major killer and disabler of our Nation's people. We must reassess our national priorities and give proper, and long overdue consideration and funds to whether our people live or die.

STATEMENT OF CARL STENZLER

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, diabetes mellitus was the eighth cause of death in the United States. Now, it is rated by Dr. George Tokuhata, professor of epidemiology 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 of 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.

Incidentially, 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.

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 adminstrations 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.

HIGHLIGHTS OF STATEMENT

Mrs. HYDE. PDI feels a moral responsibility to urge the subcommittee's careful review of proposed funding levels of various NIH institutes and HEW in general. We acknowledge that today everyone is clamoring for more funds, both as a result of inflated costs that prevent moneys from being used with maximum effect and because of increased human need, but we must urge this committee in its deliberations by appropriate funding levels for each of the institutes and HEW to consider the following three points: Loss of potential incoming revenues and the ever-increasing expenditures from the National Treasury in health maintenance costs if adequate funds for preventive research and arrest therapy for ongoing complications are not made available. Combined loss to the GNP of billions in tax revenue and productivity loss and millions for demands of services creates an intolerable tax burden in the hundreds of billions of dollars.

The nature of the disease is such that no one institute of the NIH or HEW should be favored singularly with increased sums of money. Increased attention is necessary in all the institutes if some success is to be achieved. Additionally, Federal attention must be devoted equally to people who have suffered and to the prevention of others from suffering in the future. Currently this is not being adequately addressed. In addition, as a Nation we have failed to rationalize or adequately define health delivery within HEW in a way that the services are complementary and more beneficial to recipients. The various elements of HEW are now so fragmented and torn within their own interest areas that no competent national health policy exists. There is constant competition and conflict of goals and objectives among all HEW programs, and especially the NIH. Such activity only further negates the limited effectiveness which the small amount of money currently designated to deal with so vast a problem as our Nation's health can have and must be rationalized and harmonized. This need is especially great for diabetics because of the systemic impact of the disease throughout their body that requires so many related support services.

Finally, lack of adequate health data for the establishment of objective criteria for the determination of health expenditure priorities and allocation of limited national resources for health service delivery. Currently, no adequate disease index currently exists which gives measurable dimensions by which priorities can be evaluated and the disease could be measured for impact and seriousness against other diseases and, given the limitations currently facing our National Treasury, such establishment of priorities as you have outlined today is absolutely critical.

In light of these points, therefore, we urge this subcommittee to carefully review and reconsider the proposed budget which maintains at best, given inflation and need factors, current budget levels.

Because of the multifaceted nature of the disease we are in basic agreement with proposals for the need of increased funds presented here today.

However, we wish to stress that recent evidence suggests additional funds be targeted into other institutes focusing on heart disease, neuropathy, and blindness.

We respectfully urge the committee to consider recommendations within its report, that any discretionary moneys available within the respective institutes be partially targeted at least toward additional research on this and on development of preventive and arrest therapies for the present.

The more quickly this is done, the more rapidly our national health costs, and net loss to the GNP, should be reduced.

Second, we respectfully urge the subcommittee to give attention to the critical interrelationship between support services provided within NIH research and the more consumer oriented services within HEW as a whole, and to recommend that such coordination be carried out or at least explored in its report.

Allocation of additional funds for services such as the EMS and HMO's, given the need for more doctors and high cost of maintaining chronic illness, prenatal, genetic, maternal, family and individual counseling, job counseling and training of individuals and efficient health centers is absolutely essential.

Obviously these services have special benefit for diabetics, but they also provide very valuable and absolutely essential services to all people in communities where diabetics live.

Furthermore, we believe that better coordination among these programs and NIH as well as with private sector talents, while it will surely not eliminate negative impact on our work force and unemployment statistics, may well reduce gross costs and the numbers of people required for services.

We believe this committee can recommend in its report ways in which such vital coordination could be achieved, and that the total outcome would be beneficial to both our national physical and fiscal health.

Third, we recommend—we urge this committee to recommend in its report appropriation of discretionary moneys to the full amount authorized for the National Diabetes Advisory Board.

As you know, this Board is charged to evaluate current research programs first and to make recommendations for change to both the Secretary of HEW and to the Congress, as such changes may be beneficial. However, the current budget shows no specific funds allocated for this. This money does come out of discretionary funds.

Senator SCHWEIKER. I wonder if we might put the rest in the record. I see Senators waiting. I am running late. I am imposing on the chairman's time.

Senator MAGNUSON. Oh, no, you are not. Go ahead.

Senator SCHWEIKER. All right. Go ahead.

Mrs. HYDE. Thank you, Mr. Chairman.

Senator MAGNUSON. Can I ask you a question? I am deeply interested in what you are saying. Senator Kennedy is. He handles the authorization.

When you talk about full funding——

Senator KENNEDY. That is because I listened to Senator Schweiker on diabetes. [Laughter.]

Senator MAGNUSON. No one has done more on this committee than the Senator from Pennsylvania to spur this on. I think last year's report is one of the prime examples, but we are a money committee. We listen to all these things. We know what the problem is.

I think that a lot of people do not realize that diabetes is the third worst killer we have when you get down to it. We have to have some figure, and what do you suggest?

Mrs. HYDE. For a total appropriation?

Senator MAGNUSON. Yes. What is your target?

Mrs. HYDE. I am not sure. Let me explain why I say that.

Senator MAGNUSON. The reason I asked you, because we are not sure either, because we have put the diabetes appropriation in several of the institutes last year because it is one of these diseases that is interrelated. It is a little difficult.

We hear a lot of expert testimony and have tried to separate the program so that more attention is paid to it.

You have no particular figure?

Mrs. HYDE. Let me differentiate funding.

Senator MAGNUSON. I know it is above the budget. We have to watch that, too, you know. I have been on this Committee for many, many years. I have been vetoed five times by putting extra money, primarily in the health field.

Senator SCHWEIKER. You have overridden the vetoes, too.

Senator MAGNUSON. Yes, lately we have been overriding and have a little hope.

Mrs. HYDE. Let me differentiate the budgeting I discussed here into two areas. One deals with what is allocated in NIH. That, since I am not a medical expert, I can only say that it does seem to me, given the apparent interrelationship between diabetes and the other areas outlined in previous testimony here today, that many more millions are needed. I recognize the Congress is operating under serious constraints. I would argue that money be targeted rather than spread throughout the institutes to the areas of greatest needs. On the issue we are recommending that this committee urge that the discretionary funds from which its funding will come will be made available to the fullest extent possible in order that that committee can maintain its congressional mandate.

That figure under the authorization legislation was $300,000.

Senator MAGNUSON. I do not think we have much problem with that. I do not. Of sufficient funds to keep this moving. But our problem is the spread. We have got diabetes here in the Cancer Institute, we have it in the Heart and Lung. Dental research is even in there.

Mr. STENZLER. May I sort of conclude this because we are holding up an awful lot and I am very grateful that you are asking us to talk. Let me try to if I can answer what Mrs. Hyde did not.

I mean, I have a wee bit more familiarity with it. The question of where money would go, in terms of the Institutes I think, can be measured by several things that occurred during the last year. During last year, only several weeks ago, Dr. Levi announced that diabetes was one of the four major causes of heart attack. This in itself, heart attack, is the biggest killer in the country, and diabetes in all its enormity with that additional appendage is a frightening thing.

Senator MAGNUSON. Let us get down to the facts. We know how frightening it is.

Mr. STENZLER. Last year Dr. Levi, the fund they requested was $10 million to $15 million with which to literally begin research. You cannot just take—take, I think, a million, give them 100 million bucks. They would not know what to do with it.

So that 10 or 15 a year would be an adequate beginning over and above what little they are doing now. The Institute of Neuropathy discussed areas within the $5 million to $10 million figure. They know so little about it that they were hesitant to even ask for that much because you do not need money to begin a very small program. You need to build on that. The figure in that area which is critical is somewhere between $3 million and $5 million in excess of what they have got now.

Mrs. HYDE. Mr. Chairman.

Senator MAGNUSON. Excuse me. Ted, do you want to go on?

Senator KENNEDY. I do not want to interrupt, but I can come back in an hour. Would that be OK ?

[Discussion off the record.]

Senator KENNEDY. I just want you to know you have my strong support.

Mrs. HYDE. May I say one thing?

I wasn't trying to convert people who are already converted. It was a matter of dealing with issues, not only the need for money but get into management and support of other services and functions of the board.

See, Senator, the reason I can't answer your question about how much money is because nobody really knows. One of the functions of the board and the reason I am hitting on the need for full-funding for their functions is that they are charged to evaluate and monitor what is currently ongoing and to assess existing facilities and programs and then to make recommendations——

Senator MAGNUSON. Well, we understand that. We have had a problem out at NIH. I am hopeful with the new director that the President has confirmed will continue to do a very good job. There are times that feuds go on out there, I understand that.

We still have to come up with a figure.

Mrs. HYDE. Well, the recommendations—respectfully, sir—as to how it is to be used.

Senator MAGNUSON. Well, we always recommend that they get together out there and do a better job. That is obvious. We put that in every report. I think by and large we have the best research in the world, by and large.

Mrs. HYDE. Yes, sir, I agree, sir.

Senator MAGNUSON. Our problem in health is what Senators Kennedy and Schweiker have directed themselves to over the years; our problem is delivery of health. That is what our problem is. We are not getting it down.

The research is good. It is some of the finest. It can be better.

## STATEMENT OF HON. EDWARD M. KENNEDY, U.S. SENATOR FROM MASSACHUSETTS

Senator MAGNUSON. All right, Senator.

Senator KENNEDY. Thank you, Mr. Chairman.

This is a working sheet which is before the committee. I thought if we could just go with this working sheet. I will submit the full statement and commentary on each of the provisions.

Senator MAGNUSON. We have them.

Senator KENNEDY. The first item is community health centers. We go from $229 million which is the Carter budget, to $254 million. I would mention just two or three very brief comments on this.

In the area of cost and cost control, we have seen in the community health centers a reduction of 34 percent in terms of hospitalization for those involved in these particular programs, and a reduction of 28 percent in terms of infant mortality and 50 percent reduction in days of hospitalization for children.

The best estimate is the number of people that will use it will climb from 2.5 to 3.3 million in 1977.

The Community Health Centers are very important in terms of cost control.

Senator MAGNUSON. That would be 25 million.

Senator KENNEDY. Yes.

Senator MAGNUSON. Approximately.

Senator KENNEDY. Approximately.

Senator MAGNUSON. OK.

Senator KENNEDY. Migrant health—basically what we are talking about is less than 15 percent of the migrants are now being served in that particular program.

The Congressional Budget office says just to maintain the current service of 125 centers, you will have to go to $32 million, so we go to $35 million. It is a very small—but it is essential.

Senator MAGNUSON. $3 million more.

Senator KENNEDY. $3 more than current services.

I have neglected to mention, Mr. Chairman, that with all matters not mentioned here or in my written statement, I would recommend the same figures as President Carter.

Let's now turn to the Health Maintenance Organization figures.

The HMO programs—Senator Schweiker and I have been wrestling with this issue for 5 years. Senator Schweiker is extremely familiar with the changes we made last year in order to try to encourage——

Senator SCHWEIKER. Have you seen the new figures? They have gotten a lot of new applicants in already because of this. They do need some money.

Senator KENNEDY. We passed a $2.2 billion authorization on an HMO program about 5 years ago. Eventually, we are all the way down now to $15 million.

The Carter administration recommends $18 million, the same as 1977.

We have seen, in terms of the savings under medicaid—in my own State of Massachusetts where we have seven or eight of the programs, we have a 30 percent reduction in terms of Medicaid, the comparative costs.

What we are basically hoping on this is to give it just a reasonable chance in terms of an alternative way of delivery.

Senator SCHWEIKER. You mean 30-percent saving over the old way?

Senator KENNEDY. On the fee for service under medicaid. Just in comparing in the Harvard community program, which has to take a certain percentage of their membership at random in comparing that with the other program, we are having a 30-percent savings in terms of the medicaid program.

Basically, what we hope, Mr. Chairman, is if we give a reasonable opportunity under the HMO program, both in terms of cost and quality, then we can come back in 3 years or whatever and say, "You know, this is what is happening in terms of our country."

I think we can make that case. We want to give it a reasonable try.

So we are just asking that it be increased that amount.

Senator MAGNUSON. How much?

Senator KENNEDY. We go up to $30 million.

Senator MAGNUSON. You suggest $30 million?

Senator KENNEDY. That is right.

Senator MAGNUSON. All right.

Senator KENNEDY. For the Center for Disease Control—I would recommend $22,000,000 for venereal disease project grants. The administration recommends $18 million. For the Institutes of Health, I would suggest 1977 appropriation plus 6 percent. We are doing an extensive review of NIH.

Then there is an increase in the community programs in the areas of alcoholism, which I think are justified—$82 million for project grants—as compared with administration recommendation of $69 million.

Senator MAGNUSON. We just marked up the supplemental over there and added a little, just now.

Senator KENNEDY. OK. Good.

Now, on page 11, coming into just really the final programs I want to mention, that is in the areas of health resources and also the manpower programs.

It starts with health resources administration.

Senator MAGNUSON. Page 11?

Senator KENNEDY. That is right.

Now, we go down to the planning programs. I have submitted written recommendations on the health resources. I think the planning and resources development programs are absolutely crucial. This is

the absolutely crucial area in terms of a certificate of need to insure we won't have duplication of planning and services.

The planning agencies are the ones best equipped to do it. I have submitted written recommendations what the support ought to be for the planning agencies, what state agencies, the transitional cost, even rate regulation. These are all higher than what the Carter administration does.

The resource development fund is important in terms of taking the recommendations of the planning commissions and actually implementing them.

Senator MAGNUSON. Well, I have your figures here. They are going up——

Senator KENNEDY. I have a justification. Rather than delaying your time, I want to just impress upon you, as I know that you understand, the importance of the planning function in terms of what it can mean in long-term savings for getting the elimination of either facilities—I mean hospital beds—we have 200,000 more hospital beds than we need. It is costing about a billion and a half dollars a year.

To bring all of those into focus, which the States are wrestling with now, they really need the kinds of requests we have made in this particular area.

Senator MAGNUSON. In that case, the Carter budget for all those items—

Senator KENNEDY. $125 million.

Senator MAGNUSON. $125 million.

Senator KENNEDY. We say $176 million.

Senator MAGNUSON. Up $51 million.

Senator KENNEDY. $176.

Senator MAGNUSON. Total.

Senator KENNEDY. The last item I would like to mention is in the very important area of our Health Professions Act, the manpower program. First of all, you know that the institutions themselves have been under the heavy restraint of continuing resolution for the last 3 or 4 years, so it is important in terms of catching up for capitation for the MOD's to be fully funded.

It isn't right, I think, they have been held down in the continuing resolution and move from there.

As we saw 25 years ago, 80 percent of the medical graduates were GP's, 20 percent specialists. Three years ago, the other way around. Yet the public needs the general practitioner—I am therefore recommending higher figures for family medicine, primary care and in particular pediatric residencies and training.

We also have an underserved problem. So we have through the financial kind of mechanism tried to work out—working with the medical schools so we would have a higher number of GP's, and also through the scholarship program more money going through the students which had the obligatory service, going to pay that off in underserved areas—we are trying to get people out into the eastern slope of the State of Washington down into the dells, some of those areas that you are very familiar with. We need full funding for the National Health Service Corps and exceptional need scholarships.

I am exceedingly hopeful that we can get adequate funding in terms of the professional health manpower.

We have, as Senator Schweiker knows, certain triggering devices and other mechanisms which really only help us to implement it.

I am glad to take the time—but I know the time is precious to the members of this committee—to indicate, as we go through this, the reasons for it. But these are the most significant increases.

On a related matter in terms——

Senator MAGNUSON. Before you leave that, we have been talking in some of these hearings and we just got through in the supplemental—there was an argument that the administration seems to be wanting to cut down on capitation grants.

How do you feel about that?

Senator KENNEDY. I am opposed to that, Mr. Chairman.

I think that is really unrealistic.

Senator MAGNUSON. I don't know how firm they are on it.

Senator KENNEDY. You can make the conceptual argument if you flow more money through the student's tuition kind of program, the old approach which was no capitation, run through the student, and get to about $100 million on it, then you can probably make a case that capitation ought to be removed.

What we have attempted to do in terms—is to blend these, both in terms of upgrading the scholarship program working through your program, the National Health Service Corps, through the Magnuson program.

We want to see that that program is going to be given the kind of funding which will be the resource in terms of the scholarship program, but also to meet what are some of the basic institutional grant, capitation grants.

We think we have a blend in this.

Senator MAGNUSON. I am glad to hear you say that.

Senator SCHWEIKER. I feel——

Senator MAGNUSON. We are not at a point where we can take one and discard another. It is too important to keep moving.

Senator KENNEDY. That's right.

The only other item, just about the last page, Mr. Chairman, is under the resource administration.

What we do is just a very modest increase in the schools of public health that have, done extraordinary work in terms of preventive health care. They are doing excellent work on the relationship between diet and nutrition, and as we are seeing in so many other areas, primarily in the family medical residencies and training. That just reinforces the thrust I mentioned earlier to ensure adequate residencies in the primary care, primary care function is what we are really kind of talking about.

Senator MAGNUSON. Ford budget was $9 million. There it is $45 million, you suggest $55 million.

Senator KENNEDY. If we go back in terms of where we had the request—basically the request to OMB, I think is really more realistic.

I think those are really the important parts. Both in terms of, just capsulizing, Mr. Chairman, the aid to the medical schools, but also in the scholarship program, the National Health Service Corps, those two items in terms of the medical education, as well as the funding of the family practitioners residency program, will move us an important way towards primary care and also to under-served areas. Those along with the others.

I have a much more detailed analysis which I will submit.

Senator MAGNUSON. We are always glad to get that because we find this very helpful to the committee because in many cases the analysis of the problems, you people spend a lot of time and we try and work together.

Senator KENNEDY. That's right.

Senator MAGNUSON. Give each other the benefit of each other's information.

Senator KENNEDY. That's right.

Senator MAGNUSON. And so we will take a look at it.

Senator KENNEDY. Fine.

Senator MAGNUSON. Of course, you may not get them all.

Senator KENNEDY. Well, I can tell you, Mr. Chairman, as you mentioned yourself, very good in the health area.

I think Senator Schweiker understands these programs.

PREPARED STATEMENT

Senator MAGNUSON. Thank you, Ted, very much. We would be happy to include any additional information you may have for the record.

[The statement follows:]

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LETTER FROM SENATOR EDWARD M. KENNEDY

United States Senate

COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

April 11, 1977

Senator Warren G. Magnuson
United States Senate
Washington, D.C. 20510

Dear Maggie:

I just want to let you know how much I appreciated the opportunity to testify before your subcommittee on Wednesday.

Because of my tight schedule that afternoon I was unable to go into detail on all the programs in which I have an interest. I am therefore sending you a copy of my recommendations and the prepared written statement that I had prepared.

My thanks for your consideration of these most important health care programs.

Warm regards.

Sincerely,

Ted

EMK/cbs

Edward M. Kennedy, Chairman
Subcommittee on Health and
Scientific Research

APR 13 1977

STATEMENT OF SENATOR EDWARD M. KENNEDY

MR. CHAIRMAN, I AM PLEASED TO HAVE THIS OPPORTUNITY TO AGAIN APPEAR BEFORE YOUR ESTEEMED APPROPRIATIONS SUBCOMMITTEE. THE ACCOMPLISHMENTS WHICH HAVE ALREADY BEEN ACHIEVED IN IMPROVING THE HEALTH AND WELFARE OF THE AMERICAN PEOPLE ARE A HALLMARK OF YOUR LEADERSHIP. I AM PROUD TO HAVE WORKED CLOSELY WITH YOU ON MANY OF THESE PROGRAMS.

TODAY, I WOULD LIKE TO FOCUS THE SUBCOMMITTEE'S ATTENTION ON WHAT I BELIEVE TO BE THE HIGHEST PRIORITY HEALTH PROGRAMS FOR FISCAL YEAR L978. I KNOW THAT IT IS NOT POSSIBLE TO DO ALL THAT EACH OF US WOULD WANT IN TERMS OF FULLY FUNDING HEALTH EVERY PROGRAM. THE ECONOMIC CONDITIONS AT THE PRESENT TIME DO NOT AFFORD US THAT LUXURY. CONSEQUENTLY, MY TESTIMONY IS DESIGNED TO TAKE THAT INTO ACCOUNT AND I WILL DEAL ONLY WITH THOSE PROGRAMS, WHICH, IF NOT FUNDED NOW, WILL COST US SIGNIFICANTLY MORE LATER.

FIRST OF ALL, AND MOST IMPORTANTLY, MR. CHAIRMAN IS THE HEALTH MANPOWER ACT. AS YOU KNOW THIS NEW LAW, WHICH TAKES EFFECT IN FISCAL YEAR L978, WAS THREE YEARS IN THE MAKING. IT AMOUNTS TO SWEEPING REVISIONS OF THE LAWS WHICH IT REPLACES. IN IT THERE IS THE OPPORTUNITY, FOR THE FIRST TIME, TO EFFECTIVELY COMBAT THE HEALTH MANPOWER PROBLEMS WHICH BESET THE NATION.

I DO NOT NEED TO DWELL AT LENGTH ON THE SCOPE AND MAGNITUDE OF THE HEALTH MANPOWER DILEMMA. SUFFICE IT TO SAY THAT IT IS ESSENTIAL THAT WE BEGIN NOW TO REDRESS THE GEOGRAPHIC AND SPECIALTY MALDISTRIBUTION OF PHYSICIANS AND DENTISTS SO THAT EVERY AMERICAN CAN HAVE ACCESS TO THE KIND OF CARE THEY NEED. IN DOING THIS WE WILL FREE THIS NATION FROM ITS DEPENDENCE UPON SO MANY FOREIGN MEDICAL GRADUATES FOR THE PROVISION OF MEDICAL CARE.

WHAT IS NOW NECESSARY FOR THE ACCOMPLISHMENT OF THESE OBJECTIVES IS THE COMMITTMENT OF YOUR SUBCOMMITTEE TO IMPLEMENT THE KEY ASPECTS OF THAT LEGISLATION.

BRIEFLY, MR. CHAIRMAN, THERE ARE THREE PARTS OF THE MANPOWER LEGISLATION WHICH NEED TO BE FULLY FUNDED.

FIRST OF ALL, IT IS CRUCIAL THAT FUNDS BE MADE AVAILABLE

FOR THE NATIONAL HEALTH SERVICE CORPS AND FOR SCHOLARSHIPS FOR STUDENTS IN EXCEPTIONAL FINANCIAL NEED.

THE NATIONAL HEALTH SERVICE CORPS TOGETHER WITH ITS SCHOLARSHIP PROGRAM IS INTENDED TO BECOME THE VEHICLE FOR EVENTUALLY ASSURING THE AVAILABILITY OF FULLY QUALIFIED DOCTORS OR DENTISTS FOR THOSE MILLIONS OF AMERICANS IN RURAL AND INNER CITY AREAS WHO TODAY DON'T HAVE ACCESS TO THE HEALTH CARE THEY NEED.

RECIPIENTS OF CORPS SCHOLARSHIPS WILL EVENTUALLY BE PROVIDING CARE IN THESE SHORTAGE AREAS. IT IS NO ACCIDENT THAT WE HAVE CHOSEN TO RELY UPON THE CORPS TO COME TO GRIPS WITH THIS MOST VEXING MANPOWER PROBLEM. IT WAS YOUR VISION AND WISDOM WHICH WAS LARGELY RESPONSIBLE FOR THE CREATION OF THE NATIONAL HEALTH SERVICE CORPS IN 1970, MR. CHAIRMAN. WITH THE AMENDMENTS TO IT WHICH BECAME LAW LAST OCTOBER, THE OPPORTUNITY NOW EXISTS TO TURN YOUR DREAM OF 1970 INTO REALITY. I RECOMMEND:

A. NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS $75,000,000 (SECTION 756(A)),

B. EXCEPTIONAL NEED SCHOLARSHIPS $16,000,000 (SECTION 785(D)) AND,

C. NATIONAL HEALTH SERVICE CORPS OPERATION $47,000,000 (SECTION 338(A)).

SECONDLY, MR. CHAIRMAN, WE MUST ALSO EXPAND OUR EFFORTS TO INCREASE THE NUMBER OF PRIMARY CARE PHYSICIANS, FAMILY PHYSICIANS, INTERNISTS, AND GENERAL PEDIATRICIANS. WE ALL KNOW THAT AMERICA HAS TOO MANY SUPER-SPECIALISTS, PARTICULARLY SURGEONS WHO UNNECESSARILY CONTRIBUTE TO THE RAPIDLY ESCALATING COSTS OF HEALTH CARE AND TO THE NATION'S MORTALITY AND MORBIDITY. I, THEREFORE, RECOMMEND FULL FUNDING FOR THESE VITALLY IMPORTANT ASPECTS OF THE MANPOWER LEGISLATION IN THIS REGARD. I RECOMMEND:

A. DEPARTMENTS OF FAMILY MEDICINE $10,000,000 (SECTION 780(C)),

B. FAMILY MEDICINE AND GENERAL DENTISTRY $45,000,000 (SECTION 786(D)),

C. FELLOWSHIPS IN GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS $15,000,000 (SECTION 784(B)), AND

D. AREA HEALTH EDUCATION CENTERS $20,000,000 (SECTION 781(G)).

FINALLY, MR. CHAIRMAN, IT IS ESSENTIAL THAT WE ASSURE THE STABILITY OF THE EDUCATIONAL INSTITUTIONS WHICH WILL BEAR THE

BURDEN OF EDUCATING THE FUTURE GENERATIONS OF THIS NATION'S DOCTORS AND DENTISTS. I RECOMMEND:

A. MEDICAL, OSTEOPATIC, AND DENTAL INSTITUTIONAL SUPPORT--$176,000,000 (SECTIONS 770(E) (1), (2), AND (3).

PLANNING

IN 1974 WE PASSED THE NATIONAL HEALTH PLANNING AND DEVELOPMENT ACT (P.L.93-641). THE INTENT WAS TO DEVELOP A PLANNING SYSTEM WHICH COULD BETTER DISTRIBUTE HEALTH CARE RESOURCES -- FACILITIES AND MANPOWER -- IN SUCH A WAY THAT HIGHER QUALITY HEALTH CARE COULD BE DELIVERED AND THAT SIMULTANEOUSLY THE INCREASING COSTS OF HEALTH CARE COULD BE CONTROLLED.

IN THE UNITED STATES WE HAVE 93L,000 HOSPITAL BEDS -- BUT AN INSTITUTE OF MEDICINE STUDY STATES THAT WE NEED ONLY 700,000 BEDS AND EACH ADDITIONAL BED COSTS MONEY.

THE PRESENT LEVEL OF FUNDING FOR THE BUREAU OF HEALTH PLANNING IS $125 MILLION AND THE PRESIDENT'S BUDGET FOR L978 REMAINS STATIC AT THIS LEVEL--JUST AT A TIME WHEN THE PLANNING AGENCIES ARE BEGINNING TO COME TO GRIPS WITH THE TOUCH ISSUES AT A LOCAL AND STATE LEVEL. IF PLANNING IS TO BE AT ALL MEANINGFUL, I BELIEVE THE OVERALL PLANNING PROGRAM NEEDS $174 MILLION.

THE CORNERSTONES OF HEALTH PLANNING ARE THE HEALTH SYSTEM AGENCIES (HSA'S) -- WHICH WILL ALLOCATE RESOURCES ON THE REGIONAL LEVEL. EACH HSA MUST DEVELOP A HEALTH SYSTEMS PLAN AND ANNUAL IMPLEMENTATION PLAN WHICH WILL ADDRESS THE REGIONAL PRIORITIES. IN ORDER TO DO THIS ADEQUATELY AND DEVELOP THE NECESSARY LINKAGES WITH OTHER ORGANIZATIONS, SUCH AS PROFESSIONAL STANDARD REVIEW ORGANIZATIONS, $125 MILLION IS NEEDED.

THE ADDITIONAL $51 MILLION IS NEEDED FOR THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES; TECHNICAL ASSISTANCE FOR HSA'S AND THE STATE AGENCIES; AND FOR THE AREA HEALTH SERVICES DEVELOPMENT FUND.

HMO'S

MR. CHAIRMAN, I RECOMMEND A TOTAL OF $30 MILLION FOR L978 FOR HEALTH MAINTENANCE ORGANIZATIONS. IT HAS BEEN DEMONSTRATED THAT HEALTH CARE IS DELIVERED MORE EFFICIENTLY AND MORE COST EFFECTIVELY THROUGH HMO'S. WHEN THE ORIGINAL HMO LEGISLATION

WAS PASSED IN L973, THE INTENT WAS TO DEVELOP THROUGHOUT THE UNITED STATES AN ALTERNATIVE DELIVERY SYSTEM. BY INCREASING THE FUNDING LEVEL TO $30 MILLION -- AN ADDITIONAL 12 FEASIBILITY STUDIES, 22 PLANNING GRANTS AND 8 INITIAL DEVELOPMENTAL GRANTS COULD BE FUNDED IN ADDITION TO INCREASING THE NECESSARY CENTRAL AND REGIONAL OFFICE STAFF REQUIRED TO ADMINISTER THE LAW.

MULTIPLE STUDIES HAVE DEMONSTRATED THAT HMO'S DELVIER SERVICES TO MEDICARE AND MEDICAID RECIPIENTS AT A COST AT LEAST 20% BELOW THE TRADITIONAL FEE FOR SERVICE SYSTEM. IN MY OWN STATE OF MASSACHUSETTS A STUDY DEMONSTRATED A 30% SAVINGS. AS WE TRY TO SAVE FEDERAL DOLLARS THIS IS ONE VERY COST EFFECTIVE PROGRAM.

COMMUNITY HEALTH CENTERS

MR. CHAIRMAN, I RECOMMEND $254 MILLION BE APPROPRIATED FOR COMMUNITY HEALTH CENTERS FOR FY L978. IN FY 1976 APPROXIMATELY 2.5 MILLION INDIVIDUALS WERE SERVED BY THE CHC'S AND IT IS ESTIMATED THAT THIS WILL RISE TO 3.3 MILLION IN 1977. THE NUMBER OF CLIENTS HAS DOUBTED SINCE 1975. HEW'S DATA INDICATES THAT COMMUNITY HEALTH CENTER CLIENTS HAVE A 34% LOWER RATE OF HOSPITALIZATION THAN MATCHED OCMMUNITIES NOT SERVED BY CHC'S. STUDIES HAVE INDICATED THAT INFANT MORTALITY DECREASED BY 28% IN AREAS SERVED BY COMMUNITY HEALTH CENTERS, AND THAT THERE WAS A 60% REDUCTION IN DAYS HOSPITALIZATION FOR CHILDREN IN AREAS SERVED BY COMMUNITY HEALTH CENTERS. AS THERE IS HIGH UNEMPLOYMENT IN THE INNER CITY AND MANY FAMILIES ARE WITHOUT ADEQUATE HEALTH CARE INSURANCE AND NOT ELIGIBLE FOR MEDICAID, COMMUNITY HEALTH CENTERS COULD SERVE LARGER VOLUMES OF PEOPLE BUT ONLY IF ADEQUATELY FUNDED.

MIGRANT HEALTH

FUNDS FOR THE MIGRANT HEALTH PROGRAM PROVIDE COMPREHENSIVE HEALTH SERVICES TO MEMBERS OF MIGRANT AND SEASONAL FARM WORKER FAMILIES. THERE ARE APPROXIMATELY 2,700,000 ELIGIBLE FOR THIS PROGRAM, BUT, SADLY, IT IS ESTIMATED THAT LESS THAN 20% OF THESE WILL BE SERVED IN FY 1977.

MR. CHAIRMAN, THE CONGRESSIONAL BUDGET OFFICE PROJECTION FOR JUST MAINTAINING CURRENT SERVICES IN THE L25 MIGRANT HEALTH CENTERS IS $32 MILLION. I WOULD RECOMMEND THE FULL FUNDING FOR 1978 -- $35 MILLION. THE HOSPITALIZATION PROGRAM IS INADEQUATELY FUNDED -- AND FOR THE MOST PART THIS PROGRAM SERVES MOTHERS AND THE DELIVERY OF THEIR CHILDREN. PRESENTLY, HUNDREDS OF MIGRANT CHILDREN ARE BORN WITHOUT THE BENEFIT OF HOSPITAL CARE. THE PROGRAMS HAVE TRIED TO QUALIFY MIGRANT WORKERS FOR MEDICAID IN ORDER TO REDUCE COSTS, BUT LESS THAN 5% QUALIGY FOR COVERAGE UNDER TITLE 19. AN INCREASE OF $5 MILLION IN FY 1978 WOULD PERMIT AN INCREASE IN THE NUMBER OF PEOPLE SERVED IN THIS IMPORTANT PROGRAM.

ALCOHOLISM

MR. CHAIRMAN, I WOULD ALSO LIKE TO RECOMMEND THE APPROPRIATIONS FOR ALCOHOLISM COMMUNITY PROGRAMS GRANTS AND CONTRACT BE $82 MILLION. THIS MOST SERIOUS NATIONAL PROBLEM NEEDS MORE SUPPORT AT THE FEDERAL LEVEL. I WOULD PARTIUCLARLY LIKE TO SEE MORE MONEY BE DIRECTED UNDER THIS APPROPRIATION FOR WOMEN'S ALCOHOLISM PROGRAMS. IN L976, THESE PROGRAMS FOR WOMEN RECEIVED ONLY $2.5 MILLION.

CONCLUSION

MR. CHAIRMAN, I WOULD LIKE TO THANK YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE FOR THE OPPORTUNITY TO APPEAR BEFORE YOU THIS AFTERNOON. I WOULD LIKE TO ALSO GIVE YOU A PAPER IN WHICH I HAVE OUTLINED THE PROGRAMS WHICH I AS CHAIRMAN OF THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH HAVE A PARTICULAR INTEREST IN, INCLUDING SPECIFIC RECOMMENDATIONS REGARDING FY L978 FUNDING LEVELS.

APPROPRIATIONS RECOMMENDATIONS FROM SENATOR KENNEDY

Listed below are items that are of interest to Senator Kennedy and for which he recommends a figure higher than the budget requests of President Carter. With all items not listed, Senator Kennedy's recommendation would be the same as President Carter's.

These have been listed in order given on your subcommittee's work sheets of 3/21/77.

| Program | Page number on worksheet | EMK recommendations |
|---|---|---|
| Community Health Centers | 2 | $254,000,000 |
| Migrant Health | 2 | $35,000,000 |
| National Health Service Corps | 2 | ~~$38~~ 47,000,000 |
| Health Maintenance Organizations | 3 | $30,000,000 |
| Venereal Diseases | 4 | $22,000,000 |
| Health Education | 4 | $9,000,000 |
| National Institute of Health | all items on page 5 | Total '77 Approp. plus 6% |
| General Mental Health Research & Training | 6 | Total '77 Approp. plus 6% |
| Alcoholism | | |
| (c) Community Programs | | |
| (1) Project grants and contracts | 7 | ~~$81~~,959,000 |
| National Health Statistics | 8 | Total '77 Approp. plus 6% |
| Health Planning | 8 | |
| Local Planning Agencies | | $125,000,000 |
| State Agencies | | $27,000,000 |
| Planning Methods development | | $12,000,000 |
| Rate regulation | | $2,000,000 |
| Resource Development Fund | | $10,000,000 |
| | | ~~$176~~,000,000 |
| Health Professions Education | | $176,000,000 MOD |
| (a) Health Professions | 9 | Total '77 Approp. |
| (1) Institutional Assistance | | plus 6%-VOPP |
| (2) Student Assistance | 9 | |
| National Health Service Scholarships | | $75,000,000 |
| Exceptional Need Scholarships | | $16,000,000 |
| (c) Nursing all items | 9 | Revised Department request to OMB |
| (d) Public Health | 10 | $11,000,000 |
| (f) Special Education Programs | | |
| (1) Family Medicine Residencies and Training | | $55,000,000 |
| (2) Primary Care Residencies and training | | $15,000,000 special interest in pediatrics program |
| (3) Project grants-MOD | | $4,000,000 |
| (4) Project grants-VOPP | | $6,000,000 |
| (6) AHEC | | $20,000,000 |

## STATEMENT OF HON. JOHN MELCHER, U.S. SENATOR FROM MONTANA

Senator MAGNUSON. Now, the Senator from Montana is here.

Senator MELCHER. Thank you, Mr. Chairman.

The appropriation request for the general appropriations for the Community Services Administration, Emergency Energy Conservation Service, is one lump.

Included in that, but not in any significant, any special amount, would be the funds for the National Center for Appropriate Technology Review. It is one year old.

Its first efforts have been to see how we can get low cost home weatherization, a very practical energy-saving problem.

It is set up and going now. This year it wants to branch out to continue with the ways of saving energy utilizing small-scale technology and alternate sources of energy.

What we would like to see, Mr. Chairman, is the opportunity for this, after going through a little over a year, get into a bigger program, bigger problems.

We would like to see $10 million within that fund earmarked for use out in Butte.

This is one lump in the President's budget.

The appropriate technology is coming. It is very vital and necessary and this is a center that is alive and working.

Senator MAGNUSON. It seems to me that if—that it is because we have nearly $200–$282 million.

Senator MELCHER. Yes. Well, we can see a wise use of about $10 million this next fiscal year.

### PREPARED STATEMENT

Senator MAGNUSON. All right. We will be glad to submit any additional information you have into the record

Senator MELCHER. Thank you very much.

[The statement follows:]

STATEMENT OF SENATOR JOHN MELCHER

Mr. Chairman, I appreciate the opportunity to appear today to urge an appropriation of $10 million for the National Center for Appropriate Technology at Butte, Montana, as part of the FY 1978 General Appropriation for the Community Services Administration's "Emergency Energy Conservation Services" program.

The reality of the nation's home heating energy crisis, dramatically brought home during the recent winter, has led to a significant increase in requests for home weatherization. In Montana alone, it is estimated that there are 30,000 homes in need of weatherization assistance, and there have been only enough funds available to weatherize 2205 homes. Most of these homes belong to the elderly and families on low income.

In its first year of operation, the National Center for Appropriate Technology has been concentrating on creating the foundation for providing the technical assistance to expand various types of low cost weatherization programs to fit local demands and needs. They have worked hard to develop methods of expanding energy education programs, community projects in the areas of solar heating, as well as innovative insulation and weatherization projects.

As it enters its second year of operation the Center plans to expand its activities beyond current energy and weatherization efforts. Efforts to deal with the energy crisis cannot be restricted just to weatherization but must branch out and include areas such as food, agriculture, shelter, waste recycling, transportation and community economic development. The major focus of the Center will be to support community economic development utilizing small scale technology and alternative sources of energy which will be labor intensive, thus creating meaningful jobs in the community.

The National Center will expand its activities in the areas of:

A. Food and Agriculture: In working with hydroponics green-

houses, solar crop dryers and other low energy methods of farming, the Center will be involved in testing and evaluating such small scale farming that increases food production.

B. Shelter: Designing of structures to be more suitable for passive solar collectors, using natural pathology and vegetation to enhance effectiveness, and other structures such as geodesic domes, and utilizing waste materials such as glass and plastic in the building of low income housing.

C. Waste Recycling: Small scale waste recycling technologies exist for both organic and inorganic materials. Expanding research in methane digesters and recycling gray water for showers and cleaning.

D. Transportation: Developing appropriate transportation technology, which can include greater use of mass transportation, carpooling education and other technologies that assist low income people.

E. Community Economic Development: There is a direct relationship between energy costs and job creation and the Center will be involved in support of community economic development projects that focus on alternative energy sources -- solar and wind, recycling of waste products, food production, etc. These small economic development projects not only create jobs but provide products and materials for community consumption. Examples could be separation and reclamation of garbage, a small paper pulp factory, dry toilet industries, methane production industry, and insulation production.

FY 1978 funding will support grants, major field tests, increases in technical research staff, additional field staff operations, and increases in the information sharing network. A breakdown is as follows:

| | | |
|---|---|---|
| (1) | Administrative overhead 10%, for evaluation, monitoring and fiscal control | $550,000 |
| (2) | Increased allocations for field test operations and grants to community organizations | $5,300,000 |

| | | |
|---|---|---|
| (3) | Increased technical research data for testing and research of energy related programs, including field test support | $1,400,000 |
| (4) | Information and research dissemination, including technical reports information data and evaluation | $650,000 |
| (5) | Increase field staff to evaluate and support field tests products, and provide technical assistance | $2,100,000 |
| | TOTAL ..... | $10,000,000 |

Mr. Chairman, Appropriate Technology is here to stay. It is, more than anything, a matter of economics. As energy costs continue their upward spiral, everyone pays an increasing large percentage of his income for food, clothing, housing, heating cooling -- necessities that depend upon energy.

With these rising costs, and the increasing hardship which results, particularly for elderly and low income families, comes the need to solve our energy and related problems as simply, and inexpensively as possible. This is the heart of appropriate technology -- technology that is appropriate to solving problems on a small scale, that is for individuals, for small businesses or for communities, without the necessity to invest billions of dollars in sophisticated plants and equipment that use exotic processes.

Some examples of appropriate technologies that will become increasingly important, or are already beginning to pay off are low-cost solar collectors that individuals can construct with materials available at the local lumber yard and hardware store, compact wood or coal burning stoves which can achieve amazing efficiencies and heat an entire home with readily available fuels like wood or coal, improved weatherization of mobile homes, development of safe, efficient and inexpensive flue-gas dampers for use on hot water heaters and furnaces, and small-scale solar greenhouses.

Thus, Mr. Chairman, I urgently request that $10 million be appropriated to allow the National Center for Appropriate Technology to continue and expand its important activities in the field of energy alternatives and conservation.

## STATEMENT OF HON. NORMAN D. DICKS, U.S. REPRESENTATIVE FROM WASHINGTON

### AMENDMENT INTRODUCED IN HOUSE

Senator MAGNUSON. All right, Norm.

Mr. DICKS. Mr. Chairman, I have introduced an amendment in the House. I am submitting a table which compares amounts received by school districts in my district this year with the amounts recommended by President Carter.

In my district people support schools with their property taxes. The economy is dominated by the Federal Government, an employer which does not contribute to the tax base. People have accepted the Federal Government's decision to place their military installations and Federal agencies in their communities.

In return, they shouldn't be asked to lower the quality of their children's education. Without full funding of Public Law 874, the quality of education in these communities will deteriorate immediately.

To illustrate, I would like to describe the Clover Park School District serving Fort Lewis near Tacoma, Wash.

It is typical of the school districts in my district and of the other federally-impacted districts in that region.

In the Clover Park District title I funds are used to provide instructional and support staff to reduce class size and provide materials and resources of all kinds.

Over half of the school population is federally connected and one-third are classified as A students.

Property owners in the district provide $863.35 for basic student support. Title I of Public Law 874 provides $555.22 per child.

If Public Law 874 funds had to be replaced by property taxes, property owners would have to pay 30.5 percent more in property taxes.

An owner of a $30,000 home would have to pay an additonal $186.30 per year to support the school system.

Last year——

Senator MAGNUSON. That figure is new to me, Norm. The one-third.

Mr. DICKS. That is Clover Park because they have Fort Lewis and McCord right there.

Senator MAGNUSON. But A students——

Mr. DICKS. Ones that live on the base. B students——

Senator MAGNUSON. I see.

Mr. DICKS. In that situation, because so many——

Senator MAGNUSON. B students are the ones that work on the base.

Mr. DICKS. Their folks work there and they go to schools in the local area.

Senator MAGNUSON. That's right.

Mr. DICKS. Last year the title——

Senator MAGNUSON. Because the Administration's budget wants to cut out all these students.

Mr. DICKS. Is it B or A? B.

Well, I have a great deal of respect for the Administration, but I don't support them on that one.

Last year the title I funds to Clover Park School District increased only 3.4 percent.

Basic salary in the school district rose 8.3 percent at the same time, although actual salary increases were closer to 15 percent.

As a result, Clover Park cut back drastically in supplies of materials and teacher-aide support as well as eliminated a summer component that would have provided reading and math classes.

In recent years the district has been dependent on carrying over funds from a previous Presidential freeze in part B incentive funds and is now dependent on increases in basic allocation, application for part B funding, and cutbacks on supplies, materials, and teacher-aide supports in order to maintain other activities.

In addition to existing funded needs, Clover Park has identified and documented unfunded needs in the following areas: kindergarten to first grade readiness services expansion, elementary math, junior high language arts, alternative school math.

The financial needs of the Clover Park District are not unique. The same situation is present in almost every school district in my district.

The Federal Government has the responsibility for providing basic education to federally-connected students.

Congress passed Public Law 874 which, as I recall, the distinguished Chairman authored the first bill because school districts cannot afford to provide basic education without property tax revenue.

We need to live up to our commitments to provide basic education in Federally-impacted areas by fully funding impact aid.

I will just submit those figures for the record.

Coming here and testifying—I know that the Chairman has always supported impact aid funding. It is just such a serious matter that we get that amount of money restored.

Senator MAGNUSON. The problem, I just was through all yesterday afternoon up at the Budget Committee.

Mr. DICKS. Right.

Senator MAGNUSON. Of which I am a member. Some of the members of the—our congressional budget——

Mr. DICKS. Right. I understand.

Senator MAGNUSON. They want to phase out all impacted aid. There was a motion to do that. It lost.

Of course, a lot of us thought, as you know very well, that the Legislative Committee should have some different rules because in some places it was abused.

Mr. DICKS. That's correct.

Senator MAGNUSON. They just don't do it. It is almost an entitlement now. There is no money at all.

We have to figure out money for the Class B.

So I think the Appropriations Committee does have a green light to go ahead with impacted aid now, but it looks like trouble down the line.

Mr. DICKS. I am glad to know about that because I will certainly take it up with the Chairman of the House Budget Committee and make certain we are not in trouble over there on the same basis.

I agree with your comment, too, that some areas, funding isn't as desperately needed where they have other sources of tax base.

When you have got situations like in Tacoma where you don't have any other industry, if they don't have that impact aid funding they are just not going to be able to finance the schools.

Senator MAGNUSON. I started impact aid.

Mr. DICKS. Grand Coulee.

Senator MAGNUSON. Yes. When they didn't have anything to tax but jackrabbits.

Mr. DICKS. You can't tax those.

Senator MAGNUSON. No tax base at all.

It has gotten out of hand. Where there is a definite Federal impact, I know, as well as you do, in these areas, you have just got to have impacted aid of some kind. Or payment in lieu of taxes which is what impacted aid is, actually.

Mr. DICKS. Yes.

Senator MAGNUSON. The money is in both House and the Budget Committee proceeding now.

Mr. DICKS. One other thing I wanted to point out. When we talk about the Clover Park-Fort Lewis situation, you have a number of schools, school buildings—and I am unable to be here tomorrow to introduce him—Robert Chissolm is going to testify on the subject tomorrow.

We have a number of schools built on these military bases that should be spun off to the local school districts. They are a little bit reluctant to take the schools until the repair work is done.

The only way we are going to be able to get that done is to add some funding to Public Law 815 if that is possible, which is under school construction.

I think it would be a prudent investment this year.

Senator MAGNUSON. Is he going to testify here tomorrow?

Mr. DICKS. Tomorrow.

Senator MAGNUSON. He doesn't need to do that. We already know it.

Mr. DICKS. He is already scheduled, I believe. [Pause.]

You and I have a problem with Achilles' tendon.

Senator MAGNUSON. Oh, mine is terrible. How long did it take you?

Mr. DICKS. I tore it on December 14 and I was doorbelling by April 1. So it took a few months.

Senator MAGNUSON. That is bad news. Get out of here. [Laughter.]

Mr. DICKS. Thank you, Mr. Chairman. I ruptured mine completely. I had to have it surgically reattached.

## PREPARED STATEMENTS

Senator MAGNUSON. All right. We will include your written statement and also the statements of other Members of the Congress who could not attend this hearing.

[The statements follow:]

## STATEMENT OF NORMAN DICKS

Mr. Chairman, I would like to thank you for the opportunity to testify today on federal impact aid to education. I have introduced legislation in the House to restore cuts made in P.L. 874. I am submitting for the record a table which compares the amounts received by school districts in my district this year with the amounts recommended by President Carter.

In my district, people support the schools with their property taxes. The economy is dominated by the federal government, an employer which does not contribute to the tax base. The people have accepted the federal government's decision to place these military installations and federal agencies in their communities. In return, they should not be asked to lower the quality of their children's education. Without full funding of P.L. 874, the quality of education in these communities will deteriorate immediately.

To illustrate my point, I would like to describe the Clover Park School District, serving Fort Lewis near Tacoma, Washington. Clover Park is typical of the school districts in my district and of the other federally impacted districts in that region.

In the Clover Park District, Title I funds are used to provide instructional and support staff, to reduce class size, and to provide materials and resources of all kinds. Over half of the school population is federally connected, and one-third are classified as "A" students. Property owners in the Clover Park District provide $863.35 for basic student support and Title I provides $555.22 per child. If Public Law 874 funds had to be replaced by property taxes, property

owners would have to pay 30.5 percent more in property taxes. An owner of a $30,000 home would have to pay an additional $186.30 per year to support the school system.

Last year the Title I funds to Clover Park School District increased only 3.4 percent. The basic salary in the district rose 8.3 percent at the same time, although actual salary increases were closer to 15 percent.

As a result, Clover Park cut back drastically in supplies, materials, and teacher aide support, as well as eliminated a summer component that would have provided reading and math classes.

In recent years, the District has been dependent on carry-over funds from a previous Presidential freeze and Part B incentive funds, and is now dependent on legislative increases in basic allocations, an application for Part B funding and cutbacks in supplies, materials, and teacher aide support in order to maintain other activities. Should the Part B application not be successful, further cuts will have to be made.

In addition to existing funded needs, Clover Park has identified and documented unfunded needs in the following areas:

1. Kindergarten-First Grade Readiness Services expansion
2. Elementary Math
3. Junior High Language Arts
4. Alternative School Math

The financial and program needs in the Clover Park School District are not unique. The same situation is present in almost every school district in my district. The Federal

Government has a responsibility to provide basic education to federally connected students.

Congress passed Public Law 874 because school districts cannot afford to provide basic education without property tax revenue. We need to live up to our commitment to provide basic education in Federally impacted areas by fully funding impact aid.

COMPARISON OF FY '78 APPROPRIATIONS FOR FEDERAL IMPACT AID
(Estimated)

| | FY '77 Estimates Full Funding | FY '77 A's Only |
|---|---|---|
| KITSAP COUNTY | | |
| North Kitsap | 308,700 | 88,900 |
| Central Kitsap | 1,026,700 | 427,900 |
| Bremerton | 804,200 | 120,300 |
| Bainbridge | 48,700 | 11,000 |
| South Kitsap | 708,500 | 11,800 |
| KING COUNTY | | |
| Federal Way | 118,800 | 8,000 |
| Auburn | 208,000 | 128,500 |
| PIERCE COUNTY | | |
| Franklin Pierce | 226,100 | none |
| Clover Park | 3,944,900 | 3,546,500 |
| Steilacoom | 110,900 | 17,500 |
| Tacoma | 638,900 | 14,800 |
| University Place | 100,800 | none |
| Peninsula | 95,000 | none |

## STATEMENT OF SENATOR JOHN A. DURKIN

I am deeply concerned about the proposed budget cuts in the Impact Aid program and ask that the Committee restore funds which compensate school districts for the cost of educating children where the enrollment and availability of revenue resources are adversely affected by federal activities. Any reduction in category "B" payments will have a drastic affect on the school districts in my State of New Hampshire. Cities and towns will be forced to raise local property taxes, reduce education programs or both.

The School Assistance in Federally Affected Areas program which was instituted over 25 years ago was intended to reduce the inequities caused by the presence of federal tax exempt property and to reduce the burden placed on school districts by the children of parents living or working on that federal property. The need for this aid has not diminished over time.

In 1977, approximately 2,743 school districts nationwide receive only "B" category payments. They stand to lose over $300 million under the President's proposal. This reduction can only add to the burden placed on the already beleaguered taxpayer. In a State such as New Hampshire where income to run schools and related services comes almost totally from local property taxes, asking parents to bear the expense of a federal installation is outrageous, especially at a time when the cost of raising and educating children is increasingly on the rise.

School districts depend on federal Impact Aid funds to plan their budgets and towns depend on the federal aid to decide on local tax rates. Deletion of these funds will have a significantly negative impact on local school budgets. Special services will be the most severely affected. Small towns which depend on impact aid to support reading/learning

disabilities programs, occupational and other services will be forced to disrupt these programs. The student will be the big loser.

The State of New Hamsphire currently has 3,105 students covered under category "B" of Pl 81-874 due to the many federal government installations located throughout our area. The Portsmouth Naval Shipyard, Pease Airforce base, the Army's Cold Regions Research and Engineering Laboratory as well as many other properties aid in diminishing the tax resources of the cities and towns surrounding them. Recently, the Army expanded the Cold Regions Research Lab thereby increasing the number of persons enjoying the services offered by the town of Hanover, New Hampshire while at the same time decreasing the available taxable property. The taxes paid by some of the employees working on these federal properties bears little relation to the true costs of supplying them with educational and other services and certainly does not cover the property tax revenue lost. When a private employer moves into a town he pays taxes on the space he occupies. It is only reasonable that the government pay some compensation in lieu of property taxes.

Congress has authorized money for all categories of the School Assistance in Federally Affected Areas program and the Human Resources Committee has recommended that it be fully funded. I urge that the Committee consider both the intent of Congress and the needs of the many cities and towns which depend on federal Impact Aid to offer quality education services.

## Statement of Senator Spark Matsunaga

In his Fiscal Year 1978 Budget request, President Carter has proposed to cut $395 million from the impact aid program. By limiting the scope of assistance to certain conditions or categories of economic hardships created by the presence of federal departments and military installations in school districts, this proposed budget request would deprive our nation's schools of vital federal dollars. School districts are already financially hard-pressed to meet the numerous escalating costs of providing free public education. Steep cuts in the impact aid program, as proposed by the Administration, will place this program of federal assistance in serious jeopardy and cause hundreds of school districts to face considerable difficulties in meeting their budgetary requirements for the upcoming academic year. Because of this dire need for financial aid and because of the federal obligation to school districts in federally impacted areas, I strongly urge this Subcommittee on Labor-HEW Appropriations to restore the $395 million for the impact aid program.

For over 25 years, federal impact aid to education has been an important vehicle through which the Federal Government has duly compensated school districts for the cost burden of extending educational opportunities to children of federally-connected parents. Because federal activities have brought in more families who require the services of local schools and because the tax-exempt status of federal property has reduced local and state revenues, the Federal Government has recognized this responsibility and obligation to help the schools meet the instructional costs of these federally-connected students.

Impact aid monies are general funds which can be used for numerous education expenses, including teachers' salaries, school supplies and equipment. Funds are awarded to eligible school districts through an elaborate formula procedure that distinguishes between two main types of federally-connected students. Those whose parents live AND work on federal property (Category A pupils), and those whose parents live OR work on federal property (Category B pupils). Currently, the Federal Government pays approximately 90 to 100 percent of the local cost of the education of Category A students. Fifty to forty percent of the local cost of Category B pupils are assumed by the Federal Government.

The Administration's proposal to eliminate funds for Category B children has sparked considerable alarm from the States. This alarm is understandable, since the elimination of this funding source would be a staggering blow for many school districts whose budgets are already being pared to the bones. Moreover, the proposed cuts would reduce the quality of education programs and services currently being provided by school districts impacted by federal activities.

The impact aid program is an extremely crucial source of education funds for my own State of Hawaii, where there are large federal landholdings occupied by the military and other federal departments and agencies. The reduction in the impact aid program, as proposed in the President's FY 1978 budget request, would cost Hawaii approximately $5.5 million of valuable impact aid funds.

Hawaii is unique in its statewide approach to educational finance. It is the only State in the nation with a single State school system financed by general state tax revenues. Its Department of Education annually reports funds received

from the impact aid program, as a partial reimbursement to the State for expenses incurred because of the presence of large numbers of federal dependents.

Of the 227 public schools in Hawaii, 212, or 94 percent of the State's schools, have students who meet the federal criteria for impact funds. Furthermore, 43,268 pupils (over 22 percent of Hawaii's total enrollment) have been identified as being federally-connected for the fiscal year 1977.

According to data published by the Hawaii Department of Education, approximately 1,655 teachers are needed to service these students. In terms of salaries alone, these 1,655 teachers require an annual expense of $27,719,595. Total federal payments amount to only $12,400,000. This means that in teachers' salaries alone, the State of Hawaii is absorbing as much as $15,319,595, which should rightfully be paid by the Federal Government. The withdrawal of $5.5 million of federal impact aid for Hawaii would add to an already over-burdensome cost to the State in providing educational services to federal dependents. This sizeable reduction in federal aid would surely result in drastic cutbacks in our educational programs.

The impact aid program has withstood repeated attacks by critics who argue that funds are often given to wealthy school districts which do not need this aid but get it simply because some federally-connected children happen to live in such school districts. To meet this argument the Congress in 1974 took major steps to reform the impact aid program. It tightened the entitlement and payment provisions of the impact aid law, and through the use of graduated entitlement and payment rates and overriding hold harmless provisions,

the Congress reduced the number of local education agencies which would qualify for aid. These changes further directed higher percentages of aid towards local education districts with larger percentages of federally-connected children. Furthermore, these amendments were designed so as not to precipitate severe and immediate payment losses to school districts.

Further revisions in calculating entitlements for Category A and B children were made effective for Fiscal Year 1976. By defining various subclasses of Category A and B children, and by varying the percentage of the local contribution rate paid for each subclass, a more precise determination of the presumed tax loss or service burden on the school district from the federal presence resulted. Consequently, conditions which contributed to over-compensation under the existing impact aid law were minimized.

Finally, effective in Fiscal Year 1978, a new Section 3(b) absorption clause would reduce by 4 percent or less the number of eligible Category B children counted for entitlement purposes. These changes would occur in school districts where Category B children comprise less than 10 percent of their total average daily attendance or with less than 25 percent dependency on Section 3 for total revenue.

For more than 25 years, the impact aid program has served as an effective mechanism of regularizing federal assistance to States and communities with revenue loss caused by federal landholdings. Until a more stable and equitable program of compensating local school districts for costs incurred in educating federally-connected children is designed, funding of the impact aid program should be maintained. I, therefore, urge this Subcommittee on Labor-HEW Appropriations to restore the $395 million to the federal impact aid program.

Thank you.

## STATEMENT OF SENATOR THOMAS J. MCINTYRE

Mr. Chairman: Thank you for permitting me to testify before you today on this most important issue.

I have received numerous letters and calls from my constituents in New Hampshire and concerned citizens throughout the country protesting the potential cut in Category B Impact Aid funds. While I am not myopic as to the necessity of efficient and effective utilization of Federal funds nor to the existing inequities in the present allocation formula, I am greatly disturbed over the potential effects of total elimination at this time.

New Hampshire's level of funding for Category B and the Hold-Harmless funds in 1977 was in excess of $1 million. While this is a mere drop in the bucket when taken in light of the entire Impact Aid appropriations for 1977, it is vital to the educational systems in my State. At a time when the financial pinch is being felt at every level of government and when the cities and towns are being forced to juggle every penny to provide even the most essential services, this proposed reduction could well be crippling. In New Hampshire in particular, our educational systems are being asked to cut their budgets when inflation is the order of the day and our population is experiencing steady and sustained growth. To indiscriminately eliminate these funds would place additional hardships on our people during the most trying of times.

In New Hampshire alone, 38 school districts receive Category B Impact Aid funds. The following list shows the towns and cities and their respective allocations for 1977.

| | | | |
|---|---|---|---|
| 1. Portsmouth | $245,580 | 20. Rollinsford | $ 3,411 |
| 2. Manchester | 162,178 | 21. Farmington | 3,081 |
| 3. Dover | 57,725 | 22. Epping | 2,937 |
| 4. Oyster River | 44,927 | 23. Waterville Valley | 9,118 |
| 5. Merrimack | 33,360 | 24. Bow | 6,024 |
| 6. Rochester | 32,818 | 25. Gorham | 8,156 |
| 7. Somersworth | 21,443 | 26. Lyme | 6,314 |
| 8. Exeter | 19,764 | 27. Concord | 51,609 |
| 9. Hampton | 18,183 | 28. Salem | 5,469 |
| 10. Winnacunnet | 17,947 | 29. Hudson | 15,350 |
| 11. Rye | 16,177 | 30. Litchfield | 3,510 |
| 12. Greenland | 11,692 | 31. Hanover | 12,131 |
| 13. Newington | 10,283 | 32. Mascoma Valley | 3,584 |
| 14. Newmarket | 10,111 | 33. Brookline | 5,320 |
| 15. North Hampton | 9,372 | 34. Amherst | 16,108 |
| 16. Stratham | 9,161 | 35. Dresden | 14,613 |
| 17. Raymond | 6,300 | 36. Milford | 14,807 |
| 18. New Castle | 4,430 | 37. Nashua | 80,331 |
| 19. Kensington | 3,897 | 38. Lebanon | 30,800 |

It is evident from these figures that not only would the larger cities with the million dollar funding suffer from this reduction in funds but the smaller towns and cities would also be placed in economic jeopardy. However, the most drastic affects of this action would not be felt by the taxpayers themselves but rather by their children. For it would be the school systems who would be forced to trim their budgets to make up for such a loss and the net effect would be the reduction in services to our children. Education has always held the highest priority and any attempts to streamline the Federal budget at the expense of our educational systems should be very carefully scrutinized.

Mr. Chairman, what troubles me as much as the cut itself is the manner in which the cut is imposed.

Such a sudden and indiscriminate elimination as this fails

to distinguish between those communities which suffer a direct and substantial burden and those communities which simply are enjoying a windfall from an imperfect system.

These issues deserve the utmost consideration when arriving at an equitable solution in any attempt to implement change in the present system.

I sincerely hope that the Committee will find that the wisest course of action at this time is to reinstate these funds.

Again, thank you for presenting me with the opportunity to testify before your Committee.

## STATEMENT OF SENATOR JAMES B. PEARSON

Mr. Chairman, I want to take this opportunity to indicate my strong support for an appropriation of $1.8 million for architectural and engineering drawings for three Statewide Demonstration Continuing Education Centers in the states of Kansas, Virginia, and Washington.

The federal government provides considerable financial support for adult and continuing education programs. However, until recently, the government did little to assist in the development of physical facilities to house these programs. In 1974, Congress recognized the need to provide limited funding for the construction of several demonstration continuing education centers, and $250,000 was appropriated for preliminary planning grants. The Department of Health, Education, and Welfare awarded the planning grants to the University of Kansas, University of Washington, and Old Dominion College. Preliminary plans for the centers have now been successfully completed, and there is a need for $1.8 million to provide architectural and engineering drawings for the three centers.

Continuing education is one of the most important facets of our overall educational effort. Continuing education allows the resources of our institutions of higher learning to better serve local communities and the special educational needs of adults. Today, there is a significant trend across the country for colleges and universities to become more responsive to the educational needs of

part-time students who cannot attend campus classes on a full-time basis.

The University of Kansas has made great strides in the area of continuing education, and its program has enhanced educational opportunities for many rural Kansans.

I believe the federal government should encourage strong imaginative continuing education programs. Therefore, Mr. Chairman, I urge you to include in the FY 78 Labor-HEW appropriations bill $1.8 million for architectural and engineering drawings for Statewide Demonstration Continuing Education Centers at the University of Kansas, University of Washington, and Old Dominion College. These centers will serve as models of innovative continuing education for the entire country, and will demonstrate Congress' sincere interest in the program.

## NONDEPARTMENTAL WITNESSES

### AMERICAN CANCER SOCIETY

### STATEMENT OF GEORGE P. ROSEMOND, M.D., PAST PRESIDENT

#### TWO MAJOR ADVANCES

Senator MAGNUSON. We have Dr. Rosemond here for the American Cancer Society.

Dr. ROSEMOND. Mr. Chairman, thank you for inviting this testimony, allowing me to appear and continuing the tradition of giving citizens an opportunity to testify directly to your committee. You all undertake a burden that we in the American Cancer Society deeply appreciate.

Mr. Chairman, in the interest of saving time, I will describe what many of us in the American Cancer Society consider just two of the major advances in recent years.

First, in basic research, work on the development of the cell, how one cell passes on characteristics to a daughter cell, has now advanced to the point that cancer and other diseases are more understandable than ever before.

As you know, the National Cancer Institute supports more basic research than any other NIH institute.

Now, for the first time, we are ready to try to intervene—in human beings—directly in the process wherein a normal cell turns into a cancer cell, a truly remarkable advance. Here is how it works, so far, in experimental animals.

When the National Cancer Plan was designed, the scientists agreed that what we call "cancer" is the result of years—maybe 20 to 30 years—of changes in the tissues of a human body and in certain body functions. One part of these changes has long been identified as the precancerous cell, which is what the cell laboratory technicians look for in a Pap smear.

Cancer in the epithelial, or lining tissues of the body, such as lung tissue, definitely follows a sequence of a normal cell's changing to a precancerous cell and ending up as an element in a tumor.

In view of all the years involved in this slow change, science has asked the question: Isn't there a way we can intervene in this development?

Several things have been proven in the last 5 years. First the body, itself, functions in a way to prevent, or slow, this development. We don't know all of the mechanisms. It has to do with the immune mechanisms. It has been proven, though, that lack of vitamin A derivatives in the body can produce precancerous conditions in the lining tissue of the windpipe and lung passages. It is possible that this process accounts for half of the primary cancer in humans because of involve-

ment of lining tissue in the lung, windpipe, stomach, intestine, uterus and a number of other disorders. So, if we solve this one, we've come a long way.

This information ties in with what we're learning about occupational cancer—vinyl chloride and the like. In those cases, though the diet is balanced, it would appear that the carcinogenic challenge to the body is so severe that normal defenses are overcome.

The more exciting news of the year is that we have indisputable proof that vitamin A derivatives—retinoids—and this is not just vitamin A that you get out of the health stores, so don't go buy vitamin A for this purpose—reverse the transformation of precancerous cells to cancer in laboratory animals. A cohort of animals is given a carcinogenic material. They develop precancerous lesions, proven by autopsy. They are given vitamin A derivatives. The precancerous condition is reversed. This is proven by autopsy. Remaining animals are allowed to live until they die of old age or something else. Very, very few die of cancer after they've been treated fully with retinoids.

We have reason to believe that the treatment will apply to humans. Further, we are especially optimistic because the chemistry of retinoids has improved a great deal. These are synthetic compounds, incidentally.

Senator MAGNUSON. A synthetic derivative of A.

Dr. ROSEMOND. That's right.

We have forms of the chemicals that were previously unavailable. We are keeping our fingers crossed that the freedom from toxicity continues. We are not sure of that, though vitamin A is toxic if too much is taken. So far, the drugs do not appear dangerous. Of course, this statement is premature at the moment, but I think it's a good way to describe it.

Let me describe just a couple of possibilities with these drugs.

First, we already are able to identify high risk factors which tell us some women have a higher than average chance of suffering an onslaught of breast cancer. If tests work out, we might be able to give these women preventive medicine, retinoids, to delay or prevent the disease.

Senator MAGNUSON. How do you give retinoids?

Dr. ROSEMOND. You can take it by mouth.

Senator MAGNUSON. Nutrition plays a big part in it, too.

Dr. ROSEMOND. Yes, it plays a big part in the treatment of any cancer.

Second, where we know that people alive now have been highly exposed to carcinogens, maybe asbestos, aniline dyestuffs, vinyl chloride, for instance, they, too, might be able to escape the cancer which we know for certain that many will get otherwise.

Third, some 40 to 70 percent of persons treated for bladder cancer suffer a recurrence of the disease. Where treatment is successful in the short run, as it almost always is, we now might in certain instances be able to seal in that success for life. We have been able with retinoids to reverse precancerous lesions in the bladders of experimental animals. The situation is hopeful. There will be 29,800 new cases of bladder cancer in this country this year, and approximately 9,500 of those will die of the disease.

We are ready for a clinical trial. One of the major pharmaceutical manufacturers is ready. The bladder cancer task force administered from the National Cancer Institute under your funding is ready. The scientific staff is ready. The patients are, shall we say, tragically ready.

A second advance we in the American Cancer Society think is of outstanding importance is in cancer control. The American Cancer Society invests $17.5 million a year in putting new information in the hands of physicians and the public. We are demonstrably entirely in agreement with what some Members of Congress feel to be a critical factor in the entire Federal biomedical research effort, namely, the quick application to patient care of the research results coming out of the NIH.

Senator MAGNUSON. There again, we get back to application. I was pleased to see that they put a great deal of stress on getting this stuff out. Getting more clinical care. We should have it wherever women get a Pap test, somehow. It doesn't cost anything, comparatively, and too many, even when they go for their physical in the clinic, don't think of a Pap test.

Dr. ROSEMOND. We are trying to right that.

Senator MAGNUSON. As you know, we can stop a lot of it with that.

Dr. ROSEMOND. We think surgical cancer could probably be eliminated if people really do what they could do and that is, of course, what the educational program is for.

I am pleased to report to you a practically unprecedented accomplishment under Federal funding of cancer control projects.

For the first time that I know of, one entire segment of cancer treatment, in this case radiation therapy, has been surveyed to find out what therapy is being given, where it is being given, to what classifications of patients it is being given, how that therapy compares with standards of optimum treatment, and what is the outcome of that therapy.

We thus have the basis for evaluating and then upgrading, where necessary, an entire field of cancer therapy.

I might say this field is involved in approximately the treatment of one-half of the cancer patients.

Further, we have the mechanisms, now, where we can feed directly into radiotherapy facilities all over the country whatever scientific improvements come from research in the future.

The Congress often hears horror tales of the recalcitrance of the American physician, his unwillingness to subject his work to scrutiny and evaluation. The Professional Standards Review Organization, for instance, have not exactly won the hearts and minds of the practicing physician. In a carefully designed approach to professionals delivering radiation therapy, the National Cancer Institute cancer control people have funded a 2½ year study led by Dr. Simon Kramer, a physician at Thomas Jefferson University in Philadelphia—that is a competitor of ours, of course, Temple University—and achieved active professional cooperation and positive results.

Dr. Kramer was able to make almost a total survey of the 1,010 radiotherapy facilities in the United States. Only 11 failed to provide survey data. He got equipment, personnel, and treatment statistics.

From those 1,010, a rather considerable sample of 170 facilities was selected. It might amaze some medical researchers, but Dr. Kramer was able to gain access to patient histories in each of the 170 facilities.

Now this, of course, was without name, as listed in the treatment record.

The project then won a major victory by bringing together an authoritative group of therapists to describe diagnosis and treatment categories to be used as standards. Imagine, we have here a group of doctors setting explicit standards of medical care and, even more astonishing to many who are eternally ready to criticize what goes on in medicine, the doctors voluntarily submitting their work to the most intimate type of scrutiny and judgment.

The next, and crucial, step was to measure the work done in a sample of 170 facilities from the cross section identified in the survey. Computer analysis was based on a scheme shown at the end of this testimony, and I won't go into that, but it is in your record.

I don't think the details will interest you, but a glance at it will show how medical care can be voluntarily systematized and outcomes studied.

The work was centered on cancer of the breast, cervix uteri, corpus uteri, Hodgkin's disease, seminoma, anterior two-thirds of the tongue, floor of the mouth, larynx, nasopharynx, bladder, and prostate.

The study found that in some diseases, such as Hodgkin's, therapy was most often well within the authoritative standard limits. In other diseases there were wider variations.

Now for the payoff! What all this leads up to is a physician education program. On the basis of these findings, the National Cancer Institute will be able to identify and evaluate departures from the standards and to find out their impact on patients. They will also be able to design educational programs on the basis of the variances observed and defined gaps in treatment quality.

In other words, the NCI cancer control program has in place a system for continuing evaluation, continuing education, continuing improvement in radio therapy, and continuing check on the outcome of treatment.

This self-improvement tool is now built into the system.

What of chemotherapy? What of immunotherapy? What of rehabilitation? What of a whole variety of community hospital and comprehensive center attempts to prolong useful, productive life of the cancer patient?

I have just discussed one study. We need many more. We cannot have many more unless realistic funding is available to the National Cancer Institute.

About the appropriations, the President's Cancer Panel last met on March 22, 1977. Cancer centers in a number of cities were heard from. The panel chairman announced after they had testified that we have built up an excellent cancer research and treatment community since enactment of the conquest of cancer program.

Senator MAGNUSON. What happened to Seattle?

Dr. ROSEMOND. It's not in that list there, but it's there.

Senator MAGNUSON. We have one of the finest in the country.

Dr. ROSEMOND. That's right.

Congress has put a priority on this disease research. We have brought scientists in large numbers, and of unquestioned brilliance into the field. We can't keep this machinery going on the practically-level funds we're now getting from the Congress. You know this thing has to kind of progress or else you lose momentum. The Chairman said he was hard-pressed. He had tried over and over again to find some place in the institute budget to cut dollars and to shift them to higher priorities. "I have done my best," he announced. "I invite each of you or all of you to come into the institute and we'll open the books to you and tell you where we can do better."

He pointed out that the National Cancer Advisory Board, the Congress, outside consultants, the President's Cancer Panel, NIH, the HEW Secretary, OMB, and possibly others had gone over the budget.

If we follow the cancer budget presented by Presidents Ford and Carter and they are essentially the same, they recommended the same.

Senator MAGNUSON. At that point let's put in the record, in 1977 comparable appropriation, $814,000,936. The so-called Ford budget was $818,936,000. The Carter budget was $818,936,000 that we have now in front of us.

Dr. ROSEMOND. Yes.

Senator MAGNUSON. For the 1978 appropriation. So even going back to 1977 as you point out, we are sort of standing still.

Dr. ROSEMOND. Yes, it's staying essentially the same, which means, of course, it's being reduced. The record shows us that only 32.3 percent of the approved new applications for research——

Senator MAGNUSON. We're a little like the queen in Alice in Wonderland where she told Alice she had to run like the devil to stay where she was.

Dr. ROSEMOND. That's about right. A treadmill. That means that, taking all of those new research applications which have passed scientific scrutiny and which have been found highly promising, fewer than one out of three will be funded.

The panel was told that supplemental appropriations and recapture of illegally impounded funds glossed over modest percentage increases in the cancer program in recent years.

Senator MAGNUSON. You see, when they made out this budget, they take into consideration impounded funds.

Dr. ROSEMOND. That's right.

Senator MAGNUSON. Make the suggestion, well you have these funds and they will be spent. We have no assurance of that.

Dr. ROSEMOND. That's right.

Senator MAGNUSON. They were from the last year's program.

Dr. ROSEMOND. That's right.

Senator MAGNUSON. It has a lot to do with this year's program, but the impounded funds should have been added to this.

Dr. ROSEMOND. Right.

Senator MAGNUSON. Whatever they might be. In other words, this $818,936,000 figure, the figure should be what would be the reasonable budget figure for 1978 fiscal year.

Dr. ROSEMOND. Yes, sir. I'll get to that if we have time.

Senator MAGNUSON. Yes.

Dr. ROSEMOND. Fiscal 1978 will be a year of bona fide activity decline if the laboratories and scientists don't get adequate funding

this year. In fiscal 1976, for instance, NCI funded 372 new, regular program research grants. Under the President's budgets there would only be 342 new projects funded in fiscal 1978.

Senator MAGNUSON. Of course, now, some of those projects, and you know it as well as I do, some of these projects are—have to be routed out, some may be cancelled, some may need a redirection and things of that kind.

Dr. ROSEMOND. Oh, definitely.

Senator MAGNUSON. So, we will sponge a little out of that.

Dr. ROSEMOND. Oh, yes.

Senator MAGNUSON. It doesn't necessarily mean it will help a new project.

Dr. ROSEMOND. Not a bit in the world.

There has been much loose talk about the largesse visited upon cancer research. Under the President's fiscal 1978 budgets only 36.3 percent of all approved new and competing renewals research applications could be funded. That includes those that had to be funded so that figure is about a third, just slightly higher.

As this testimony was being prepared last week, Congress had not finished work on an extension of the cancer act's authorization. The National Cancer Advisory Board has recommended $1.3 billion for fiscal 1978. We understand that the Senate will cut that to $1.1 billion.

The American Cancer Society stands firm on the proposition that a minimum of $1.1 billion is needed, there is a crying need for it, to exploit the magnificent research work that has begun to issue from the conquest of cancer program under the priority for it set by the Congress. As you know, that was a long-term priority. Our detailed budget is appended to the testimony, so I'll not go into that unless you wish to question me about certain aspects of it.

Mr. Chairman, I know that cost containment is a major goal of the Congress, the Administration and certainly the patient these days. We in cancer research feel very strongly that the estimated $20,000 cost per case of cancer must be one of the main research targets.

In line with this, the cancer control division of the National Cancer Institute has a $250,000 contract with Blue Cross to devote 18 months to preparation of an insurance package of Blue Cross payments for cancer screening, detection, and health education. This package, after design and pilot project testing, would be offered to Blue Cross units across the country as a pioneering effort to use the health insurance mechanism to fund preventive medicine. This is not just a pioneer project in cancer, it is a pioneer project in health in general.

If the National Cancer Institute appropriation for fiscal 1978 is merely the present amount plus some pro forma cost-of-living increase, this project will not get the $500,000 needed to exploit it across the country.

We are investing about $300,000 in cancer control funds for improving methods of pain control. That is a discrete consideration apart from life and death. New methods, it is likely, are not being adopted promptly enough to help, and now, all who have cancer and are getting less than optimum treatment. The startup of this project cannot be developed to full exploitation without an expanded budget.

If we are concerned with today's patient, we must, and I repeat, must, be concerned with alternatives to the present treatment of terminal patients. In too many cases the clinical signs of therapy defeats are followed by returning the patient to his home to die, or oftentimes by keeping him in the hospital, which is very expensive. This is rational. It prevents expenditures for hospitals and nurses and medications that, in our hearts we agonizingly hope will succeed, but that science tells us will not.

Cancer is physically and psychologically damaging enough without adding irrational financial damage. Cancer control at NCI is investing $1.1 million in less financially burdensome ways of treating the terminal patient. In Connecticut, New Jersey, Arizona, and California we are working on the hospice approach, an idea from Europe, where good care is given the patient in a small clinic which concentrates on the special needs of the cancer patient without incurring the vast overhead costs of a general hospital.

In the whole of Philadelphia we have only one area that does this kind of job.

Senator MAGNUSON. I'm hopeful the Veterans Administration will have that, too, where they have so-called outpatient clinics and those that don't have to take up a sophisticated acute hospital bed.

Dr. ROSEMOND. These have associations with hospitals so if they need hospitalization they can always get in.

Whatever value there is in this demonstration project will be lost if there is not at least $1.2 million to exploit the work now in progress.

Cancer Control is spending $30,000 each—certainly an economical figure when you think about it—for large conferences which bring together the best known practitioners, the specialists, the leading researchers in bladder cancer screening, gastro-intestinal cancer screening and gastro-intestinal cancer treatment. That's $90,000 for three. Out of this work comes what a layman would call suggestions for standard treatment. By that is meant, the National Cancer Institute can bring the medical profession together to decide what is the optimal way to operate in therapy or detection with regard to cancer of a given organ site. This has been oftentimes in conjunction with the American Cancer Society to split the cost.

Then we have a tool to upgrade treatment where necessary, to educate, to set a standard by which progress can be assessed, and to set a standard by which new research developments can be measured. We must evaluate what's being done now according to some reliable yardstick. Our original investment of $90,000 or so in these conferences will be wasted if we cannot institute contracts to exploit the information already gathered.

Senator MAGNUSON. How much will the society take in last year?

Dr. ROSEMOND. Cancer Society? It was roughly $115 million.

There's been a great deal of talk about preventive care, particularly with regard to the work place—vinyl chlorides, asbestos, exhaust fumes—but medical schools have not entered into this on a routine basis.

At least $3 million is needed to set up pilot programs, make them work, publish the results so that medical educators will see the value of it, see that it is feasible, and want to do it.

The committee has often heard testimony that 85 percent of the cancer patients are treated, not in comprehensive centers, but in community hospitals. As a matter of fact, that X-ray program I mentioned, radiation therapy, approximately 80 percent of these patients were treated in community hospitals, but by a therapist who was well trained.

We have funded a half dozen projects at about $75,000 each to find ways of creating community cancer centers that will use the latest therapies that come out of new research. Even to turn these explorative projects into demonstrations ready for inspection and ready for duplication elsewhere will cost about $150,000 each. That money is not available in today's cancer institute budget.

Mr. Chairman, I won't go into details of the citizen's budget, but I do want to address one point, its balance.

For a couple of decades, the American Cancer Society has supported research on environmental sources of cancer. The leading figure in the world in this field, Dr. Irving Selikoff, says he could not have done this work without the help he got from the American Cancer Society. It is his work which gives us the scientific basis for saying that, possibly, 85 percent of all cancer is triggered by something humans eat, drink, breathe or smoke. Smoke is quite important, I might say, not cigars, but cigarettes.

Senator MAGNUSON. I was going to say, the Chairman went through the smoking bit for a long while. I wrote the language on cigarettes because after weeks of testimony, I came to the layman's conclusion that it's inhaling that does it.

Dr. ROSEMOND. That's right.

Senator MAGNUSON. If you smoked corn tassels behind the barn, if you inhaled it, you would be in trouble.

Go ahead.

I have an appointment here.

Dr. ROSEMOND. I'll finish up.

The American Cancer Society at its annual meeting last year gave its highest scientific award to Dr. Selikoff. We believe we have been the prime force in American society which put the spotlight on environmental cancer.

Therefore, we believe that efforts to change the balance in research emphases in recent years, certainly abetted by your committee, have served the American people well.

The American Cancer Society, the National Cancer Advisory Board, the President's Cancer Panel all agree that more money could be invested wisely in the national cancer program.

As witnesses come before you, you will once again be struggling with requests far beyond any immediate scope of response in terms of appropriations.

I want to call your attention to one fact that convinces me that practically all of these requests can be validated, namely this: The direct cost of health care in this country is now running about $139 billion per year, according to the National Center for Health Statistics. This does not include the indirect cost of disability or premature death. Approximately 15 billion of that is direct cost of cancer patients and it's been estimated that cancer costs about $30 billion overall, including work loss and the like.

In two widely separated studies, one conducted by Dr. John Spratt when he was the chief of the Ellis Fischel Cancer Center in Missouri, and one conducted by the National Cancer Foundation in a variety of therapy settings in the Metropolitan New York City area, the direct cost of a case of cancer was shown to run about $20,000. A very intense study of 115 families in the New York area put the average cost at almost $22,000. Since the New York data were gathered during 1971 and 1972, obviously the toll per family would be closer to $24,000 per year now.

This devastating burden, possibly the costliest of all categorical disease burdens in the country, can be lightened. Research has produced a marked turndown in mortality from heart disease, as you have heard. Now, the official cancer rate in 1975, the latest year for which full data have been analyzed, shows a slight decline, about seven-tenths of one percent. This is a little faster than we expected because of the delay in finding out how things are really doing, so I think this is a very, very important finding. At least, it's beginning to——

Senator MAGNUSON. When I first got interested in this, the first bill I passed in Congress was the establishment of the cancer institute.

Dr. ROSEMOND. You have been a tremendous help all through the years. We are well aware of it.

Senator MAGNUSON. I hate to mention this, but that was 40 years ago, forty years ago. That was the first institute at NIH. You people have been so helpful to all of us all the way along, and my interest in the matter of course is great, it's a personal interest, too.

Dr. ROSEMOND. We all have to work together.

Senator MAGNUSON. Yes. In my family we have had it.

Dr. ROSEMOND. Yes, I have had the same experience in my family, too.

What is so remarkable, is that lung cancer from smoking has produced a high rise in cancer mortality, particularly among women, but the overall death rate figure for all cancers afflicting both sexes still reflects a slight decline. If we could get rid of lung cancer and we know how to do that, we could really make that impressive.

The Metropolitan Life Insurance Company survey of its standard ordinary policy holders brings figures up-to-date for 1976 and records a 3 percent decline in mortality below 1975. Every type of cancer they measured show decline, with death from Hodgkins disease 17 percent below 1975.

There is little question in my mind, gentlemen, that Federally funded disease research in general and conquest of cancer research in particular is paying off.

I will close with a photograph. In prior testimony the American Cancer Society showed that the historical two-year survival rate of osteogenic sarcoma, bone cancer, is about 20 to 25 percent. At Sidney Farber Cancer Center in Boston, work under Dr. Norman Jaffe, who appeared before this committee sometime in the past, in fact I appeared here with him——

Senator MAGNUSON. We know Dr. Jaffe well, and I knew Sidney well, too.

Dr. ROSEMOND. We wish Sidney were with us today. At Sidney Farber Cancer Center in Boston, work under Dr. Norman Jaffe is regularly producing a 2-year survival rate of 95 percent disease free.

I don't know whether you can read X-rays, but there are obvious lumps here.

So the prognosis is that we will be able to record a strikingly higher 5-year survival rate—getting on into the cure territory—just as soon as we can rack up the years. This is only two years, as I say.

Senator MAGNUSON. When we started this in 1938 it was said as a rule out of thumb that four out of five people that had cancer died.

Dr. ROSEMOND. Right.

Senator MAGNUSON. Now we have a rough figure, I think you people verified this, a rough figure, that two and a half out of every five die from cancer.

Dr. ROSEMOND. That's right.

This picture is an X-ray of a 12-year-old osteogenic sarcoma patient whose leg was amputated in 1962 at M.D. Anderson Hospital in Houston. There were eight lesions in the lung and one lobe was removed because the disease had metastisized.

This second picture shows a recent photograph of her lung. Nearly 15 years later she is a mother of two children.

She was treated with surgery for the primary cancer, with surgery where the disease had spread to her lung, and with chemotherapy to finish the treatment and prevent recurrence.

American Cancer Society President R. Lee Clark, who heads M.D. Anderson, believes this case represents the very first documented instance of a complete cure of disseminated cancer.

When Dr. Jaffe's patients, and thousands like them at other institutions, begin to pump these higher survival rates into the statistical system, you will see the benefits of your years of concern and your support for this area of biomedical research.

Senator MAGNUSON. Thank you very much. We will look at the figures.

We are glad to see there is some progress.

Dr. ROSEMOND. We are, too, and we are surprised it came quite this fast because as I mentioned, there is a delay factor before we can really see what we are doing.

Senator MAGNUSON. Yes.

Well, I'm very excited about this vitamin A substitute.

Dr. ROSEMOND. So are we, but it's still preliminary and we don't like to let our hopes get too high. I don't like to be overly enthusiastic, but it certainly looks awfully good.

Senator MAGNUSON. I hope you are very conservative.

Dr. ROSEMOND. We are getting into the area of prevention of cancer with that and that is something we have been wanting to get into for some time.

Senator MAGNUSON. Thank you very much.

PREPARED STATEMENT

We will take a 15-minute recess. If you have a written statement, we will be glad to include it in the record.

[Recess.]

[The statement follows:]

STATEMENT OF GEORGE P. ROSEMOND, M.D.

Mr. Chairman, thank you for inviting this testimony, allowing me to appear, and continuing the tradition of giving citizens an opportunity to testify directly to your committee. You all undertake a burden that we in the American Cancer Society deeply appreciate.

Mr. Chairman, in the interest of saving time, I will describe what many of us in the American Cancer Society consider just two of the major advances in recent years.

First, in basic research, work on the development of the cell, how one cell passes on characteristics to a daughter cell, has now advanced to the point that cancer and other diseases are more understandable than ever before. As you know, the National Cancer Institute supports more basic research than any other N.I.H. institute.

Now, for the first time, we are ready to try to intervene--IN HUMAN BEINGS--directly in the process wherein a normal cell turns into a cancer cell, a truly remarkable advance. Here is how it works:

When the National Cancer Plan was designed, the scientists agreed that what we call "cancer" is the result of years--maybe 20 to 30 years--of changes in the tissues of a human body and in certain body functions. One part of these changes has long been identified as the precancerous cell, which is the cell laboratory technicians look for in a Pap smear.

Cancer in the epithelial, or lining tissues of the body, such as lung tissue, definitely follows a sequence of a normal cell's changing to a pre-cancerous cell and ending up as an element in a tumor.

In view of all the years involved in this slow change, science has asked the question: Isn't there a way we can intervene in this development?

Several things have been proven in the last five years. First the body, itself, functions in a way to prevent, or slow, this development. We don't know all of the mechanisms. It has been proven, though, that lack of

vitaimin A derivatives in the body can produce precancerous conditions in the lining tissue of the windpipe and lung passages. It is possible that this process accounts for half of the primary cancer in humans because of involvement of lining tissue in the lung, windpipe, stomach, intestine, uterus, kidney, bladder, testis, prostate, pancreas, and skin. So, if we solve this one, we've come a long way.

This information ties in with what we're learning about occupational cancer--vinyl chloride and the like. In those cases, though the diet is balanced, it would appear that the carcinogenic challenge to the body is so severe that normal defenses are overcome.

The exciting news of the year is that we have indisputable proof that vitamen A derivatives--retinoids--reverse the transformation of precancerous cells to cancer in laboratory animals. A cohort of animals is given a carcinogenic material. They develop precancerous lesions, proven by autopsy. They are given vitamin A derivatives. The precancerous condition is reversed. This is proven by autopsy. Remaining animals are allowed to live until they die of old age or something else. Very, very few die of cancer after they've been treated fully with retinoids.

We have reason to believe that the treatment will apply to humans. Further, we are especially optimistic because the chemistry of retinoids has improved a great deal. We have forms of the chemicals that were previously unavailable.

We are keeping our fingers crossed that the freedom from toxicity continues. So far, the drugs do not appear dangerous.

Let me describe just a couple of possibilities with these drugs.

First, we already are able to identify high risk factors which tell us some women have a higher than average chance of suffering an onslaught of breast cancer. If tests work out, we might be able to give these women preventive medicine, retinoids, to delay or prevent the disease.

Second, where we know that people alive now have been highly exposed

to carcinogens, maybe asbestos, aniline dyestuffs, vinyl chloride, for instance, they, too, might be able to escape the cancer which we know for certain that many will get otherwise.

Third, some 40 to 70 percent of persons treated for bladder cancer suffer a recurrence of the disease. Where treatment is successful in the short run, as it almost always is, we now might be able to seal in that success for life. We have been able with retinoids to reverse precancerous lesions in the bladders of animals. The situation is hopeful. There will be 29,800 new cases of bladder cancer in this country this year. We anticipate 9,500 deaths.

We are ready for a clinical trial. One of the major pharmaceutical manufacturers is ready. The bladder cancer task force administered from the National Cancer Institute under your funding is ready. The scientific staff is ready. The patients are, shall we say, tragically ready.

A second advance we in the American Cancer Society think is of outstanding importance is in cancer control. The American Cancer Society invests $17\frac{1}{2}$ million a year in putting new information in the hands of physicians and the public. We are demonstrably entirely in agreement with what some Members of Congress feel to be a critical factor in the entire federal biomedical research effort, namely, the quick application to patient care of the research results coming out of the N.I.H.

I am pleased to report to you a practically unprecedented accomplishment under federal funding of cancer control projects.

For the first time that I know of, one entire segment of cancer treatment, in this case radiology, has been surveyed to find out what thereapy is being given, where it is being given, to what classifications of patients it is being given, how that therapy compares with standards of optimum treatment, and what is the outcome of that therapy.

We thus have the basis for evaluating and then upgrading, where necessary, an entire field of cancer therapy.

Further, we have the mechanisms, now, where we can feed directly into radiotherapy facilities all over the country whatever scientific improvements come from research in the future.

The Congress often hears horror tales of the recalcitrance of the American physician, his unwillingness to subject his work to scrutiny and evaluation. The PSRO, Professional Standards Review Organizations, for instance, have not exactly won the hearts and minds of the practicing physician. But in a carefully designed approach to professionals delivering radiotherapy, the National Cancer Institute cancer control people have funded a 2½ year study led by Dr. Simon Kramer, a physician at Thomas Jefferson University in Philadelphia, and achieved active professional cooperation and positive results.

Dr. Kramer was able to make almost a total survey of the one thousand and ten (1,010) radiotherapy facilities in the United States. Only 11 failed to provide survey data. He got equipment, personnel, and treatment statistics.

From these one thousand and ten, a rather considerable sample of 170 facilities was selected. It might amaze some medical researchers, but Dr. Kramer was able to gain access to patient histories in each of the 170 facilities.

The project then won a major victory by bringing together an authoritative group of therapists to describe diagnosis and treatment categories to be used as standards. Imagine, we have here a group of doctors setting explicit standards of medical care and, even more astonishing to many who are eternally ready to criticize what goes on in medicine, the doctors voluntarily submitting their work to the most intimate type of scrutiny and judgment.

The next, and crucial, step was to measure the work done in a sample of 170 facilities from the universe identified in the survey. Computer analysis was based on a scheme shown at the end of this testimony.

I don't think the details will interest you, but a glance at it will show how medical care can be systematized and outcomes studied.

The work was centered on cancer of the breast, cervix uteri, corpus uteri, Hodgkin's disease, seminoma, anterior two-thirds of the tongue, floor of mouth, larynx, nasopharynx, bladder, and prostate.

The study found that in some diseases, such as Hodgkin's, therapy was most often well within the authoritative standard limits. In other diseases there were wider variations.

Now for the payoff! What all this leads up to is a physician education program. On the basis of these findings, the National Cancer Institute will be able to identify and evaluate departures from the standards and to find out their impact on patients. They will also be able to design educational programs on the basis of the variances observed and defined gaps in treatment quality.

In other words, the NCI cancer control program has in place a system for continuing evaluation, continuing education, continuing improvement in radio therapy, and continuing check on the outcome of treatment.

This self-improvement tool is now built into the system.

But what of chemotherapy? What of immunotherapy? What of rehabilitation? What of a whole variety of community hospital and comprehensive center attempts to prolong useful, productive life of the cancer patient?

I have just discussed one study. We need many more. We cannot have many more unless realistic funding is available to the National Cancer Institute.

About the appropriations, the President's Cancer Panel last met on March 22, 1977. Cancer centers in Baltimore; Los Angeles; Philadelphia; Madison, Wisconsin; and Durham, North Carolina were heard from. The Panel Chairman announced after they had testified that we have built up an excellent cancer research and treatment community since enactment of the Conquest of Cancer program. Congress has put a priority on this disease

research. We have brought scientists in large numbers, and of unquestioned brilliance into the field. But we can't keep this machinery going on the practically level funds we're now getting from the Congress. He said he was hard pressed. He had tried over and over again to find some place in the institute budget to cut dollars and to shift them to higher priorities. "I have done my best," he announced. "I invite each of you or all of you to come into the institute and we'll open the books to you and you tell us where we can do better." He pointed out that the National Cancer Advisory Board, the Congress, outside consultants, the President's Cancer Panel, NIH, the HEW Secretary, OMB, and possibly others had gone over the budget.

If we follow the cancer budget presented by Presidents Ford and Carter--they recommended the same, then, now please see that the record shows this--then only 32.3% of the approved new applications for research project grants will be funded in fiscal 1978. That means that, taking all of those new research applications which have passed scientific scrutiny and which have been found highly promising, fewer than one out of three will be funded.

The Panel was told that supplemental appropriations and recapture of illegally impounded funds glossed over modest percentage increases in the cancer program in recent years. But fiscal 1978 will be a year of bona fide activity decline if the laboratories and scientists don't get adequate funding this year. In fiscal 1976, for instance, NCI funded 372 new, regular program research grants. Under the Presidents' budgets there would only be 342 new projects funded in fiscal 1978.

There has been much loose talk about the largesse visited upon cancer research. Under the Presidents' fiscal 1978 budgets only 36.3% of all approved new and competing renewals research applications could be funded.

As this testimony was being prepared last week, Congress had not finished work on an extension of the cancer act's authorization. The

National Cancer Advisory Board has recommended $1.3 billion for fiscal 1978. We understand that the Senate will cut that to $1.1 billion. The American Cancer Society stands firm on the proposition that $1.1 billion is needed, there is a crying need for it, to exploit the magnificent research work that has begun to issue from the Conquest of Cancer program under the priority for it set by the Congress.

Our detailed budget is appended to this testimony.

Mr. Chairman, I know that cost containment is a major goal of the Congress, the Administration, and certainly the patient these days. We in cancer research feel very strongly that the estimated $20,000 cost per case of cancer must be one of the main research targets.

In line with this, the cancer control division of the National Cancer Institute has a $250,000 contract with Blue Cross to devote 18 months to preparation of an insurance package of Blue Cross payments for cancer screening, detection, and health education. This package, after design and pilot project testing, would be offered to Blue Cross units across the country as a pioneering effort to use the health insurance mechanism to fund preventive medicine. This is not just a pioneer project in cancer, it is a pioneer project in health in general.

If the National Cancer Institute appropriation for fiscal 1978 is merely the present amount plus some pro forma cost-of-living increase, this project will not get the $500,000 needed to exploit it across the country.

We are investing about $300,000 in cancer control funds for improving methods of pain control. That is a discrete consideration apart from life and death. New methods, it is likely, are not being adopted promptly enough to help, now, all who have cancer and are getting less than optimum treatment. The start-up of this project cannot be developed to full exploitation without an expanded budget.

If we are concerned with today's patient, we must, and I repeat, must, be concerned with alternatives to the present treatment of terminal

patients. In too many cases the clinical signs of therapy defeats are followed by returning the patient to his home to die. This is rational. It prevents expenditures for hospitals and nurses and medications that, in our hearts we agonizingly hope will succeed, but that science tells us will not. Cancer is physically and psychologically damaging enough without adding irrational financial damage. Cancer control at NCI is investing $1.1 million in less financially burdensome ways of treating the terminal patient. In Connecticut, New Jersey, Arizona, and California we are working on the hospice approach, an idea from Europe, where good care is given the patient in a small clinic which concentrates on the special needs of the cancer patient without incurring the vast overhead costs of a general hospital.

Whatever value there is in this demonstration project will be lost if there is not at least $1.2 million to exploit the work now in progress.

Cancer Control is spending $30,000 each--certainly an economical figure when you think about it--for large conferences which bring together the best known practitioners, the specialists, the leading researchers in bladder cancer screening, gastro-intestinal cancer screening and gastro-intestinal cancer treatment. That's $90,000. Out of this work comes what a layman would call suggestions for "standard treatment." By that is meant, the National Cancer Institute can bring the medical profession together to decide what is the optimal way to operate in therapy or detection with regard to cancer of a given organ site.

Then we have a tool to upgrade treatment where necessary, to educate, to set a standard by which progress can be assessed, and to set a standard by which new research developments can be measured. We must evaluate what's being done now according to some reliable yardstick. Our original investment of $90,000 or so in these conferences will be wasted if we cannot institute contracts to exploit the information already gathered.

There's been a great deal of talk about preventive care, particularly with regard to the work place--vinyl chlorides, asbestos, exhaust

fumes--but medical schools have not entered into this on a routine basis. At least $3 million is needed to set up pilot programs, make them work, publish the results so that medical educators will see the value of it, see that it is feasible, and want to do it.

The committee has often heard testimony that 85% of the cancer patients are treated, not in comprehensive centers, but in community hospitals. We have funded a half dozen projects at about $75,000 each to find ways of creating community cancer centers that will use the latest therapies that come out of new research. Even to turn these explorative projects into demonstrations ready for inspection and ready for duplication elswehere will cost about $150,000 each. That money is not available in today's cancer institute budget.

Mr. Chairman I won't go into details of the Citizens' Budget, but I do want to address one point, its balance.

For a couple of decades the American Cancer Society has supported research on environmental sources of cancer. The leading figure in the world in this field, Dr. Irving Selikoff, says he could not have done this work without the help he got from the American Cancer Society. It is his work which gives us the scientific basis for saying that, possibly, 85% of all cancer is triggered by something humans eat, drink, breathe, or smoke. The American Cancer Society at its annual meeting last year gave its highest scientific award to Dr. Selikoff. We believe we have been the prime force in American society which put the spotlight on environmental cancer.

Therefore, we believe that efforts to change the balance in research emphases in recent years, certainly abetted by your committee, have served the American people well.

The American Cancer Society, the National Cancer Advisory Board, the President's Cancer Panel all agree that more money could be invested wisely in the National Cancer Program.

As witnesses come before you, you will once again be struggling with requests far beyond any immediate scope of response in terms of appropriations.

But, I want to call your attention to one fact that convinces me that practically all of these requests can be validated, namely this: The direct cost of health care in this country is now running $139 billion per year, according to the National Center for Health Statistics. This does not include the indirect cost of disability or premature death.

In two widely separated studies, one conducted by Dr. John Spratt when he was the chief of the Ellis Fischel Cancer Center in Missouri, and one conducted by the National Cancer Foundation in a variety of therapy settings in the Metropolitan New York City area, the direct cost of a case of cancer was shown to run about $20,000. A very intense study of 115 familes in the New York area put the average cost at $21,718. Since the New York data were gathered during 1971 and 1972, obviously the toll per family would be closer to $24,000 per year now.

This devastating burden, possibly the costliest of all categorical disease burdens in the country, can be lightened. Research has produced a marked turndown in mortality from heart disease, as you have heard. Now, the official cancer death rate in 1975, the latest year for which full data have been analyzed, shows a slight decline, about seven-tenths of one percent.

What is so remarkable, is that lung cancer from smoking has produced a high rise in cancer mortality, particularly among women, but the overall death rate figure for all cancers afflicting both sexes still reflects a slight decline. The Metropolitan Life Insurance Company survey of its standard ordinary policy holders brings figures up-to-date for 1976 and records a 3% decline in mortality below 1975. Every type of cancer they measured show decline, with death from Hodgkins disease 17% below 1975.

There is little question in my mind, gentlemen, that federally funded

disease research in general and Conquest of Cancer research in particular is paying off.

I will close with a photograph. In prior testimony the American Cancer Society showed that the historical two-year survival rate for osteogenic sarcoma, bone cancer, is about 20 to 25 percent. At Sideny Farber Cancer Center in Boston work under Dr. Norman Jaffe is regularly producing a two-year survival rate of 95 percent, with over 50 percent disease free. So the prognosis is that we will be able to record a strikingly higher five-year survival rate--getting on into the cure territory--just as soon as we can rack up the years.

Here is a picture of what I am talking about. This is an X-ray of a 12-year-old osteogenic sarcoma patient whose leg was amputated in 1962 at M.D. Anderson Hospital in Houston. There were eight lesions in the lung and one lobe was removed because the disease had metastisized.

This second picture shows a recent photograph of her lung. Nearly 15 years later she is a mother of two children.

She was treated with surgery for the primary cancer, with surgery where the disease had spread to her lung, and with chemotherapy to finish the treatment and prevent recurrence.

American Cancer Society President R. Lee Clark, who heads M.D. Anderson, believes that this 1962 case represents the very first documented instance of a complete cure of disseminated cancer.

When Dr. Jaffe's patients, and thousands like them at other institutions, begin to pump these higher survival rates into the statistical system, you will see the benefits of your years of concern and your support for this area of biomedical research.

CITIZENS' BUDGET

for

National Cancer Institute

Fiscal 1978 -- Dollars in Millions

Table I

| | Dollars | Percent |
|---|---|---|
| I. Research | | |
| Cause & prevention | $271.6 | 25% |
| Detection & Diagnosis | 80.0 | 7 |
| Treatment | 355.0 | 32 |
| Basic cancer biology | 164.7 | 15 |
| TOTAL RESEARCH | 871.3 | 79% |
| II. Resource Development | | |
| Centers planning & core grants (center research incl. in I above) | 52.4 | 5% |
| Research manpower development | 45.9 | 4 |
| Construction | 47.0 | 4 |
| TOTAL RESOURCE DEVELOPMENT | 145.3 | 13% |
| III. Cancer Control | 88.5 | 8 |
| TOTAL NATIONAL CANCER INSTITUTE | $1,105.1 | 100% |

CITIZENS' BUDGET

National Cancer Institute

Fiscal 1978 -- Dollars in Millions

Table II

| | Dollars | Percent |
|---|---|---|
| Grants | | |
| Regular research projects | $213.1 | 19% |
| Program projects | 119.4 | 11 |
| Organ site task forces | 40.0 | 4 |
| Research career program | 4.9 | 0.5 |
| Radiation development research | 8.9 | 1 |
| Cancer Research Emphasis Grants (CREG) | 37.0 | 3 |
| Total research grants | $423.3 | 38% |
| Cancer centers, comprehensive & specialized | | |
| Core support | 47.1 | 4% |
| Planning | 3.5 | 0.5 |
| Clinical education | 14.4 | 1 |
| Fellowships | 27.8 | 2 |
| Training grants | 1.8 | 0.1 |
| Construction | 38.7 | 3 |
| Cancer control studies | 13.0 | 1 |
| Total grants | $569.6 | 51% |
| Contracts | | |
| Research | 177.2 | 16% |
| Research support | 110.8 | 10 |
| Transfer to Environmental Protection Agency and other federal groups | 15.6 | 1 |
| NCI construction | 7.0 | 0.5 |
| Cancer control demonstrations | 65.5 | 6 |
| Cancer control transfer to other agencies | 3.5 | 0.5 |
| Total contracts | $379.6 | 34% |
| Research within NCI | $ 60.3 | 5% |
| NIH Campus Manaement Fund & other NCI support | $ 95.6 | 9% |
| Total National Cancer Institute | $1,105.1 | 100% |

Cancer Mortality Report

Standard Ordinary Policyholders, Metropolitan Life Insurance Company

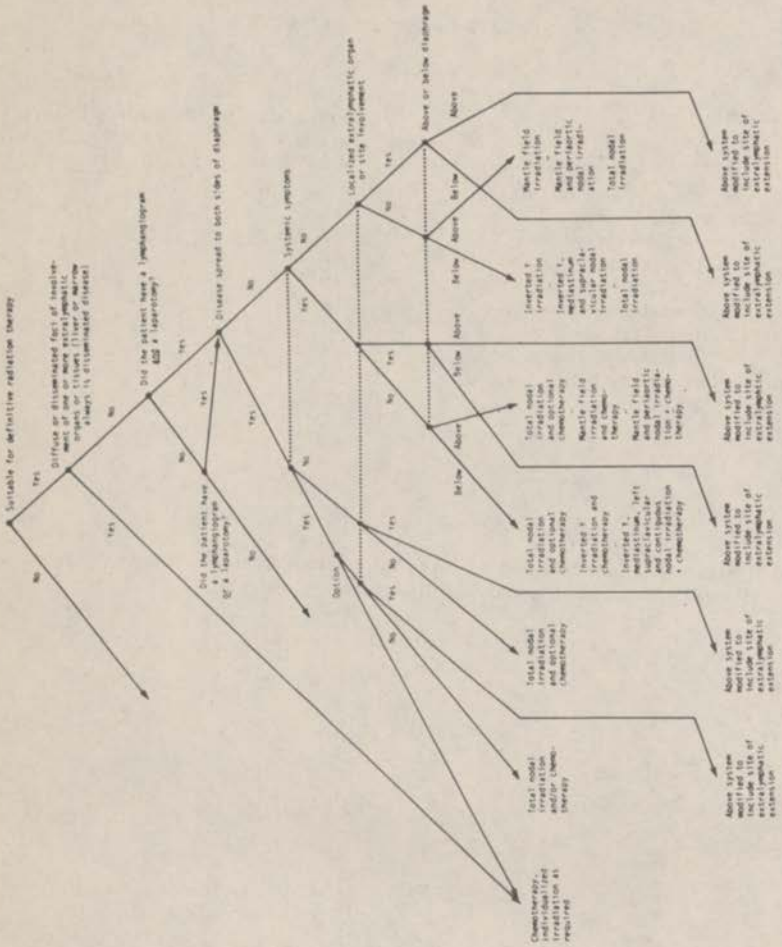
1976 Compared with 1975

Table III

| Cause of Death | Death Rate per 100,000 in 1976* | 1976 Death Rate as Percent of That in 1975* |
|---|---|---|
| Cancer--all forms | 152.4 | 97% |
| Digestive system | 39.8 | 95 |
| Respiratory system | 41.5 | 99 |
| Lung | 49.7 | 99 |
| Breast | 10.6 | 97 |
| Genital organs | 14.7 | 99 |
| Hodgkins disease | 1.2 | 83 |
| Leukemia | 6.2 | 95 |
| All other cancers | 41.8 | 99 |

*Death rates for 1975 are adjusted to correspond to the age and sex distribution of the Standard Ordinary policyholders in 1976.

Decision tree showing key decisions for the pretreatment evaluation and treatment of Hodgkin's disease by radiation therapy.



Source: "The Study of Cancer Care Patterns in Radiation Therapy," by Simon Kramer, M.D., September 28, 1976.

Table IV

Summary Justification for Citizens' Budget
Increase Over FY 1977's $814 mil.

+ Breast Cancer Task Force ..... $11 mil.
88,000 deaths; 33,000 new cases/year. Need for safer mammorgraphy; better tailoring of treatment to individual (estrogen analysis), clinical trials of best drugs.

+ Carcinogenesis Research including Viral Co-Carcinogenesis .. 15 mil.
Evidence indicates that apparently normal human cells may contain genetic information which enables the cells to become cancerous when provoked by irradiation or environmental chemicals; possibly fundamental disease cause.

+ Testing chemicals..... 40 mil.
60 compounds now being tested annually, should be 200; new ones entering environment @ 900-1,000/yr.

+ Adding toxicologists & pathologists..... 8 mil.
A critical shortage exists.

Preclinical Treatment Research ..... 10 mil.
Recent clinical trials for the first time have shown weaknesses and strengths of existing drugs vis a vis specific tumors. Need for more screening for new drugs is urgent.

+ Clinical Trials..... 40 mil.
Disease-oriented strategies have been developed for head & neck cancer, lung, breast, ovarian, stomach, melanoma, colorectal and uterine cancer, adding up to 50% of all cancers in man. These strategies need evaluation and improvement.

Community Activities..... 19 mil.
80% of cancer cases first seen by MDs in community hospitals. Cancer awareness must be heightened for earlier detection.

Epidemiology..... 6 mil.
Now possible to "profile" individuals according to cancer risk to them; sharper data needed for preventive medicine.

Computerized Axial Tomography..... 3 mil.
Probably the most important cancer disease use of this new scanner is in non-invasive diagnosis of size and scope of tumors, brain for instance. This over-used method needs sharp focus on specific applications where it is needed.

Nutrition ..... 11 mil.
Theories on diet causes of cancer are primitive; need intense exploration, as do dietary approaches in therapy.

+ High Priority Research Project Grants ..... 78 mil.
With only approximately 30% of approved grants being funded, many high priority projects are going undone.

Construction..... 49 mil.
Biohazard safety in laboratories is outmoded; new dangers have been identified; old labs not designed to handle them.

( + = 6 highest of 12 priority areas) TOTAL $290 mil.

# Biographical Sketch

| | |
|---|---|
| Born: | August 23, 1910, Hillsboro, North Carolina |
| B. S. | University of North Carolina, 1932 |
| M. D. | Temple University School of Medicine, 1934 |
| M. S. (Surgery) | Temple University School of Medicine, 1939 |
| Internship: | Temple University Hospital, 1934-36 |
| Residency (General Surgery): | Temple University Hospital, 1936-39 |
| Certification: | Diplomate, American Board of Surgery, 1942 |
| | Diplomate, The Board of Thoracic Surgery, 1960 |
| Fellow: | American College of Surgeons |
| Medical School Appointments: | Temple University School of Medicine |
| | Instructor in Surgery, 1937-41<br>Assistant Professor of Surgery, 1941-43<br>Associate Professor of Surgery, 1943-47<br>Clinical Professor of Surgery, 1947-50<br>Professor of Surgery and Co-Chairman, Department of Surgery, 1960-63<br>Professor of Surgery and Chairman, Division of Surgery, 1960-June 30, 1973<br>Professor of Surgery and Chairman, Department of Surgery, 1963-June 30, 1973 |
| Hospital Affiliations: | Surgeon, Temple University Hospital, 1939-present<br>Associate Attending Surgeon, St. Christopher's Hospital for Children, 1950-74<br>Consultant, Department of Surgery, Paoli Memorial Hospital<br>Consultant Physician, Thoracic Surgery, Veterans Administration Hospital, Wilkes-Barre, Pennsylvania<br>Medical Advisory Committee to 1973<br>Consultant, Department of Surgery, Hanover General Hospital, Hanover, Pennsylvania |
| Member: | American Medical Association<br>American Association for Thoracic Surgery<br>Membership Committee, 1965-67<br>Senior Member, 1969 (at the 49th Annual Meeting)<br>American College of Chest Physicians<br>Committee on Educational Grants, 1971<br>Fellow Emeritus, 1975<br>American Surgical Association<br>Senior Fellowship, 1970<br>American College of Surgeons<br>State Advisory Committee, District #8<br>Chairman: State & Provincial Advisory Committee, 1972-78<br>Senior Member, Commission on Cancer, 1956-71 |

Liaison Fellow, 1956-
Nominating Committee of Fellows, 1970-71
Chairman: Nominating Committee of Fellows, 1972-73
Pennsylvania East Credentials Committee, 1957-76
Surgical Education Knowledge Self-Assessment Committee, 1970-73
Committee on Continuing Education, 1974
American Trudeau Society
International Society of Surgery
Society of Surgical Chairmen, 1960-June 30, 1973
Committee on Professional Fees from Surgical Patients
Philadelphia College of Physicians
Joseph N. Pew, Jr. Memorial Loan Fund Committee
Council, 1973-78
Nominating Committee, 1972
Secretary, June, 1976 - October, 1976
Vice-President, October, 1976
Philadelphia Academy of Surgery
President, January, 1968 - December, 1969
Nominating Committee, 1972-73
Philadelphia County Medical Society
President, 1965-66
Chairman: Committee for the Study of Diagnostic Delay in Breast Cancer, 1951-67
Dean's Committee, 1971-75
Hospital Affairs Committee, 1971
Subcommittee Cancer Control, 1971-76
Committee on Long Range Planning, 1971-72
Installation Committee
Subcommittee on Strittmatter Award
Subcommittee on Benjamin Rush Award, 1971-74
Medical Society of the State of Pennsylvania
President, 1971-72
Chairman: Philadelphia County Delegation, 1967-70
Philadelphia County Delegate, 1961-78
Delegate: Committee on Comprehensive Health Planning
Member: Advisory Committee to Woman's Auxiliary, 1972-73
Committee on Mammography and Diseases of the Breast American College of Radiology
Pennsylvania Association for Thoracic Surgery
Council, 1971-72
Vice-President, 1972-73
President, 1973-74
Surgeon's Travel Club
Laennec Society of Philadelphia
President, 1964
Wainwright Tumor Clinic Association
Director, 1969-73
American Cancer Society, National
President, 1974-75
President-Elect, October, 1973
Director-at-Large, 1971-77
Delegate Director, 1967-71
Delegate, 1963-67
Chairman: Professional Nominating Committee, 1975-76
Chairman: Legislative & Government Programs, 1975-76
Chairman: National Task Force on Breast Cancer Control, 1971
Vice Chairman: National Task Force on Breast Cancer Control, 1977
Vice Chairman: Awards, 1975-76
Chairman: Credentials Committee, 1975
Chairman: Medical & Scientific Executive Committee, 1971-73

Vice Chairman: Professional Education Committee, 1969-70
Chairman: Professional Education Committee, 1971
Ex-Officio: Subcommittee on Films
Clinical Fellowship Committee
Professional Education Subcommittee on Honors
Ad Hoc Committee to Evaluate Impact of Professional Education Materials on Medical Students
Ad Hoc Study Group on Breast Cancer
Service & Rehabilitation Committee
Ad Hoc Committee on Oral Cancer Monograph
Study Group on Cancer Information Services
Chairman: Subcommittee on Rehabilitation of the Mastectomy Patient, 1968-70
Constitution, Bylaws and Organization Committee, 1969-70
Research & Clinical Investigation, 1977
Legislative & Government Programs Committee, 1977
Committee on Tobacco & Cancer, 1977
Committee to Advance World-Wide Fight Against Cancer, 1977
Program Committee National Conference on Cancer of the Colon and Rectum, 1971
Chairman: Program Committee Second National Conference on Cancer of the Breast, 1971
National Survey Committee, 1972
Member Task Force Study Group I, 1972
Breast Cancer Task Force to Evaluate Grant Applications for Demonstration Projects for Earlier Detection of Breast Cancer, 1972
Member: Committee on Cooperative Government Program, 1972
Member: Program Committee Seventh National Cancer Conference, 1972
Chairman: Sixth National Cancer Conference, 1971
Chairman: 1973 Postgraduate Course - "Breast Cancer"
Member: Program Committee, National Conference on Cancer Nursing, 1973

American Cancer Society, Philadelphia Division
President, 1967-68
All Committees Ex-Officio
Eastern Area Speaker, 1972
Member: Breast Cancer Task Force, 1976-77
Member: Medical & Scientific Committee, 1976-77

Pennsylvania Society for the Advancement of Medical Research
President, 1967

Board of Directors: Blue Cross of Greater Philadelphia, 1977-'78

United Health Services
Board of Directors, 1967-71
Research Council, 1967-71

United Fund Torch Drive
Co-Chairman: Hospital Group, 1972

Year Book of Cancer (Year Book Medical Publishers, Inc.)
M. D. Anderson Hospital and Tumor Institute
Consultant on Surgery of the Breast, 1971-77

American Public Health Association, 1971

Yugoslavian-United States Medical Association, 1971-
Council, 1971
Board of Directors, 1972

J. Aithen Meigs Medical Association, 1965-

Who's Who in America
Advisory Member: The Marquis Biographical Library Society

The Blue Book

The Society of Surgical Oncology Founded as the James Ewing Society, 1972 (Senior Status, August, 1975)
American Men and Women of Science, 1972
Advisor: Inglis House (The Philadelphia Home for the Incurables), 1972
Allen Whipple Surgical Society, 1972
Philadelphia Society for the Preservation of Landmarks, 1974
National Cancer Institute
Cancer Control Advisory Group, 1972-75
Site Visit Committee, Breast Cancer Demonstration Projects, 1974
Member: US-USSR Working Group on Cancer Control and Cancer Centers (American Cancer Society & National Cancer Institute), 1974-75
Consulting Editor: BREAST (Cliggott Publishers), 1975-

Honorary Memberships:

Venezuela Cancer Society, 1970
Honorary Diploma: Caracas Hospital, Venezuela, 1970
Alaska State Medical Society, 1973
Daviess-Martin County Medical Society, State of Indiana, 1976

Awards:

Saint Francis Surgical Award, April 27, 1973
Humanitarian Award, Kain Moses Group for Cancer Research, American Cancer Society, Philadelphia Division, 1974
The Owl Award, Temple University, March, 1976
Myrtle Wreath Award, Hadassah Eastern Pennsylvania Region, March, 1976
Silver Anniversary Award - Field of Cancer - The Chapel of Four Chaplains, May 30, 1976
Physicians Recognition Award in Continuing Medical Education - American Medical Association, 1976

Portrait Unveiling
Temple University School of Medicine
May 23, 1976

NATIONAL HEART, LUNG, AND BLOOD ADVISORY COUNCIL

**STATEMENT OF JAMES C. HUNT, M.D., CHAIRMAN, MAYO FOUNDATION**

**ACCOMPANIED BY:**

**ALFRED P. FISHMAN, M.D., UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA**

**JOSEPH C. ROSS, M.D., FACEP, AMERICAN COLLEGE OF CHEST PHYSICIANS**

**DEAN MASON, M.D., AMERICAN COLLEGE OF CARDIOLOGY**

**AARON KELLNER, M.D., DIRECTOR, THE NEW YORK BLOOD CENTER**

Senator MAGNUSON. All right.

What did we have next here, Heart. Next panel. Who is the main speaker? All right.

Dr. HUNT. Senator——

Senator MAGNUSON. I will have to leave you folks at 4 o'clock unless we can get somebody else down here, because I have a delegation meeting that has been set up for a long time. As a matter of fact, it is about what he was talking about.

Dr. HUNT. Mr. Chairman, we are cognizant of the demands on your time and we will finish by 4 o'clock, unlike our predecessor, who inappropriately used your time.

Senator MAGNUSON. Well, it isn't my time. I was hoping some other Senators would be here.

PREPARED STATEMENTS

Dr. HUNT. I am Dr. James Hunt. This is the fourth year that I have had the pleasure of testifying before you and your committee. With your permission, Mr. Chairman, we would like to submit our statements for the record.

Senator MAGNUSON. All right. They will be put in the record in full.

[The statements follow:]

# STATEMENT OF JAMES C. HUNT, M.D.

## SUMMARY

Mr. Chairman and Members of the Committee:

I am Dr. James C. Hunt, Professor and Chairman of Medicine, Mayo Clinic and Mayo Medical School, and a member of the National Heart, Lung and Blood Advisory Council. I appear before you today to support increased funding for the programs of the National Heart, Lung and Blood Institute.

1. When the National Heart Institute was formed in 1948, it's mission was to develop and support programs in biomedical research. Goals and objectives included the development of new knowledge and to improve medical care and health care.

2. During the past twenty-five years the death rate from heart disease has been reduced by thirty percent with the most dramatic improvements in the past five years. Despite an increasing population, for the first time since 1967 the number of deaths from cardiovascular disease was less than 1 million in 1975.

3. In 1969, 1972 and 1976, the Congress progressively enlarged the charge to the Institute which, as the National Heart, Lung and Blood Institute is now responsible for the development and support of biomedical research and training programs in heart, lung, blood vessel and blood diseases and blood resources.

4. Health advances in lung, blood vessel and blood diseases have not yet reached the dramatic improvement stage noted in heart disease; however, an impressive start has been made. The Fourth Report of the National Heart, Lung and Blood Advisory Council describes the Institute's initiatives and contributions in detail. One contribution cited was our assistance in the development of the American Blood Commission which we believe necessary to assure a safe and readily available supply of blood to the American people. Additionally, we report on progress by the National High Blood Pressure Education Program, established by the Institute as a public awareness and education campaign in 1973, which has been increasingly successful in aiding health care providers to bring this disease which afflicts more than 25 million Americans under control. We believe that effective treatment of high blood pressure will strikingly reduce the death rate from heart attack, stroke and kidney failure and reduce the cost of medical care.

5. The Institute's increased program responsibilities please the Advisory Council in that you have expressed great confidence in us. However, the budget for F Y 78, as proposed by the past and current administrations, would permit the Advisory Council to fund only 30 to 40 percent of the approved grant applications submitted to us. This would be a drastic reduction of support at a time when the programs of the Institute are showing great progress and substantive results.

On behalf of the National Heart, Lung and Blood Institute, the National Heart, Lung and Blood Advisory Council and the American public, we appeal to the Chairman and the members of this Committee and to the Congress for an F Y 78 appropriation of $492,000,000 in support of the National Heart, Lung and Blood Institute. The National Heart, Lung and Blood Advisory Council is committed to the wise utilization of monies made available to the Institute by the Congress.

Thank you.

Summary of Prepared Statement. _____

Mr. Chairman and Members of the Subcommittee:

I am Dr. James C. Hunt, Professor and Chairman, Department of Medicine, Mayo Clinic and Mayo Medical School, Rochester, Minnesota. For the past three years, it has been my privilege and pleasure to testify before you as the

President of the National Kidney Foundation in support of the National Institutes of Health. Previously, I have strongly endorsed increased funding for the National Heart, Lung and Blood Institute and the National Institute of Arthritis, Metabolism and Digestive Diseases. Today, on my own behalf, I am especially grateful for the opportunity to present a statement in support of the programs of the National Heart, Lung and Blood Institute.

Currently, I serve as a member of the National Heart, Lung and Blood Advisory Council. The Council is responsible for review and evaluation of the programs of the National Heart, Lung and Blood Institute. The results of the council's review are contained in our annual reports to the President and to the Congress as required by the National Heart, Blood Vessel, Lung and Blood Act of 1972 which was renewed by the Congress in 1976. Our Fourth Annual Report was recently forwarded to the Congress and we commend you for your vision in requiring this detailed description of the activities of the National Heart, Lung and Blood Institute. The Council exercises its mandate to assess the progress of the Program toward the accomplishment of its objectives with great dedication as I believe is evident from the Report.

The Advisory Council recently examined in considerable detail all of the ongoing research, education and health care activities in cardiovascular, lung, blood diseases and blood resources which have been developed and sponsored by the Institute. During this annual review and evaluation, we obtained recommendations from many advisory committeees to the Institute. Some of the impressions gained during our review process seem worthy of emphasis and we wish to make some general observations and specific recommendations to the Chairman and the members of the Subcommittee.

Mr. Chairman, as a citizen volunteer in the health care movement and as a health care professional, I have become increasingly impressed with the dedication of the Congress in its careful review of the health care and medical care needs of the American public. Further, my exposure to the peer review system of the National Institutes of Health has convinced me of the wisdom of this system as developed by the Congress. On the basis of the evidence available, the National Heart, Lung and Blood Advisory Council believes that significant progress is being made in the areas of heart, lung and blood diseases and blood resources development within our country. For many years our people have experienced a high morbidity and mortality from heart, lung and blood diseases. For the past several years, morbidity and mortality statistics for heart diseases have pointed in a more favorable direction and there has been an overall decline

in the death rate for all cardiovascular diseases which now has reached some 30 percent (over the past 25 years). This decline has been especially dramatic since the passage of the National Heart, Blood Vessel, Lung and Blood Act of 1972. The evidence suggests that better control of high blood pressure may be a major factor in this trend and I will elaborate on this problem subsequently. The same favorable trend in general health statistics has not yet become evident in lung, blood vessel and blood diseases, yet I am also favorably impressed with the progress that is being made in our understanding of the fundamental nature of these disease problems and believe that health care improvements will be accomplished in the areas of lung, blood vessell and blood diseases.

There is an increased movement toward volunteerism in the donation of blood by the American public. The health of the American people necessitates the availability of an adequate supply of blood which is safe for use by the individual. More than 90 percent of blood now being obtained for transfusion purposes is from volunteers. The Congress has strongly supported the development of a National Blood Policy and we support your judgment that the responsibility should be in the private sector and with the volunteer agencies through an American Blood Commission. We believe that the Commission will be successful in furthering the cause for a safe and readily available blood supply and the National Heart, Lung and Blood Institute has responded in a vigorous fashion to aid in the development of the American Blood Commission as a volunteer and public spirited group.

Mr. Chairman, I wish to emphasize our belief that John J. Corson as President of the American Blood Commission has performed an outstanding duty for all of us in consummating the establishment of the American Blood Commission. We think that this gentle and dedicated man has done more than any one person to organize the American Blood Commission. He is largely responsible for bringing together the volunteer agencies and the many diverse elements of the health care community concerned with blood and blood resources so as to assure the availability of blood and blood products to fulfill the extensive medical needs of the public. Dr. Corson simply refused to allow failure as the American Blood Commission was being established. Further, he has assured consumer participation.

Mr. Chairman, please forgive my diversion from the central task at hand. As a result of the organization and development of the American Blood Commission, we believe that more and more of the blood necessary for transfusions will be obtained from volunteers. We believe that the Commission and its member groups will assure an adequate supply. Additionally, major advances in biomedical and

scientific capabilities now make it possible to detect hepatitis-infested blood with much greater accuracy and these advances have resulted in a drastic reduction in post-transfusion hepatitis.

We believe that the Congress and the public can be extremely proud of these accomplishments by the private sector and volunteer groups. However, let us hasten to add that an impressive array of opportunities lie before us. The Institute's programs in lung disease, blood and blood resources must produce a track record which is equal to that accomplished in cardiovascular diseases and such will be effected only through the dedicated interest and support of the Congress for biomedical research in these areas.

Earlier we referred to the problem of high blood pressure as a health care consideration. More than 25 million Americans have this disease. During the past five years the National Heart, Lung and Blood Institute has made a major effort to aid in the control of this disease and to reduce associated morbidity and mortality. The former Secretary for Health, Education and Welfare, Elliot Richardson, assigned to the National Heart, Lung and Blood Institute, then directed by the Former Assistant Secretary for Health, Dr. Theodore Cooper, the task of developing a National High Blood Pressure Education Program. The latter group has coordinated efforts by several volunteer, professional and private groups to improve public awareness of the threat of high blood pressure as a major cause of death in our country. Clearly, the reduction in cardiovascular mortality has resulted from a variety of advances in biomedical science; however, better control of high blood pressure, in a large part resultant from the efforts of the National High Blood Pressure Education Program, has aided in an extremely important fashion in the reduction of deaths from heart and blood vessel diseases. The support of the Congress made this program and many other efforts of the National Heart, Lung and Blood Institute possible. The American public is deeply indebted to the Congress for your wisdom in sponsoring these endeavors. However, this effort is only one of many clinical trials, public education programs and patient education endeavors which the Congress has instructed the institute to include in its programs.

The National Heart, Lung and Blood Institute is currently sponsoring several large clinical trials which are designed to evaluate new diagnostic and therapeutic approaches. We must continue to support these trials and others if results of research are to be properly evaluated so that efficacious new therapies

might be introduced into the clinical practice of medicine and health care. Subsequently, I will make specific reference to several of these items.

When the National Heart Institute was established by the Congress in 1948, its mission was clearly defined. In 1970, the Institute expanded its programs to include lung diseases. The 1972 National Heart, Blood Vessel, Lung and Blood Act specified additional programs in research and in disease prevention and control. In 1976, the 1972 Act was reviewed and our mission has again been expanded to include blood diseases. The Institute and the Advisory Council are fully aware that your expansion of our program is a reflection of the confidence which the Congress has in us. We will do our best to keep that faith.

Since the charge to the National Heart, Lung and Blood Institute was expanded in 1969, many important initiatives and issues have been addressed. Careful consideration has been given to many types of lung disease, to the extremely common blood vessel problem of atherosclerosis (hardening of the arteries), high blood pressure, inherited heart disease, blood diseases, the need for improved blood resources and a variety of other health care problems. The Institute has sought close working relationships with and has been assisted by the participation of the American Heart Association, the National Kidney Foundation, the American College of Cardiology, the American Thoracic Society and the Lung Association, and a host of other professional, industrial and lay groups. We believe that this conjoined effort should be continued and expanded in other areas such as in nutrition, tobacco abuse, physical education, and other initiatives where the volunteer groups and individual citizen have a rich opportunity to influence their own destiny.

As we mentioned previously, only a few short years ago the mission of the National Heart, Lung and Blood Institute was directed primarily toward conquering the problem of heart diseases. In its wisdom, the Congress indicated that this mission should be expanded. Consequently, we have become particularly aware of the necessity to provide additional biomedical research and training for health care professionals through which new fundamental knowledge might be made available if we are to improve the health of the American people. Our efforts have been handicapped. We are especially troubled by the absence of a stable financial support base for research manpower training which has existed for several years. The previous administration was not in sympathy with the will of the Congress to expand the training of health care and biomedical research professionals. Consequently, training opportunities for scientists and for academic faculty in heart, blood vessel, lung and blood diseases have declined some 35 to 40 percent during recent years. The biomedical and scientific community is unable

to provide an adequate number of new investigators to replace those who are retiring or will otherwise become inactive in the near future. More importantly, we must increase the number of young biomedical scientists - teachers in order to expand investigative efforts to seek methods of prevention and cure for the future. Our only recourse is to again call the attention of the Committee to the desperate shortage of these professionals who are needed by the Health Science Centers to fulfill our mission in research, education and health care. As a very junior member of the National Heart, Lung and Blood Advisory Council, I was especially distressed to note the large number of outstanding grant applications for support of research and research training endeavors which we were unable to fund at our most recent quarterly meetings.

In response to the specific mandates of the Congress in heart disease, diabetes, lung disease and sickle cell disease, the institute recently organized specifically targeted initiatives more directly concerned with the application of biomedical knowledge to health care. The quality of the response by the scientific community to these new initiatives is impressive; however, the institute is unable to provide adequate funding for these programs. As a corollary, the number of regular research grant requests received by the Institute has increased dramatically since the lung program was added in 1969, the blood disease mandate in 1972 and the blood resources challenge in 1976. Despite these increased responsibilities, the Institutes funding rate has declined dramatically over the same period of time and the budget request level currently before your committee will enable the institute to fund only 20 to 30 percent of the approved grant applications. Our responsibilities move forward; however, our funding capabilities have us in neutral or in reverse.

Mr. Chairman, the 1972 National Heart, Blood Vessel, Lung and Blood Act, which was renewed in 1976, authorized 30 National Research and Demonstration Centers. Today, we have only 3 active Research and Demonstration Centers. During the past year a Working Group of the Council examined the needs of these centers in great detail and the Council, in its annual report, has recommended the funding of 20 additional centers in order to fulfill our described mission. We believe that the Congress acted in a responsible fashion in authorizing the development of National Research and Demonstration Centers. We concur with your judgment that these centers are important to the health of the American public. You have strongly supported increased funding for biomedical research and research training because of the public need.

Some have observed that the costs of health care and medical care have

increased dramatically despite the biomedical advances during recent years. Indeed, individuals with lesser knowledge espouse the theme that the advances of biomedical science in recent years are a cause of the expanded costs of medical care. We believe that more expensive medical care is a direct result of less than ideal advances in medical knowledge in search of prevention and cure. The often used example of the respirator (iron lung) used to maintain the polio victim prior to the discovery of the poliomyelitis vaccine to prevent the disease and the contributions of biomedical science to this discovery is an excellent description of the advances which result to the public from adequate support of basic research and clinical investigation. Major advances in cure and prevention are the only proved effective means of reducing health care cost.

As was the instance during the polio era, we have before us an enormous opportunity to develop modern day prevention and cure for heart, lung, blood and blood vessel diseases. If we are to reduce the costs, pain, disability and morbidity of the public, we must improve knowledge in the biomedical sciences through new discovery. The National Heart, Lung and Blood Institute has made dramatic progress despite severely limited resources. With faith in our mission and with the support of the Congress, we shall persevere in our endeavors on behalf of the American public.

Mr. Chairman, you and the members of your committee have generously supported the National Heart, Lung and Blood Institute in the past. The institute has "kept the faith". To the best of our ability, we have wisely utilized the funds authorized by the Congress to support imaginative concepts, ideas and endeavors in biomedical research. We will continue our painstaking review of research applications and hopefully will utilize the public's monies to further those endeavors likely to improve health care and medical care. We respect your responsibility to command us and to direct our efforts. In order that we might fulfill the mission which we believe you desire us to accomplish, we request and urgently recommend an F Y 78 appropriation of $492,000,000 in support of the National Heart, Lung and Blood Institute. We believe that this increase in the budget of the National Heart, Lung and Blood Institute is small in comparison with the enormous health care and medical care expenditures of today. It is my personal judgment that this increase will make it possible for the Institute to pursue the most urgent of our several specific opportunities and priorities now clearly evident. The National Heart, Lung and Blood Advisory Council is committed to the wise utilization of the funds made available to us by the Congress.

We salute you for your dedication, interest and commitment and reiterate our promise that the Institute and the Advisory Council will do its best to fulfill the mandate which the Congress has prescribed.

Thank you.

## STATEMENT OF ALFRED P. FISHMAN, M.D.

Mr. Chairman, Members of the Committee, Ladies and Gentlemen:

I am Alfred P. Fishman, Professor of Medicine and Director of the Cardiovascular-Pulmonary Division of the Department of Medicine at the University of Pennsylvania School of Medicine. My special interest in medicine is in disorders that affect both the heart and lungs. I was a member of the National Advisory Council when the National Heart Institute was transformed into the National Heart and Lung Institute.

Others who have spoken before me have reviewed the charges made to the National Heart, Lung and Blood Institute [NHLBI] by the Congress and of the serious need of the Institute for continuing support by the Congress if its missions are to be properly executed. Instead of recapitulating the concerns that have been expressed, and that I share, I would like to confine my testimony to three specific points: priority of investigator-initiated research, stability in biomedical research, and harvesting the fruits of research.

Priority of investigator-initiated research. Recognizing that competing priorities exist for public funds, there is little question that the prevention, control and eradication of diseases that cause premature death, morbidity, disability, and economic hardship must be at the top of any list. The diseases for which the NHLI has primary responsibility have been estimated to account for approximately one-third of the total economic cost of illness, to cost about 57 billion dollars annually and to impose immeasurable suffering not only on hosts of patients but also on their families.

The key to fulfilling these goals is research by talented scientists working in a setting that is conducive to creativity, nurtured by society, and subject to continuing peer review that guarantees quality of performance. Whether the research is done in the laboratory, in the clinic, or in other settings will depend on the questions that are being raised and on the tools that are required for the investigation to be executed.

In setting priorities for funding, temptation is always great to identify "missions" to be accomplished by a concerted research effort. This is certainly apt to be a rewarding approach when enough information is on hand for effective mobilization of talent and resources for this purpose. But, experience has taught that in the long run, the greatest rewards are from basic science without immediate application. Strong support for this proposition has been afforded by the disclosure that two-thirds of the key contributions responsible for the ten major advances in diagnosis, prevention, and treatment of cardiopulmonary diseases were from basic research. Moreover, most of the key research was done in medical schools and in other components of universities [Comroe, J.H. Jr. and Dripps, R.D. Scientific Basis for Support of Biomedical Science. Science 192:105-111, 1976; Kornberg, A. Research, the Lifeline of Medicine. New Engl. J. Med. 294:1212-1216, 1974].

In accord with these considerations, the highest priority of the NHLBI is for adequate funding of approved research grants. These grants are approved by a peer review mechanism that relies heavily on objective appraisal of proposals. Ten years ago, 80 percent of approved research grants were funded. By 1976, the percentage had fallen to less than 50 percent. As a result, excellent research is being discouraged and scientists are rendered non-productive by being deflected for the sake of survival to irrelevant lines of activity. The proposed allotment would allow the funding of approximately 25 percent of approved proposals. The disproportion between funded and approved proposals should be remedied to at least 50 percent.

Stability in Biomedical Research. One of the more effective ways by which the productivity of a creative, industrious and disciplined body of scientists can be seriously impaired is by distraction and instability. During the last few years biomedical research has been unsettled in several different ways, particularly by the uncertainties in support of research training. Not only has the total number of post-doctoral trainees sponsored by the NHLBI decreased dramatically, but the likelihood of continued support has repeatedly been threatened. As a result, effective training programs have been cut in half, i.e. to 1100 trainees instead of

2500 and budding scientists have been diverted to other fields of endeavor. It is desirable that plans be drawn for long-term support of research training and that an appropriate level be restored in line with the needs of the different components of the Institute.

Harvesting the Fruits of Research. During the last few years the American people have experienced the first reversal in the upward trend of mortality from coronary artery disease; mortality has dropped by 13 to 14 percent. This break with previous trends is the result of a concerted effort by a large segment of the biomedical community, spearheaded by the National Heart, Lung and Blood Institute. Undoubtedly efforts along this line must continue.

But, other components of the National Heart, Lung and Blood Institute have not had the opportunity to mount a comparable campaign to decrease mortality and morbidity. For example, it is only seven years since the Lung Division was added to the Heart Institute to form the National Heart and Lung Institute; the Blood Division has even a shorter history. The problems facing the NHLBI with respect to lung diseases are formidable: lung diseases cost about 16.5 billion dollars annually; they account for more than half of all acute medical disorders and of all disability that requires confinement to bed. Chronic respiratory disorders afflict about 40 million persons and about two and one-half million people are chronically handicapped by respiratory disability. Eighty percent of deaths during the first year of life are caused by respiratory illness. Cancer of the lung is on the rise; so is chronic bronchitis and emphysema. And the indications are clear that the incidence of none of these disorders has as yet reached its peak.

For the Lung Division, the immediate target is a reduction in morbidity rather than mortality. Thousands of people are incapacitated by chronic bronchitis and emphysema. Disability from inhalational diseases of the working place are ubiquitous. Asthma compromises the physical capacities of both children and adults. The youngster with cystic fibrosis is handicapped by chronically infected lungs and is readily incapacitated by respiratory infections. Respiratory distress

of the newborn is a prevalent disorder requiring prolonged management in a specialized hospital setting.

The National Heart, Lung and Blood Institute is charged by law with research, research training, prevention and control of these and other lung diseases. During its seven formative years, the Lung Division has started on its assignment by focusing primarily on research dealing with the reactions of the lungs to injury. Injury is produced by irritants, infectious agents and allergens. By imaginative programming, it has enlarged the number and quality of scientists involved in pulmonary research. It has helped to identify areas for exploration. New techniques for dealing with individuals and populations have been developed under its sponsorship. And new training mechanisms have been introduced, notably the "Young Investigator Award". Probably its most seminal accomplishment was the mobilization of basic scientists from a wide variety of disciplines - biochemistry, physiology, immunology, pathology, epidemiology, bioengineering - for research on the lung. Voluntary agencies, particularly the American Thoracic Society and the American College of Chest Physicians, joined in generating research personnel and in exciting interest in pulmonary disease.

As a result, fundamental research on the lung has flourished and the time has become increasingly ripe for harvesting the fruits of this large research effort. A concerted effort is needed to transfer the lessons from the laboratory to the prevention, early detection, diagnosis and treatment of lung disease.

But research that is designed to promote the prevention, management and cure of disease, and the protection of health, is costly. For example, relatively modest support has sufficed to uncover tests to determine early disease of the small airways and to show that these tests are the first to become abnormal in cigarette smokers. But, to examine the effects of smoking on the airways over years by means of these tests involves clinical trials in a sizeable population. Also, to see if smoking hastens disability from "black lung", medical scientists will have to commit themselves to another costly enterprise, i.e. repeated examinations of a population of coal miners over years.

Even larger commitments of time and money will be required if the new tests are applied to long-term studies of bronchitis and emphysema. No one knows how bronchitis and emphysema begins. Does it start with small airway disease that is asymptomatic and then progress to larger airways and to disability? Can we intervene at the stage of small airways disease and arrest the progression? To answer these questions will require strong financial support.

Research has brought several other therapeutic and interventive trials into the offing. Oxygen was once the panacea for respiratory and cardiac disease. In recent years, the hazards of indiscriminate use have become apparent. How useful, or dangerous, is the administration of oxygen during the night to the patient who is breathless from bronchitis and emphysema? Much insight has been gained in recent years into mechanisms that trigger an attack of asthma. Can we now standardize approaches and agents to prevent and to manage the asthmatic attack? Cooperative research by cooperating institutions will be necessary for meaningful comparisons and appraisals. Despite improved survival rates, respiratory distress syndromes in the adult continue to take a high toll in mortality. Recent research has clarified a great deal about structure, function and repair of the lung that warrants application to a large population of these seriously ill patients under controlled conditions. Collaborative efforts are needed to standardize therapy.

Large gains have been made in coping with respiratory disease of the newborn. Now, 80 percent of newborns with this disorder survive instead of the 20 percent that used to survive. We suspect that even these statistics can be bettered. It is now possible to predict, on the basis of special tests, whether respiratory distress syndrome will occur in a particular premature infant. The mother can be treated with corticosteroids. But, a systematic, cooperative study is needed to evaluate the proper role of corticosteroids.

But even more promising than the assessment of new methods of management are the prospects for prevention. Genetic predisposition in cystic fibrosis and in uncommon forms of emphysema is well known. Is there also a genetic predisposition to certain types of lung disease associated with occupational disorders?

Does individual susceptibility shape the occurrence and outcome of a respiratory ailment? Can the immune mechanisms of the body be tailored to enhance its defense against agents that are injurious to the lungs?

The pestilence of modern times is smoking. Attempts at education have been disappointing in effecting a reduction in cigarette smoking. The malevolent role of smoking with respect to cancer of the lungs, in causing bronchitis and emphysema, and in potentiating the carcinogenic and inflammatory roles of other air pollutants - including occupational dusts - is no longer a matter for debate. Can we devise new educational approaches that will curtail cigarette smoking and thereby reduce the incidence of disorders where cigarette smoke is either a causative or potentiating agent? Can we modify attitudes and behavior in this regard? Populations of people, rather than individuals, will have to be involved in this research.

The large scale of these proposed programs, as well as their application to people instead of experimental animals makes them costly. But, they promise to be less expensive in the long run than the cost of physical inability to work, chronic illness and repeated hospitalizations.

Finally, there is a shortage of teachers of chest medicine. Therefore, both the prospective specialist and primary care physician are denied access to the burgeoning insights that research has provided into the mechanisms, prevention and management of chest disease. One innovative initiative by the NHLBI was the creation of the "Pulmonary Academic Award". The success of this venture has prompted similar efforts in training. But these are only important beginnings. Only the NHLBI can undertake this type of educational effort and ensure the high quality of training in pulmonary medicine that is currently needed.

Budgetary Implications. The three items that have been detailed above indicate that current appropriations are inadequate for fulfilling the mission of the NHLBI because of inadequate funding of investigator-initiated research, instability in biomedical research, and inadequate provision for harvesting the fruits of research. Adjustments in appropriations appear to be in order. The precise nature

of these adjustments should be designed to stabilize existing programs and to provide for extensions that will enable the transfer of lessons learned in the laboratory to the treatment of the sick and to the protection of the health of populations.

Summary

1. The National Heart, Lung and Blood Institute has been charged by law to cope with diseases that are the major causes of disability and death in modern times.

2. It is currently handicapped in fulfilling its mission because of under-appropriations with respect to goals.

3. The present testimony has identified three priorities for increased funding: investigator-initiated research, stability in biomedical research, and harvesting the fruits of research.

4. The Lung Division of the NHLBI is singled out to illustrate the potential for transferring the lessons derived from a seven year research program to practical applications for treating the sick and protecting the healthy.

5. Adjustments in budgetary allotments are suggested in keeping with these priorities in order to implement legislation that has charged the NHLBI with eradicating diseases of the heart, lungs and blood that cause premature death, morbidity, disability and economic hardship.

STATEMENT OF JOSEPH C. ROSS, M.D.

Mr. Chairman and Members of the Committee:

I am Dr. Joseph C. Ross, Chairman of the American College of Chest Physicians Committee on Government Liaison and Chairman of the College's Board of Governors. I am also Professor and Chairman, Department of Medicine, University of South Carolina, School of Medicine. I am presenting these views on behalf of the American College of Chest Physicians (ACCP).

As you may know, the ACCP is a professional-medical specialty society of more than 10,000 physicians, medical professors and scientists who specialize in diseases of the heart, lungs and circulatory system.

Speaking for the membership of the College of Chest Physicians, I would like to say that we very much appreciate this opportunity to offer our views to this important Committee in order to share our thoughts concerning Fiscal Year 1978 Appropriations for the National Heart, Lung and Blood Institute. As you will note in the statement to follow, we have suggested specific dollar amounts for most of the line items related to this vital segment of the National Institutes of Health.

In the main, we believe that the Administration has requested inadequate appropriations for the National Heart, Lung and Blood Institute. As such, we have requested further specific dollar additions to the budget for certain areas we think should be emphasized; these are reflected in a Table attached to this testimony. In my oral statement to you today, I would like this Committee to know our thoughts concerning priorities and general directions for the NHLBI. Reasonable men may and do differ on specific amounts for many of the programs in this important institution. We hope

that our philosphy and priorities will be of help to you in deciding the specifics.

NATIONAL HEART, LUNG AND BLOOD INSTITUTE

May I preface this statement by emphasizing that the ACCP fully supports the activities of the NHLBI. In Dr. Robert Levy, the Institute has a dedicated leader, an eminent scholar respected in the scientific community and a capable and imaginative administrator. The Institute has clearly forged ahead in meeting the statutory mandates of implementing the National Programs to combat heart, lung and blood diseases.

For your convenience, we have attached a Table which summarizes our fiscal recommendations for the National Heart, Lung and Blood Institute for FY 1978.

We believe that in times of limited resources, the emphasis of the Institute's programs should be on the development of human resources rather than on the purchase of capital goods and improvements. In making our recommendations, therefore, our emphasis is on training and research, the areas of investment which we feel yield the greatest returns over the long run.

I. PULMONARY PROGRAMS OF THE INSTITUTE

Mr. Chairman, our College represents thousands of physicians and scientists of this Country who are dedicated to the prevention and treatment of disease 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.

Diseases of the lung have increasingly become a very serious national health problem. Lung diseases, the 6th leading cause of death in the Untied States, account for more than 130,000 deaths each year, 46 million days lost from work, and 40 million days of bed restricted activity; in addition, pulmonary disease costs the economy approximatley $6 billion

annually in lost productivity and wages and medical care costs.

Although respiratory diseases effect all ages, they are most devasting among the very young and the very old. In the newborn, the most common cause of death is the neonatal respiratory stress syndrome. Neonatal RDS is implicated in the development of adult respiratory diseases as well. Fibrotic and immunologic lung diseases are a major cause of lung problems in the young adult and may cause chronic obstructive pulmonary diseases. Of the adult respiratory diseases, emphysema and chronic bronchitis are the major causes of death and taken together are now the 8th most common cause of death in the United States. An estimated 8 million Americans are currently affected by these 2 diseases alone. As a disabling disease, emphysema is the 3rd leading cause of worker retirement on worker social security disability payments. An additional 6 million Americans suffer from asthma.

As you well know, it was only 6 years ago that the research mandate of the Institute was expanded to include the lung and that a concerted strategy to meet this very serious health problem was intiated. We are pleased to report that the NHLBI and the biomedical community have worked together quickly and effectively in developing plans that are now represented in the National Heart, Blood Vessell, Lung and Blood Program.

The Institute's program in blood diseases has evolved and nurtured by originating new efforts directed at fulfilling particular research needs and capitalizing on opportunities to translate research results into health care application through clinical trials, demonstration, education, prevention and control.

As I noted above, neonatal is presently the major pulmonary disease and leading cause of perinatal mortality, accounting for 12,000 neonatal deaths and 800,000 hospital days per year. The Institute has funded many multidisciplinary

studies since the advent of the National Lung Program, which have advanced the medical community's knowledge of lung maturation and of the proper use of pharmacological interventions. In a glowing example of "applied research", a clinical trial has been initiated to evaluate the effectiveness of corticosteroids in decreasing incidence of neonatal RDS. The pediatric pulmonary disease research program projects in the causes of cystic fibrosis and in the relationship of bronchiolitis to the development of chronic adult lung diseases have also been indicative of this important Institute's commitment to its Congressional mandate that pulmonary disease be eradicated in the United States.

Funding of the NHLBI's basic and clinical research, clinical trials and demonstration, education, prevention and control programs at our recommended levels would also enable the Institute to continue its rapidly developing lung disease program and other areas as well. The Institute has intensified its research efforts to identify risk factors in emphysema and other chronic lung diseases. This is crucial because 14 million American are affected by these chronic lung diseases, whose exact etiology is as yet unknown. NHLBI has also made great progress in the development of new tests for pulmonary function.

The College is perhaps most excited about NHLBI clinical and training activities. Through the vehicle of research grants, tremendous progress has been made in the program of Specialized Centers of Research (SCORS), National Research Demonstration Centers, Pulmonary Academic Awards, and Pulmonary Young Investigator Awards.

In 1971, the Institute initiated its first series of SCORS, consisting of programs in 4 areas: arteriosclerosis, hypertension, pulmonary diseases, and thrombosis. The purpose of these Centers is to advance basic knowledge and to develop effective methods of clinical management and prevention

through basic, developmental, or applied projects as well as clinical investigations.

Currently, 24 pulmonary SCORS are being supported by the Institute. Research by these SCORS has emphasized the interdisciplinary approach which is particularly important in the area of lung disease due to the fact that the lung consists of more than 40 different types of cells making it one of the most heterogeneous organs in the body.

In May of 1975, the Institute announced a new open competition for pulmonary SCOR grants in four very important areas which require further emphasis: chronic diseases of the airways, pediatric pulmonary vascular diseases. We are pleased that 19 SCORS in these areas will be funded under FY 1977 allocations. The Institute has recently announced its intention to expand pulmonary SCOR grants into another very important area: respiratory failure. Although the blueprint calls for the establishment of five or six respiratory failure SCORS, these will be initiated only if budgetary constraints allow such funding.

The National Heart, Blood Vessel, Lung and Blood Act of 1972 and the 1976 extension legislation authorized the Institute to develop the National Research and Demonstration Centers--up to 10 Centers in areas of heart disease, 10 Centers in the area of blood and blood vessel disease and up to 10 Centers in the area of chronic lung diseases. The purpose of these Centers is to translate basic research findings into practical patient care. Under the National Research and Demonstration Program now developed by the Institute, these Centers engage in a myriad of health activities, including basic and clinical research, training and education, and demonstration of diagnostic, prevention, and treatment methods. In its limited initial stages, this program has met with great success partly due to the multidisciplinary approach

of the program. Again, especially important in the area of lung diseases.

However, it is distressing to note that due to fiscal restraints only three such centers have been developed to date: one each in the areas of heart, lung and blood, Nonetheless, we are pleased to report that recent efforts by the pulmonary diseases National Research and Demonstration Center of the University of Vermont the promise of encouraging results. Just one example of the work of this Center in the area of demonstration projects, is the development of a statewide network to monitor, diagnos, treat and control industrial-based lung diseases, tuberculosis, and other pulmonary disorders in ambulatory patients.

Finally, we would like to express our strong support for two other research grant awards programs within the Institute. First, the Pulmonary Academic Awards Program has as its purpose the upgrading of teaching in medical institutions so that medical students will be attracted to the pulmonary field and provide support for physicians who are dedicated to such an effort. The goal of the Institute would be to have an award grantee at every American medical school. At present, and under the Administration's FY 1978 budget, only one-third of the Nation's medical schools will be priviledged to have a Pulmonary Academic Award grantee so enrolled.

The second program which we feel warrants substantial funding is the Young Investigator Awards, which are awarded by the Institute to young scientists who pursue pulmonary-related research projects. This program was initiated as the Pulmonary Young Investigator Award Program and has been so successful that the Institute has adopted the program for its National Programs in heart and blood diseases as well. The problem is that under the Administration budget request, less than one in five application for wards will be able to be funded. We feel that our recommended appropriations for FY

1978 would provide adequate fiscal support for this important investment in the type of human resource that the National desperately needs in the battle against respiratory disease.

II CARDIOVASCULAR PROGRAMS OF THE INSTITUTE

In his testimony before this Committee last month, NHLBI Director, Dr. Robert Levy,stated that diseases of the heart and blood vessel account for 54% of all deaths in the United States annually. Moreover, virtually all Americans are afflicted with atherosclerosis, 27 million suffer from hypertension and 4 million from coronary heart disease. Yet, from 1970 to 1976 deaths due to cardiovascular disease declined by 15%. In a few brief words, I would like to emphasize the College's support for the efforts of the Institute in combating heart disease. For it is, in great measure, due to the work of the Institute, backed by the Congress' recognition of the problem and its generous support, which have yielded such an improvement in what was a devastatingly tragic situation a decade ago.

To enact appropriations at the levels requested by the Administration could have the effect of stifling these strides of progress. The accomplishments of the Institute in the last two years have been significant, particularly in the areas of clinical trials -- the Aspirin-Myocardial Infarction Study, the Multiple Risk Factor Intervention Trial, the Hypertension Detection and Follow-up Program, and the Coronary Artery Surgery Trial. The Institute has initiated many new program studies for which high funding is necessary. These include studies of the epidemiology of hypertension in the young, an anti-arrythmiaa trial by administration of beta-blocking agents, and a collaborative clinical trial to evaluate techniques to protect ischemic myocardium (damaged heart muscle) and minimize the size of heart damage associated with acute heart attack.

It is the belief of the College that our FY 1978 recommendations reflected in the Table following this testimony would enable the Institute to continue its excellent progress in meeting the Congressional mandate of the National Program to combat cardiovascular disease.

III ACCP BUDGET PROPOSAL

In touching upon specific examples of the work of the Institute in the area of lung and heart diseases, we have attempted to outline both the importance and scale of this effort. It is evident that substantial progress is now being made in the battle against both cardiovascular and cardiopulmonary diseases; it would, therefore, be unfortunate if this very vital progress were to be jeopardized as a result of insufficient funding.

The Administration's budget request for the National Heart, Lung and Blood Institute for FY 1978 is $403.6 million. The 1972 Heart Act (P.L. 92-423) and the 1976 extension legislation (P.L. 94-278) requires that at least 15% of the Institute's budget be spent on lung programs. For FY 1978 the Administration has requested $55.7 million for lung disease programs in the Institute an increase over FY 1977 levels of less than $1 million; in 1977 dollars, this appropriation would represent a decrease in dollars for the important lung initiative.

We believe that the bottom-line figure put forth by the Administration is far too low. As you will note from the attached Table, we think that the total appropriation ought to be in the range of $480 million. Obviously, 15% of this latter total will provide for a significantly expanded effort in the battle against cardiopulmonary and cardiovascular diseases.

CONCLUSION

Mr. Chairman, on behalf of the American College of Chest Physicians and its more than 10,000 members, I would like to convey our deepest appreciation for your having afforded us this opportunity to share our views and judgments with you. As you will have noted, we have emphasized the lung and heart aspects of the National Heart, Lung and Blood 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.

Again, may I thank you for this opportunity to appear before this important Committee.

NATIONAL HEART, LUNG AND BLOOD INSTITUTE
(in thousands)

| | FY77 Appropriations | FY78 President's Budget | FY78 ACCP Recommendation |
|---|---|---|---|
| 1. RESEARCH GRANTS | | | |
| Noncompeting Continuations | $128,225 | $145,762 | $154,000 |
| Competing Continuations | 58,274 | 46,297 | 66,000 |
| SCORS | 33,000 | 35,000 | 38,500 |
| National R & D Centers | 5,775 | 5,764 | 5,720 |
| Research Career Programs | 4,456 | 4,450 | 5,280 |
| Pulmonary Academic Awards | 1,544 | 1,550 | 3,300 |
| Sickle Cell Centers | 8,000 | 8,000 | 9,680 |
| TOTAL RESEARCH GRANTS | 239,274 | 246,823 | 282,480 |
| 2. MANPOWER PROGRAMS | 21,988 | 19,954 | 33,000 |
| 3. RESEARCH AND DEVELOPMENT CONTRACTS | | | |
| Heart and Vascular Clinical Trials | 50,000 | 50,000 | 50,600 |
| Other Heart and Vascular Contracts | 13,755 | 13,755 | 26,400 |
| Respiratory Diseases | 9,008 | 9,008 | 14,850 |
| Blood Diseases and Resources | 8,689 | 8,689 | 15,400 |
| TOTAL CONTRACTS | 81,452 | 81,452 | 107,250 |
| 4. INTRAMURAL LABORATORY AND CLINICAL RESEARCH | 33,950 | 35,139 | 35,200 |
| 5. RESEARCH MANAGEMENT AND PROGRAM SERVICES | 19,997 | 20,274 | 24,200 |
| TOTAL, NHLBI | $396,661 | $403,642 | $482,130 |

# STATEMENT OF AARON KELLNER, M.D.

## SUMMARY

1. Passage of the Heart, Lung and Blood Act of 1972 and the inclusion of "Blood" in the name of the Institute in 1976 expanded the mission of the Institute in the field of blood and gave it much enhanced visibility. The funding of the Institute and its Division of Blood Diseases and Blood Resources, unfortunately, has not been commensurate with these new obligations.

2. The nation's blood resource is a nodal point in modern health care. A scientifically oriented and well managed blood resource is essential to support advances in cardiac surgery, in the treatment of cancer, and for the very life of those with blood-related disorders such as hemophilia, Thalessemia, and sickle cell disease.

3. Notable advances have been made not only in new knowledge but in its prompt clinical application. For example, the virus of Hepatitis B has been identified; highly sensitive tests for detecting the virus are already in routine use; and the risk of post-transfusion hepatitis has been sharply reduced. Even more important, vaccines to prevent this world-wide disease have been developed and are now being actively tested in animals and in human beings. Similarly, laboratory and engineering advances have been quickly put to use in restoring the hemophiliac to productive living.

4. The Institute's Division of Blood Diseases and Blood Resources is seriously underfunded. It is hampered in the critical support of investigator-initiated research; it has no flexibility in undertaking new initiatives consonant with its new mandate; and it can support but one Research and Demonstration Center. An estimated $10,000,000 are required for proper funding of these central responsibilities.

5. There is a critical shortage of trained manpower in this field. We do not now have enough trained people to staff existing regional and hospital blood banks, and the situation worsens rapidly with regionalization of the nation's blood resource and as hospitals treat more and more very complicated clinical problems. Training programs are urgently needed both for research and clinical care. I recommend that provision be made this year for fifty training positions at an estimated cost of $1,000,000.

6. A National Blood Data Center is a basic requirement for gathering reliable information on a timely basis. Without it, it is not possible to plan rationally, to monitor performance, to measure cost-effectiveness, or to target areas needing further study. The sum of $1,500,000 to $2,000,000, not now available, is required to get this essential national facility off the ground.

In summary, I urge you to consider adding $13,000,000 to the Institute's budget for Blood Diseases and Blood Resources, and not at the expense of Heart and Lung, to provide it with the sinews that will convert our now fragmented blood resource into a strong and dynamic national blood system that will pay dividends in research and in improved health care for many years to come.

PREPARED STATEMENT

I am Aaron Kellner, M.D., Director of The New York Blood Center, and Clinical Professor of Pathology at Cornell. My professional interests for some thirty years have revolved around blood transfusion and blood banking - the clinical care of patients, research, the education of medical students and house staff, and for the past twelve years, the administration of the nation's largest blood center. In 1972-73 I served as Chairman of the Panel on Blood Resources established by the National Heart and Lung Institute in response to the Congressional mandate embodied in the National Heart, Lung and Blood Act of 1972 to include blood within the Institute's purview. I have also been President of the American Association of Blood Banks, and of the Council of Community Blood Centers.

Because of my special interest, I shall focus my remarks on problems of blood diseases and blood resources. I do, however, wish to add my voice to that of Dr. Hunt in strong support of increased funding for all the programs of the Institute - in heart, lung, and blood.

The nation's blood resource is one of the nodal points in modern health care. An ample supply of blood, its components, and derivatives is essential for today's treatment of cancer, for today's major surgery - such as that on the heart and blood vessels, and for the maintenance of the hemophiliac and the child with sickle cell disease or Thalessemia, to mention but a few. A community's blood supply is as important as its water supply. Without it, much of modern medicine and surgery becomes difficult or impossible, progress is slowed, and access to a better life for many of our people is sharply curtailed. It is to strengthen this precious and vital resource that the Congress included "blood" in the Act of 1972 and added it to the name of the Institute in 1976.

There has been some concern expressed that advances in the laboratory are slow to percolate into practical health care application. Let me assure you that in the field of blood transfusion and blood banking, research, development, and clinical application march hand in hand, and that biomedical or engineering advances, wherever made, are translated with remarkable rapidity into daily practise. To illustrate this, I should like to cite two instances, which at the same time demonstrate clearly how productive and well spent have been the funds allocated by the Congress to the National Heart, Lung, and Blood Institute as well as to other Institutes.

1. Hepatitis B.

A chance laboratory observation made little more than ten years ago, colorfully labelled "the Australia antigen," was soon found to be associated with the virus of Hepatitis B and led to an avalanche of new information on the virus and the epidemiology of the diseases it caused. We now know that the agent is transmitted by many routes in addition to blood transfusion, that approximately one million people in this country and well over a hundred million throughout the world are active carriers of the virus at any given time, and that the viral carrier state is associated with serious liver disease, cirrhosis, and probably even primary cancer of the liver. In short, what was originally thought to be merely a hazard of a blood transfusion has turned out to be a major public health problem of global proportions. Pari passu with this explosion of knowledge, a series of progressively more sensitive tests were developed to identify the presence of the virus, and these are now standard laboratory procedures in every hospital and blood bank in the nation. Every pint of blood donated must be tested for Hepatitis B, and the incidence of this serious complication of blood transfusion has been sharply reduced. Gratifying as this improvement in the safety of blood transfusion has been, we are on the

threshold of a much more exciting development - the prevention of Hepatitis B. There are at the moment at least three vaccines against Hepatitis B that are in various stages of animal and human trial, and the preliminary evidence indicates that they are safe and effective. As the Hepatitis B story unfolds before our eyes, it promises to be one of the great triumphs of modern medicine. It bids fair to rank with the conquest of poliomyelitis as the classic example of how a modest investment in research pays handsome dividends in lives and in dollars. This remarkable achievement has been made possible over the past decade by the joint support of the National Heart, Lung,and Blood Institute and the National Institute for Allergy and Infectious Disease.

2. Hemophilia.

Another illustration of progress which is less spectacular though no less heartwarming is the dramatic improvement in the quality of life of the hemophiliac. There are about 25,000 moderately to severely affected victims of this genetically determined coagulation disorder in the United States. Those born thirty or more years ago are for the most part severely handicapped, crippled, and require extensive orthopedic care and psycho-social rehabilitation. Those born some twenty years ago, are only moderately disabled and are capable, with proper care, of leading reasonably productive lives. Those born within the past ten years can function as essentially normal human beings; they can attend school regularly, engage in most of the normal activities of boys their age, and can look forward to being full and useful members of our society. It is significant that this dramatic transformation has taken place without any profound scientific breakthroughs. It was knitted together from small advances in knowledge and from bits and pieces of technological improvement that were promptly put into practise by the pharmaceutical industry and by the country's blood banks, without waiting for the "whole story" to be disclosed. With each small

step forward, the missing clotting factor was made available to patients in progressively increasing quantity and purity. It is of course essential to continue to support those laboratory scientists who are exploring the molecular defect of this affliction, while at the same time striving for better methods to produce the needed material and to lower its cost. In this field, clearly, research and the application of research have been closely and happily interwoven.

The insertion of the word "Blood" into the Institution's name last year was an event of great symbolic significance; it put "blood" up in lights, as it were. Not only did this highlight the importance placed by the Congress in this area of health care, it also broadened the charge to the newly renamed Institute to include responsibility for studies into all phases of the management of the nation's blood resource. As a result, blood now has great visibility, but unfortunately too few dollars. It is time to bring the financial resources of the Institute into line with its new visibility and new responsibilities. Unless the broadened mandate is matched by an appropriate increase in funding, it could be detrimental to the Institute's other ongoing programs, and will surely result in missed opportunities, and unfulfilled and thwarted expectations. To force the Institute, and particularly its Division of Blood Diseases and Blood Resources, to spread its already limited funds over a much larger area, is shortsighted indeed. It creates a financial pinch which can endanger existing sound and prudently supported programs; it curtails the flexibility of the Institute in taking advantage of targets of opportunity as they arise; and it forces the Institute to move into its new areas of responsibility in only a feeble and tentative way. Surely this was not the intent of the Congress.

The keystone of America's magnificent biomedical research enterprise continues to be investigator-initiated research.

This must be nurtured at all cost and be given top priority for support. Sad to say, though the Division of Blood Diseases and Blood Resources has experienced a large increase this year in this category of grant requests, it lacks the financial support to respond adequately. Similarly, it can sustain only one National Research and Demonstration Center in blood, and can create no new ones. And in a like vein, its funds for supporting contract research are stringently limited, curtailing its ability to explore new initiatives. Without in any way wishing to reflect adversely on the Heart and Lung Divisions of the Institute, which have been dealing in a highly effective manner with our country's leading health problem areas, I wish to emphasize that Blood - the youngest sibling in that trinity, is painfully underfunded. An estimated $13,000,000 is urgently needed this year to make the Institute's capabilities in blood commensurate with its new obligations.

I should like now to address myself in somewhat greater detail to two specific areas which, though undramatic in themselves, are in my view critically important for the future. They are as follows:

1. Manpower

As blood banks during the past ten years have moved out of the closet into the brightly lit mainstream of medicine and science, the acute shortage of trained physicians and scientists has become strikingly evident. There is, to put it bluntly, no pool of trained professional personnel to direct the nation's hospital or regional blood banks. Key positions go unfilled for long periods; leading institutions make do with untrained or on-the-job trained personnel; and young people in training are snapped up even before completion of the training program.

There is urgent need for training along two tracks. We need

research training programs to develop the young investigators, both M.D. and Ph.D., who will provide the scientific base for the field in immunohematology, immunogenetics, protein chemistry, blood coagulation, and cryobiology. Unless we can attract and train able young people, the field will soon suffer a dearth of new ideas; it will make little progress and our blood banks will revert to being mere drugstores for blood. At the same time, there is a rapidly growing demand for clinically trained blood bankers. Regionalization of the nation's blood banks has been strongly recommended by a Task Force of the American Blood Commission, supported by funds from the National Heart, Lung, and Blood Institute, and the process of regionalization is proceeding apace. What is evolving here is a network of regional blood centers, closely linked to universities, that will serve as the major loci for collecting and distributing the nation's blood supply, for technical training, for research, and for interfacing with the practising physician at the hospital and bedside level. At the same time, large acute care hospitals which treat many patients with complex medical and surgical problems are creating a demand for a new breed of physician with professional and technical expertise in blood bank science to direct hospital laboratories and to interact with their clinical and surgical colleagues to provide an improved level of care for critically ill patients.

To the best of my knowledge, there are presently only two or three centers that provide either clinical or research training in blood banking. The largest of these is in New York, and it turns out only four or five qualified individuals a year, a pitifully small trickle when compared to the scores now needed, and the hundreds that will be needed in a few years. Unless we can see our way clear to mount vigorous, sustained, and stable training programs, we will not have the professional manpower to support regionalization of the blood resource nor for optimal

patient care. The addition of $1,000,000 to the Institute's budget would provide training opportunities for fifty very much needed young people in this field.

2. National Blood Data Center

The appalling lack of reliable statistical information on this country's blood resource is little short of a national disgrace. The Congress, if it so wishes, can readily find out how much water flowed in the Mississippi River last year, how much corn was planted in Iowa, or how many tokens were inserted into the subway turnstiles in New York. It cannot find out with any reasonable degree of certainty how much blood was collected in the United States last year, nor what happened to it. The only year for which there exists a respectable amount of data is 1971, when the National Heart, Lung and Blood Institute commissioned a special study, and even for that one year there are glaring lacunae. For the rest, we have had to make do with fragmentary figures and educated guesses. During the past year, a Task Force of the American Blood Commission, again supported by NHLBI, has carefully studied the problem and has recommended the creation of a National Blood Data Center. In my view, such a data center is indispensable and may well be the single most important accomplishment of the American Blood Commission. If we are to develop a rational system for managing the nation's blood resource, it will be mandatory to have hard data in a timely fashion. How else will it be possible to plan effectively, to evaluate performance, to target problem areas, to compare cost effectiveness, and to assess the impact of new therapeutic agents or new surgical procedures on the blood supply? Although the proposed data center is expected in due course to be largely self-sufficient from user fees, it will unquestionably need financial support during its formative years. Such support, amounting to between $1,500,000 and $2,000,000 per year, should logically come from the Institute's Division of Blood Diseases

and Blood Resources; it is implicit in its mandate and entirely consonant with its mission. Yet, the funds to do this do not exist. I urge you most strongly to provide these additional sums. Without a data center, the Institute will lack an essential tool for performing its newly acquired functions, and the nation's blood resource will lack a sound base for orderly growth.

In conclusion, the coming together within the space of a few years of three major events - the enunciation of the National Blood Policy, the creation of the American Blood Commission, and the assignment by the Congress of new responsibilities to the National Heart, Lung, and Blood Institute, taken together, provide us with an unparalleled opportunity. Adequate support at this fortunate juncture in time will create the machinery - the trained manpower, the programs, and the institutions - to convert our fragmented and far-from-optimal blood resource into a strong and dynamic national blood system that will pay dividends in research and in improved health care for many years to come.

STATEMENT HIGHLIGHTED

Dr. HUNT. We will briefly highlight the comments. Previously I testified before the committee as the president of the National Kidney Foundation, but this year I speak as a citizen witness on behalf of the National Heart, Lung and Blood Institute.

My distinguished colleagues will each——

Senator MAGNUSON. Doctor, just for the purpose of the record so that we know what we are talking about here generally, for the National Heart and Lung Institute, in 1977 there was $389.518 million. The so-called Ford budget recommended $385.368 million. The so-called Carter budget recommended the same which is down a little from last year.

Dr. HUNT. Yes, sir.

Senator MAGNUSON. Okay.

Dr. HUNT. Mr. Chairman, I would like to comment very briefly——

Senator MAGNUSON. The Congressional budget, although it doesn't have line items, will give us a little leeway in health and we just finished that yesterday.

Dr. HUNT. Yes, sir. When the Congress established the Institutes of Health and particularly the National Heart Institute in 1948, you clearly defined the mission of that institute. It was to develop and support programs in biomedical research in heart disease. Goals and objectives included the devlopment of new knowledge and we had good news, Mr. Chairman, in that the missions and goals and specific objectives of 1948 really have been fulfilled. In the past 35 years there has been a 30 percent decrease in the death rate from heart disease.

The greatest decrease has occurred in the past 5 years. There have been many advances which have caused this. Among those with a personal interest of mine professionally have been the success that we have had in the delivery of care of people with high blood pressure. So, in the heart area the news is good news particularly with respect to new knowledge and delivery of that new knowledge in terms of preventing deaths.

The NHI of 1948 was sufficiently successful that you and your colleague increased our responsibilities.

In 1969 you added the mandate in lung disease; 1972, in blood vessel disease; 1976, in blood diseases.

You also charged us to be responsible in areas of clinical trials, demonstration, baby patient education and public education.

Well, the other members of the Heart, Lung, Blood Institute Advisory Council and I are most appreciative of the confidence that you have expressed in us, but we feel that we cannot report to you at the moment that the success in lung has been as great as it has in heart. After all, the lung mandate is only 6 years old.

The blood vessel mandate 4 and the blood one just 2 years at the time of this funding.

Senator MAGNUSON. Now, you will put in the record those figures so the rest of us can understand them.

Dr. HUNT. Yes, sir.

Senator MAGNUSON. Reduction.

Dr. HUNT. Yes, sir.

We feel the starts be made in each of these areas. My colleagues will comment more specifically on that, then I would like to come back and make a very brief closing statement on behalf of the group in terms of actual recommendations on funding.

Dr. Fishman, former member of the Council, Heart, Lung, Blood Advisory Council, and distinguished scientist himself will speak next.

Senator MAGNUSON. All right.

Dr. FISHMAN. I would like to say, Mr. Chairman, that is the first time in 10 years I have helped anybody light up a cigarette or cigar. So, we broke with tradition.

Senator MAGNUSON. Well, cigars are not——

Dr. FISHMAN. I agree.

My name is Alfred Fishman, director of a research group at the University of Pennsylvania and have a major interest in heart and lung disease.

What I would like to do, instead of being anecdotal the way some of the other testimony was or quote figures which you haven't a chance to verify I would like to confine my remarks to three areas I have identified.

The first priority I believe I would like to address is to urge a consideration of the desperate need in this country to promote basic research. I know and I have been involved in health care delivery, but as a physician who has been spending most of his life straddling the fence between bedside and research I would like to point out that we all know now that most of the advances in research and clinical medicine that have been made since the turn of the century have been directly attributable to basic research.

Let me give you one anecdote having said I wouldn't. Nobody would imagine that from a soap bubble examined over a hundred years would come the best approach to treating respiratory disease in newborn. Mortality of that disease has dropped from 80 percent to 20 percent. It all came from the fact that one man noticed that a bubble of mucous from the nose behaved entirely differently under the microscope from a bubble they got from the lung. They realized the lung was full of bubbles and suddenly they realized there was a whole new approach to diseases of the newborn.

My first point is I really don't like aimless research, but I must say one cannot do mission-oriented research until one understands everything that has to be known to complete the mission.

Senator MAGNUSON. Doctor, basic research is the hardest thing to sell.

Dr. FISHMAN. I know that.

Senator MAGNUSON. I have sat on this committee many, many years as you folks know. So often people showed up that we gave money last year to, well, what have you got to show for it? That's when it was crowded between July 1 and July 1. What do you have to show for it? Well, he doesn't maybe know. He may be thinking about August 15 or something like that.

Dr. FISHMAN. Let me tell you, when I was a fellow I went into a laboratory that was using a catheter, they were using it to collect urine and they were trying to see if you could put it into somebody's heart without killing them. They weren't interested in curing, they were interested in getting a sample of the blood from the heart.

When they got that sample they suddenly realized they could not only measure the blood flow through the heart, suddenly they began to understand heart disease, the way opened to congenital heart disease, to open heart surgery.

So, in my own lifetime I have just seen where people who started out with a piece of research just to know, ended up with a Nobel Prize. So, I don't have any trouble seeing the relationship between the two.

The second priority for me is really a note of appreciation. One of the ways I think one can ruin the research effort in this country, which really means medicine, is by having instability in support of young people who require research training. The Congress has beeen very wise over the last few years by one way or another, to protect, at least, the basic component of research so we have the well-geared group of people who can investigate medical problems.

Senator MAGNUSON. I couldn't agree with you more. I think that one of the problems we have had with every budget regardless of the Administration, Republican or Democrat, is for some reason, they always want to skimp on training programs.

This goes through the whole NIH, and the whole health field. Every year we have to fight to put more in for training purposes. I don't know why. They don't seem to think it amounts to much. If we are going to have some national health insurance program and we don't have a lot more trained people it is going to fall flat on its face, no matter how good it looks. Nobody seems to think about that.

Dr. FISHMAN. Let me just touch on the last one. The last one is how does one now having made a case for research and stability harvest what research means, because I, too, am interested in illness, health care, et cetera.

The Lung Institute is a good example. It's only been in business 7 years.

For the first 7 years if you look at the scenario they were interested in understanding how it is that the lung reacts to different kinds of injury: smoke, inhalants, occupational, et cetera. They set up a master plan to increase the number of people and to develop programs that could look into this. At the present time they are all geared to take the next step.

There are all sorts of questions that can be asked. For example, can we prevent bronchitis and emphysema? Can we improve mortality statistics from black lung which is costing the government and people fortunes. My plea at the moment is having geared up so nicely now, to apply the fruits of research, I just wonder if it wouldn't be a foolish economy to prevent the clinical trials and to learn the things we need for the care of the people. We are just at that stage. So, that completes my three points. I just make my plea to go all the way from research to health care.

Senator MAGNUSON. We haven't really touched, have we?

Dr. FISHMAN. Not at all.

Senator MAGNUSON. I don't know, we are just kind of an orphan around here, so many children.

Dr. FISHMAN. At the present time the research effort in this country in asthma is really quite impressive.

What it is is——

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Senator MAGNUSON. That has just started.

Dr. FISHMAN. It just started but I think the time has come now to look at the various stages. We tried chromaline. That hasn't been a great success. There are all sorts of understanding how the airways are—which was a boy they used to do a section of the nerves in order to cure asthma. It did nothing.

At the present time, we are far down the road, but what we need to do is have the application now.

Dr. HUNT. Mr. Chairman, Dr. Ross is going to address the lung issue on behalf of the panel.

Senator MAGNUSON. All right.

We will put your statement in the record.

Dr. ROSS. I am president-elect of the American College of Chest Physicians and chairman of the department of medicine at the Medical University of South Carolina. I am presenting my views very briefly on behalf of the American College of Chest Physicians which is an international professional organization of over 10,000 members who have an interest in heart and lung disease.

Senator MAGNUSON. Senator Hollings is a very valuable member of this subcommittee and Senator Schweiker, who was just here.

Dr. ROSS. I want to relate my brief statements to the lung programs of the National Heart/Lung and Blood Institute, but I would like my full statement to be included in the record.

Senator MAGNUSON. It will be.

Dr. ROSS. In the main we believe the Administration has requested inadequate appropriations for the National Heart, Lung and Blood Institute and in the testimony we have included a table which gives our views of it, what the appropriation should be.

Disease of the lung has become an increasingly serious national health problem. It is the sixth leading cause of death with 130,000 deaths per year.

Senator MAGNUSON. Get down to the table. Where is that, in the back?

Dr. ROSS. Yes, the last page.

Senator MAGNUSON. All right.

You have your figures there. That is what we want. All right.

Dr. ROSS. Yes. It is the sixth leading cause of death with 130,000 deaths, 46 million days lost from work, 40 million days of bed-restricted activity and about 6 billion annually in lost productivity.

So, respiratory diseases are very devastating particularly in the very young and elderly.

Dr. Fishman has already mentioned the problem of neonatal respiratory distress which causes 12,000 neonatal deaths and is implicated in the development of the upper respiratory diseases as well.

An estimated 8 million Americans are currently afflicted by emphysema and bronchitis alone. Emphysema is the third leading cause of worker retirement on disability payments. In the 6 years since the research mandate of the Institute was expanded to include the lung, much has been accomplished. Much more needs to be done.

I support the statement of Dr. Fishman that the developments in bench research that have been made now warrant extension of research closer to patients and the public, which all research ultimately serves. As the level of this knowledge is increased, grant applications

to study significance of this knowledge in relation to patients have also increased.

When you take bench research into clinical human research it costs much more. Since this is an end toward which scientists work, however, this research must receive the necessary funding. Specialized centers of research need to be increased.

Now, the Institute wants to develop additional centers in respiratory failure, four or five centers. These are very important centers. We support the pulmonary academic awards which upgrade the teaching of pulmonary diseases in medical schools and young investigators awards which encourage young scientists to pursue pulmonary related projects.

We feel our recommended appropriations would provide adequate fiscal support.

Senator MAGNUSON. Let's get down to, which reminds me, all of you, we are coming to a point where I think the NIH, we have got to, I use the word farm more out, the inhouse thing out. It is getting pretty loaded. You achieve more at times when you farm it out, like the Cancer Institutes which you spread. This is where some of this money ought to be going.

I think that Dr. Fredrickson and NIH want to do that. Now, for instance, we had, I can remember, it was just a little while ago, we only had one stroke center. Just one. What we ought to do is spread this out because our talents have spread out. You never know where it is coming from. They just get so much more out. Even between you and me, we—even the problem of quarters out there is getting so tight they have got to do something about it.

Dr. ROSS. That is what these specialized centers of research will do. We only have one lung center actually in the country, one heart center, and one blood center.

Senator MAGNUSON. That isn't what I think we want to do. We want to get this spread out so they can take advantage of good research capability anywhere. Then you are going to have—if you are going to have clinical research you have to spread it out. You can't do it all at NIH. You have got these advisory committees that I assume they do a pretty good job in passing on where it should go and how it should be.

Dr. HUNT. Mr. Chairman, Dr. Mason will address issues more closely related to heart. Of course, this area we are especially proud of our accomplishments of the past 25 years.

Senator MAGNUSON. Yes, because this has got to be done. It is a problem.

## AMERICAN COLLEGE OF CARDIOLOGY

### PREPARED STATEMENT

Dr. MASON. Mr. Chairman, I am Dr. Dean T. Mason, president of the American College of Cardiology, and professor and chairman of cardiovascular medicine in the school of medicine at the University of California at Davis.

If you would like to follow along with me, I have copies of my summary.

I would like my prepared statement to be included in the record.

Senator MAGNUSON. It will be included in the record in full.

[The statement follows:]

## STATEMENT OF DEAN MASON, M.D.

Mr. Chairman and Members of the Committee:

I am Dr. Dean T. Mason, Professor and Chief, Cardiovascular Medicine, University of California, Davis, School of Medicine and President of the American College of Cardiology.

As you may know, the American College of Cardiology is a professional, medical-specialty society of more than 8000 physicians and scientists who specialize in heart disease and other closely related disorders.

We greatly appreciate the opportunity to appear before this important Committee and to express our view concerning appropriations for Fiscal Year 1978 for both the National Heart, Lung, and Blood Institute and the National Library of Medicine.

In our statement we address priorities, general directions and general funding levels for these two important components of the Nation's health research and education effort, and we suggest specific dollar amounts for their most important elements. Relative to this, we have carefully considered our recommendations in light of the need for over-all federal fiscal restraint.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

At the outset, we would like the Committee to know that in NHLBI, we are really talking about three important Institutes, all under one umbrella. These three Institutes, one for Heart, one for Lung and one for Blood, all must compete with each other for resources. It is our hope that with your support the total dollar figure for NHLBI can be sufficient to accomodate important initiatives in all three areas.

We would like to express our pleasure with the general

trend of accomplishments taking place at the National Heart, Lung, and Blood Institute. Under the splendid leadership of Dr. Robert Levy, its Director, steady progress is being made against cardiovascular diseases. We anticipate that this steady progress will continue should the Institute be funded at adequate levels.

We feel that the 15% decline in deaths due to coronary artery disease over the past five years, the 16% decline in the death rate for strokes and drop of 39% in hypertension deaths, demonstrate the effectiveness of the National Heart, Lung, and Blood Institute's program strategy.

As required by the National Heart, Blood Vessel, Lung and Blood Act (P.L. 92-423), the NHLBI is providing leadership for a national program to attack diseases of the heart, lung and blood vessels by planning, conducting and supporting an integrated and coordinated program of research, investigation, clinical trials, demonstrations, and manpower training. The National Program Plan developed in 1973 resulted in the establishment of a rational program structure and provides a mechanism to monitor continuously, update and report progress of NHLBI programs. There are 20 elements in the program structure, half of which are directed toward heart and blood vessel diseases. Programs of the National Plan are implemented, monitored and assessed according to a disciplined strategy consisting of an ordered sequence, via acquisition of new knowledge through basic and clinical research, testing and evaluation of promising hypotheses via clinical trials, and application of existing knowledge through education, demonstration and control programs.

In order to continue the documented progress the Institute has been making, we recommend that Congress appropriate a total of $493,458 million for the entire NHLBI, with $306,362 million allocated to the Division of Heart and Vascular Diseases.

This total Institute figure represents a relatively small increase (less than 12%) over the $436.6 million which the Institute estimates is necessary just to maintain the Program effort at last year's level, when inflation is taken into account.

Research Grants

The American College of Cardiology recommends a total of $281,240 million for all Research Grants, with $196,868 million designated for Heart and Vascular Programs in the Institute.

The Adminsitration's request, while providing a meager increase in Research Grants for the whole Institute, contains

an actual decrease for Research Grants that would be awarded in Heart and Vascular Program areas.

Our recommendation affirms our belief that individual investigator-initiated research is the most effective and productive approach to the development of new knowledge. The Administration's recommendation, on the other hand, would see yet another decline in the amount of regular competing grants that could be approved -- from 45% in FY77 to about 30% in FY78. We believe it desirable for the Institute to fund approximately 50% of approved competing research grants.

Furthermore, the National Research and Demonstration Centers Program, which we fully support, has been stifled in meeting the Congressional mandate that 30 be established: due to insufficient funding at this time only 3 centers are operational. Our recommendation would provide funds that would contribute to the Institute's progress in surging forward in this endeavor to translate basic research findings into practical patient care in local communities across the nation.

Training Programs

Once again, we would like to recall that back in 1969 the Manpower Programs were funded at approximately $25 million. In FY 77, the funding level was only about $22 million. We believe that there should be sufficient funding in FY 78 ($33 million) to approach the support of about 2,000 NHLBI trainees, as compared to the 1100 NHLBI trainees that could be funded under the Administration's FY78 proposal of $20.0 million. Furthermore, the College would like to express its alarm that since 1970 there has been an alarming drop of 40% in the number of cardiovascular trainees. This trend should be totally unacceptable to those concerned with the good health of this Nation.

The Administration's proposal contemplates a complete phase-out of institutional grants with no corresponding in other training programs. Training researchers is essential to the performance of research. We urge that these institutional funds be appropriated in order to maintain the flexibility that the NHLBI has in meeting complex research problems with the right mix of talent.

Certainly, this fiscal de-emphasis of training could spell disasterous results to the biomedical research community several years from now. As such, we believe that our recommendation

will insure that competent researchers are available to conduct the research for which these tax dollars are being spent.

Research Development Contracts

The American College of Cardiology recommends $123,421 million for this area of targeted research. We propose that $86,394 million to be allocated to Heart and Vascular programs.

The Presidential request would provide funding for only 90% of the present commitments, as opposed to the traditional 100% funding level. Our recommendation would allow the NHLBI to carry on and to expand programs within their budgeting mechanism.

Many of the programs in the Research and Development Contract category test and evaluate newly developed procedures through actual clinical trials. Other contracts are aimed at the general population, through education, prevention and control programs for cardiovascular disease.

One example is the national attack upon hypertension coordinated by the NHLBI and supported by its educational research. We, along with more than 200 other organizations, have been pleased to participate in the effort. We are especially gratified with the results recently reported. From the time of the program's inception in 1972 until now, we have witnessed a 100% increase in the number of people whose blood pressure is under control from about 4 to 8 million of 23 million Americans known to have high blood pressure. The general public awareness of this silent killer has increased by remarkable proportions.

Using its considerable resources to gather data and do research, the Institute has catalyzed the National High Blood Pressure Education Program to assist a large number of organizations to serve more effectively the health needs of the American public. Long term patient compliance with treatment regimens is now the challenge facing the Institute.

As we testified to last year, we are truly concerned with continuing medical education for physicians. In plain terms, not enough is being done. Under the impact of recertification, relicensure, and most recently, professional liability insurance, which has resulted in a number of state laws mandating continuing education prior to relicensure, the demand for continuing medical education has increased enormously. The issue is not funds for operational programs and courses. The individual issue is support for research and development leading to more effective systems and methods to keep practitioners current with latest developments in treatment and diagnosis.

To date, the Institute, through staff efforts and some awards in the pulmonary area, has begun to make a modest contribution. We would urge that these first steps be capitalized upon and expanded into the cardiovascular area. Our recommendation would provide a modest beginning here. Our allocation would also provide funding for important projects such as the Institute effort towards the development of improved non-invasive diagnostic instrumentation. The College wishes to point out that we further believe that the precise allocations among the diverse elements of these programs should be left to the Director of the National Heart, Lung,and Blood Institute.

Intramural Research

The College recommends approximately $22,797 million for intramural research. We feel that this level of funding is sufficient to allow the NHLBI to continue its own research programs, blending basic research with solution of clinical problems.

The intramural program at NHLBI attracts and sustains the highest quality scientific staff to its Bethesda campus. However, we feel that the strength of the Institute has been and is in research; yet, the new emphasis for clinical care services at NIH is competing with the research goals of those performing intramural research. We feel that the Institute is effectively doing the homework and should continue to do so, so that those directly concerned with health service delivery can do their job.

NATIONAL LIBRARY OF MEDICINE

The American College of Cardiology recommends an appropriation for FY 1978 to the National Library of Medicine of $41.9 million. With an inflation rate of 8%, this figure would provide for a real dollar growth of 6% in the Library's programs.

This increase is small in view of the expanding demands for basic biomedical information dissemination reflected in inter-library loan requests which increased by 25% in FY 1976 alone.

Furthermore, your Report accompanying last year's appropriation bill stated that NLM should continue to explore advanced technological capabilities for transfer of information through satellite communication as well as library automation and document delivery. Our recommended increase would allow NLM to implement this mandate.

CONCLUSION

Mr. Chairman and Members of the Committee, thank you very much for this opportunity to present our views on the upcoming fiscal year 1978 appropriations.

TABLE I AND SUMMARY RECOMMENDATION (in thousands)

| | FY 1977 | | President's Recommendation FY 1978 | | ACC Recommendation FY 1978 | |
|---|---|---|---|---|---|---|
| | Heart&Vascular | Total | Heart&Vascular | Total | Heart&Vascular | Total |
| Research Grants | 158,582 | 239,274 | 158,332 | 246,823 | 196,868 | 281,240 |
| Training Programs | 13,963 | 21,988 | 12,066 | 19,954 | 23,100 | 33,000 |
| Research Contracts | 60,499 | 81,452 | 66,346 | 81,452 | 86,394 | 123,421 |
| Intramural Research | ---- | 33,950 | ---- | 35.139 | ---- | 33,000 |
| Program Management | ---- | 19,997 | ---- | 20,274 | ---- | 22,797 |
| TOTAL | 233,044 | 396,661 | 236,744 | 403,642 | 306,362 | 493,458 |

SUMMARY OF STATEMENT

Dr. MASON. We met before in 1972 at the college's meeting at that particular time.

The American College of Cardiology is a professional medical society of more than 8,000 physicians and scientists who specialize in heart disease.

In our prepared statement we address priorities, directions, and funding levels for appropriations for fiscal year 1978 for both the National Heart, Lung, and Blood Institute, and the National Library of Medicine.

Now, concerning the National Heart, Lung, and Blood Institute, we stress that the NHLBI in reality constitutes three important Institutes, all under one umbrella: one for heart, one for lung, and one for blood, and all which must compete with each other for resources.

It is our hope that with your support the total dollar figure for the NHLBI can be sufficient to accommodate important initiatives in all three areas.

Now, in order to continue the documented progress the institute has been making, we recommend that for fiscal year 1978 Congress appropriate a total of $493 million for the entire NHLBI, with $306 million allocated to the Division of Heart and Vascular Diseases.

Within these moneys the College of Cardiology recommends a total of $281 million for all research grants, with $197 million designated for heart and vascular programs.

Our recommendation affirms our belief, expressed by others previously, that individual investigator-initiated research is the most effective and productive approach to the development of new knowledge.

We believe it desirable for the NHLBI to fund approximately 50 percent of approved competing research grants.

Our recommendation would also provide funding towards NHLBI's congressional mandate of establishing 30 National research and demonstration centers for translating basic research findings into practical patient care in local communities across the Nation.

Now, in regard to training programs, we believe that there should be sufficient funding in fiscal year 1978——

Senator MAGNUSON. Well, 30 is a goal that you have but that still is not enough.

Dr. MASON. There are only three, as Dr. Ross just pointed out.

Senator MAGNUSON. You have to start slowly. You just can't do it overnight.

I understand.

Dr. MASON. Right.

We think that there should be $33 million allocated to this to support 2,000 NHLBI trainees.

Fiscal deemphasis of training will spell disastrous results to the biomedical research community in future years.

You just expressed your sentiments, I believe, in the same regard.

The college recommends $123 million for targeted research in the form of research development contracts, of which we propose $86 million be allocated to heart and vascular programs.

You have asked for figures, and I have given you lots of them.

This recommendation would allow the NHLBI to carry out their present commitments within their budgeting mechanism.

Further, we are truly concerned with continuing medical education for physicians. Not enough is being done.

The need is support for research and development leading to more effective systems and methods to keep practitioners current with latest developments in treatment and diagnosis.

In this regard we urge that such steps be initiated in the cardiovascular area and our recommendation would provide at least a modest beginning in this regard.

The need really is for research for more effective systems. We don't need more programs. We need more research for more effective systems.

Now, finally, the college's recommendations and rationale for NHLBI intramural research of $23 million, and for the National Library of Medicine programs of $42 million for fiscal year 1978 can be found in our detailed prepared statement. And I won't go into that further.

I will thank you for this opportunity.

Senator MAGNUSON. We thank you, too. We will include your statement in full.

Of course, we have a problem. All these figures help us to arrive—to suggest a sufficient top figure, not the bottom line, but the top figure that these allocations and distributions can be made.

We are not experts. We know sometimes we put in a report that we feel you ought to do more on this and more on that. We just presume that when we add money or mention these things, that they will follow through.

It may not be dollar for dollar, but not to neglect certain parts of it. I think we have gotten to a point where we are starting to realize, too, that these diseases you people are finding out are a combination of all kinds of things. It just isn't one thing. Therefore, research has to be correlated in that respect.

To do that you better go out, go out and find out.

Dr. MASON. We appreciate your understanding.

Senator MAGNUSON. All right.

## BLOOD DISEASES

Dr. HUNT. Dr. Kellner represents the newest initiative the Congress has charged the Institute with, Mr. Chairman.

Senator MAGNUSON. All right.

Dr. HUNT. Blood disease.

Senator MAGNUSON. OK.

Dr. KELLNER. Mr. Chairman, I am director of the New York blood center, professor of ecology at Cornell. As my colleague says, I represent the new boy on the block.

Last year, 1976, blood was added to the name of the institute. It gave blood high visibility, gave the Institute new mandates, but unfortunately, not the money to carry out the mandates. So I am going to make a pitch for more money for the Division of Blood Diseases.

Supportive of the figure cited by my colleagues, I am not in competition with them. Those figures are included in the full document.

When we speak of blood resources, we are speaking of the blood supply. Blood banking and the blood supply in this country is as important as its water supply. The blood supply of the country is one of the noble points in health care.

Without a scientifically oriented, well-mannered blood supply, many of the new things in health care can't be done. New treatments for cancer, for example, newer treatment for heart disease, cardiac surgery, are seriously impaired.

The very lifestyle of blood-related diseases—people with blood-related diseases such as hemophilia, sickle cell disease, are jeopardized.

I would like to address myself for a moment, Mr. Chairman, to the question you raised, what have we got to show for it, and to tell you we have a lot to show for it.

I would like to use two illustrations that I think would make the Congress proud of the funds it has allocated, and us as physicians and scientists proud of what we have done. One is the matter of hepatitis.

A little more than 10 years ago, somebody made a chance observation in a laboratory here in Washington—the NIH, as a matter of fact—and called it the Australia antigen. It was quickly found that this antigen was really related to the virus of hepatitis.

In short order, there was an avalanche of new information. What we thought was merely a complication of blood tranfusion turned out to be a very serious disease spread by many ways other than blood transfusion, causing serious liver disease, cirrhosis, probably even cancer of the liver, and that there were a million people in this country who were innocent carriers of the disease, and around the world well over 100 million people at any given time.

Well, to demonstrate how quickly advances in the laboratory are translated in a practical application, the delivery of health care—you talked about it earlier this afternoon.

Within the past few years, a progressive series of more and more sensitive tests to detect this virus have been developed. Today every single hospital in this country and every blood bank is doing those tests. The incidence of hepatitis has been sharply reduced and blood transfusion has been made safer.

That in itself is an interesting story, but it is only a small part of the story. We are today, barely 10 years after the initial discovery, in the position where we can now think we can prevent hepatitis. There are three vaccines to prevent hepatitis B already developed, in the testing stage, in animal testing and human testing.

It seems quite likely the tests are very promising that the vaccine is safe and effective. It is likely within 2 or 3 years we will have vaccines to prevent hepatitis.

What is unfolding before our eyes, Mr. Chairman, is one of the most dramatic stories in the history of medicine. We are seeing it right in front of our eyes. I think it will rival the classic example of poliomyelitis.

Everyone cites that as the small dollar investment with the enormous value to human lives.

The other example is hemophilia.

I have been a physician for a long time, more than 30 years. I have watched the progress of hemophilia. The hemophiliac who

was born 30 years ago—most of them are handicapped, severely crippled, subject to extensive orthopedic surgery, and all kinds of psychosocial rehabilitation.

The hemophiliac born 20 years ago gets around, can hold a job, and can function in society.

The hemophiliac born 10 years ago is a normal human being. The little boys go to school, play with boys their age, do everything boys their age are supposed to do and can look forward to a full, normal and useful life.

That is a remarkable transformation. It is a transformation that has been made without great—it's been knitted together from bits and pieces of small advances of additional pieces of information which have been applied step by step by the pharmaceutical industry, the Nation's blood banks and hospitals, so that hand in hand we have research going on to understand the molecular cause of hemophilia and that still needs to be worked on, and at the same time, making more advances in engineering and making the material more available and cheaper, we can improve the quality of life of the people who are involved.

Finally, I would like to make a pitch which is simple, almost simplistic, which is undramatic and unglamorous, but which I think is absolutely essential if we are going to improve the quality of our Nation's blood supply.

It is appalling but it is true that we have unbelievably little information about our Nation's blood supply. It is almost a national disgrace.

If you, Mr. Chairman, or the Congress wanted to find out how much water flowed in the Mississippi River last year or how much corn was planted in Iowa or how much—how many tokens are put into the turnstiles of the subways of New York last year, you could find out very easily. If you wanted to find out how much blood was collected in the United States last year, who collected it and what happened to it, you couldn't do it, not within reasonable accuracy.

And during the past year——

Senator MAGNUSON. Who would do that, NIH?

Dr. KELLNER. Well, NIH supported last year a task force of the American Blood Commission to create a National Blood Data Center.

What I would like to urge is that this National Blood Data Center be brought to being.

We cannot have a national blood supply, we can't plan, we can't evaluate performance, we can't measure cost effectiveness, we can't identify areas that need to be targeted for further study, we can't tell the impact of new treatment of cancer, new type of surgery for heart disease or blood supply unless we have the numbers. And we don't have the numbers.

For only one year in history does America know how much blood it collected. That was in 1971, when the Heart/Lung Institute paid half a million dollars to have a study done. It had a study done in 1971. Even in that one year, 28 percent of the blood was unaccounted for.

Not that it was lost or was stolen, but we had no machinery for tracking it.

Now, the recommendations being made through the American Blood Commission for the creation of a National Blood Data Center, the logical place to fund this initially, just to get it off the ground is the Division of Blood Diseases and Blood Resources of the Institute. It is completely consistent with its mandate.

Its mandate is to study all phases of the management of the Nation's blood supply. We can't study all phases of the management unless it knows what is happening.

We need a modest sum, $1.5 million, $2 million, a year, to get it off the ground. After that, it will largely support itself.

I urge you to consider this.

The moneys do not exist at the present time and we can't plan for our Nation's blood supply in the future unless we know where we have been in the past and where we are going and of the numbers.

Thank you, Mr. Chairman.

Senator MAGNUSON. Now, you suggest that we add from $1.5 million to $2 million, not now available for this sort of thing?

Dr. KELLNER. Yes, sir.

Senator MAGNUSON. Then you also suggest, again, we are getting back to the same thing, that you have got to have in your particular field more training, training programs.

Dr. KELLNER. We absolutely do. There aren't enough physicians trained now to man the Nation's blood banks.

Senator MAGNUSON. About a million dollars will train at least 50 good people which you never had before.

Then you talk about adding $13 million to the budget for—total budget for blood diseases and blood resources, not at the expense of heart and lung.

That would have to be segregated out by the Institute itself as to how they do it.

Dr. KELLNER. Yes.

Senator MAGNUSON. All right.

## CLOSING STATEMENT

Dr. HUNT. Mr. Chairman, may I make just a brief closing statement on behalf of the panel?

Senator MAGNUSON. Yes. Go right ahead.

Dr. HUNT. My colleagues have demonstrated I think to you a concern for the mandates of the Congress in terms of heart, lung, blood vessel, blood diseases.

We feel that the various groups who support the National Heart, Lung and Blood Institute do so in a very responsive fashion.

We are concerned, Mr. Chairman, that for fiscal year 1978, with the budget recommended by the administration, that the Institute would be able to fund only 20 to 30 percent of the approved grants that would come before the Council.

Dr. Fishman is a past member of that Council and he knows how difficult it is to turn down outstanding research programs that have already gone through the review process.

As a new member of that Council I am becoming very concerned about this.

We are here as private citizens, Dr. Fishman and I, not as members of the Council. We only use that background for the information that we have.

The next point I would emphasize, Mr. Chairman, is the recommended increase, so-called, in the budget, as brought forth by the adminstration to the Congress, really is less than a 2 percent increase in terms of total dollars from what it was in 1977.

This really is not an increase. It is less than inflation by far.

For this reason, it would really force us to reduce our programs, not to expand our programs, when they are being productive.

My colleagues have addressed the question of research, health manpower training.

Dr. Kellner has emphasized the necessity of actually training people in the blood resource area.

We estimate that $200 million—I think that the fiscal year 1977 budget was for approximately $185 million—but $200 million would provide for those 2,000 trainees of NIH, NHLBI, that were mentioned by Dr. Mason and Dr. Kellner.

For this reason, and not attempting to break down—since our responsibilities are across the board in heart, lung, and blood diseases, we would urge a stable base of support is far more important than the actual number of dollars that come forth from the Congress.

We know we wouldn't have any kind of program if it weren't for this committee and you and the members of the committee.

A stable program is terribly, terribly important.

Finally, in order that the Institute, very able Director Dr. Robert Levy, the dedicated members of the staff, the members of the Council—we will protect the moneys that the Congress submits on behalf of the public in terms of a budget.

We urge and strongly recommend $492 million budget as has been emphasized by my colleagues.

Mr. Chairman, for the fourth time, fourth year in a row, thank you very much for your concern.

Senator MAGNUSON. We will put all the statements in the record.

I can't help but say that I hope you people get over to the House side, you know. It gets a little—sometimes you have got to fight them and it starts to come from here.

I would like to once start from the House, come over and say, "Hey, look, we agree with you."We are pretty much agreed and in sympathy with all these programs and will do the best we can.

We run into that.

You should be in some of those conferences and listen to what we go through at the House. It is amazing.

Dr. HUNT. We will attempt to get Mr. Flood's attention tomorrow morning, Mr. Chairman.

Senator MAGNUSON. You are going over there?

Dr. HUNT. Yes, sir.

Senator MAGNUSON. Well, you lay it on Dan Flood pretty good.

OK. Thank you all very much.

Dr. HUNT. Thank you, sir.

AMERICAN DENTAL ASSOCIATION, AMERICAN ASSOCIATION OF DENTAL SCHOOLS, AND AMERICAN ASSOCIATION FOR DENTAL RESEARCH

**STATEMENT OF DR. EDWARD J. FORREST, DEAN, UNIVERSITY OF PITTSBURGH SCHOOLS OF DENTAL MEDICINE, AND MEMBER, AMERICAN DENTAL ASSOCIATION'S COUNCIL ON RESEARCH**

Senator MAGNUSON. Now, Dr. Forrest.

Doctor, are you local? Can you come back tomorrow?

Dr. FORREST. What time, Mr. Chairman?

Senator MAGNUSON. 10 o'clock tomorrow morning?

Dr. FORREST. I have to appear before Congressman Flood's committee tomorrow.

Senator MAGNUSON. Oh, yes. I don't want to stop you from that.

When you are through over there, you come over here and we will be in session tomorrow at 10 o'clock and will hear some of the other outside witnesses. So I would appreciate it very much.

Dr. FORREST. Yes.

Senator MAGNUSON. I am sorry we got caught here, but I thought somebody else would be down here and we could take this and share it a little bit.

VOICE. Mr. Chairman, we would be happy to put it in the record at the convenience of the committee.

Senator MAGNUSON. Well, if they want to come in, either put it in the record or come in tomorrow—how is that?

Depending on your timing. You can gauge that. Play it by ear over there.

Dr. FORREST. I just may say, Mr. Chairman, after sitting here and listening to you take all this testimony for all these health people, I am quite confident that you are very cognizant and supportive of all these areas.

I think the testimony in the formal statement we have written is very self-explanatory. You are already, I am sure, familiar with it, but I would be very delighted to come back if your schedule permits tomorrow.

I leave here with some confidence.

PREPARED STATEMENT

Senator MAGNUSON. If I am not here, somebody else will be here tomorrow. If you would like to submit your written statement, we would be glad to include it in the record.

[The statement follows:]

## STATEMENT OF DR. EDWARD J. FORREST

Mr. Chairman and Members of the Committee:

My name is Dr. Edward J. Forrest. I am Dean of the University of Pittsburgh Schools of Dental Medicine and a member of the American Dental Association's Council on Research. I am appearing today on behalf of the American Dental Association, the American Association of Dental Schools and the American Association for Dental Research.

Mr. Chairman, we understand the difficult time constraints the Committee is laboring under. With your permission, I would like to read an abbreviated statement to the Committee and submit for the record supplementary information on certain of the dental program areas for which we have a particular interest.

Health Manpower

Mr. Chairman, for the past few years, we have all witnessed a determined effort on the part of the Executive Branch to drastically reduce support for health manpower, particularly dental health manpower training. From fiscal year 1974 to fiscal year 1976, federal support for the training of the health professions was reduced by over 50 percent. We realize that these actions occurred in large measure because health manpower authorizations expired in June 1974, and, therefore, regular appropriations were not possible. However, after two years of debate, the Health Professions Educational Assistance Act of 1976 was enacted last October. Fiscal year 1978 will be the first full year to be funded under the new law. It is also the fiscal year during which most of the new requirements of, and new programs authorized in, the law are to take effect.

Mr. Chairman, at this point I would like to briefly discuss three of these major areas and our recommendations in each.

First, institutional assistance - the ability of our dental schools to

respond to the initiatives contained in the new health manpower law is directly related to an adequate and predictable level of institutional support. Unfortunately, the Administration's proposed fiscal 1978 budget would seem to ignore this basic premise. A total of $114.5 million in capitation grant assistance is requested for schools of medicine, osteopathy and dentistry. Not only is this amount substantially below the $177 million authorized in the law, it is also considerably less than the level of capitation grants awarded in 1974, the last year these programs received a regular appropriations. In that year schools of dentistry received over $40 million in capitation grants. Within the Administration's request for 1978, dental schools would receive only $29 million - a reduction of over 25 percent.

The dental education system is already laboring under the financial and physical strain of the mandatory enrollment increases which were imposed by the three previous health manpower laws. It is unreasonable, in our view, to expect these same institutions to launch the new and costly programs which are required by this latest legislation in return for an inadequate level of capitation grant support. In summary, Mr. Chairman we respectfully urge this Committee to recommend a minimum appropriation of $130 million in capitation grant assistance for schools of medicine, osteopathy and dentistry. Second, student assistance. We agree with the Administration that the National Health Service Corps Scholarship program appears to be the best short-term solution to the problem of attracting health professionals to areas where they are most needed. We also agree with the President's proposal to develop the new health professions insured loan program, although we have serious doubts about the ease which students may have in obtaining these large loans in the private sector. We have not seen strong evidence to show that, nationally, private lenders will be eager to loan such large amounts over such long repayment periods. Before the federal govermnent relies on insured loans for health professionals as the principal means of student assistance, we think that more

evidence should be presented that the program will actually work. We strongly disagree with the Administration's proposal to eliminate what are termed health professions direct student loans. Last year, Congress also disagreed with this proposal by extending the direct loan program through the life of thenew law. We think that the students who are not able to obtain an insured loan in the private market should not be forced into a choice of applying for a service scholarship or not applying to school at all. There should be alternative support available. We strongly recommend that funds for direct loans be restored at a level of $26 million for FY 78.

Third, dental health activities - for the past four years the Department has continued, almost without interruption, to dismantle the dental public health programs of the Division of Dentistry. Although our Associations appreciate that the continuance of the Division as an entity is not technically a budgetary problem - it nevertheless is at the heart of what we see as the fundamental issue: Will the Department provide the visability and necessary resources that the Nation's dental health problems deserve and must recieve at the Federal level? In February the Department released its proposed 1978 budget for the Division of Dentistry. Unfortunately nothing in next year's spending plan would suggest that HEW intends to meet its dental responsibilities. A total of $2.1 million is requested for Dental Health Education. This compared to almost $15 million which was allocated for the Division of Dentistry in 1974. In many respects the Administration's attitude toward the dental division programs is a contradiction. Departmental witnesses emphasize, on the one hand, the importance of the Division's programs to train dental students in the efficient utilization of auxiliary personnel - and then surprisingly reduce the support for this activity by more than 60 percent. A similar situation exists for the Educational Development and Application program. After five years of supporting projects which seek to improve the organization, delivery,

and financing of dental services to the public, the Department proposed to terminate all support for this activity in fiscal 1978.

One of the most important activities now underway in the health field relates to research upon the dental delivery system itself. It is abundantly clear to our Associations that the deeper an understanding the nation has of the way in which the system works, or fails to work as it should, the better able we will all be to move toward refinement or changes that will enhance cost effectiveness, quality assurance and accesibility to dental care.

At the present time, the delivery systems branch of the Division of Dentistry is the focal point within the Government for these types of investigations. In our view, the delivery systems branch has done work of substantial importance and has done it with excellence and with objectivity. We believe it must be encouraged to continue and expand its studies both by contract and by grant. In the coming fiscal year, we would recommend a level of $5 million for the activities of the delivery systems branch of the Division. This is, in our view, a small sum to apply to the study of an $83.6 billion health care system treating more than 100 million patients each year.

To ensure that all of these important programs may be continued in 1978 we respectfully recommend a total appropriation of $13 million for for Dental Health Education.

Dental Research

At this point I would like to comment briefly on the activities and proposed budget of the National Institute of Dental Research. We are especially pleased to note the documented progress made in six, high priority target areas, namely: Dental Caries, Periodontal Disease, Soft Tissue Stomatology and Nutrition, Craniofacial Anomalies, Restorative Materials, and Pain Control and Behavioral Studies. Our Associations believe that the time is ripe for application and evaluation

of these findings by means of new, advanced laboratory and clinical studies. The transfer of laboratory technology to practical clinical application is sometimes a difficult goal, yet economically sound and dollar-wise. It is hoped that the Committee will support the NIDR budgetary request in these areas.

Certain aspects of the NIDR budget require further comment, however. It is noted for example that funds have not been requested for the support of any new or competing Institutional Training Awards. The Committe is urged to restore this item to the budget for the following reason: Institutional Training Awards assure that personnel will be adequately trained by a faculty group which conducts research in programs targeted by the NIDR as of "high relevance." The sum of $1,288,000 is requested for support of this program. Secondly, funds for the support of the Dental Research Institutes and Centers Program have plateaued. These five institutes, now in their tenth year, are initiating clinical studies on a cooperative basis. New equipment is needed to replace those that are worn and obsolete. An additional amount of $950,000 is requested for those programs. Thirdly, it is felt that greater emphasis should be placed on the preventive aspects of periodontal disease. The etiology of the disease process is highly complex, especially in relation to the many types of organisms involved. It is recommended that the appropriation for periodontal research be increased by $800,000. It is also recommended that greater emphasis be placed on developing the capability of diagnosing oral cancer at an earlier state. An additional level of $400,000 is requested for these studies.

Complementing the Institute's investigations' into the causes and prevention of dental disease is an ongoing collaborative research effort with the National Bureau of Standards. This unique program, which combines the skills of the dental scientist with the facilities of the world's leading physical science laboratory, has had a remarkably successful record of developing and improving dental materials and

instruments. Most importantly, these advances have had a direct and positive impact upon dental practitioners and their patients. Examples of this transfer of technology include: (1) the turbine or "highspeed" dental handpiece which virtually revolutionized the cutting of hard tooth tissues. It has enabled the dentist to prepare cavities quickly and accurately, thus reducing the time patients need to spend in the dental chair and consequently the length of time the "drill" is used. This in turn has also reduced the fear, tension and pain associated with visiting the dentist. An average cavity took about 12 minutes to prepare by the old slow speed "drill", but now the same can be accomplished in 3 minutes, (2) the development of the panoramic dental x-ray machine which is so useful in mass surveys, saves the Veterans Administration over $800,000 annually and the Air Force about $100,000 annually as it practically substituted a complete x-ray of the dental arches on a single film for the customary 20-film intraoral radiographic examination. For these two Federal dental services alone, the cost-benefit ratio annually was $1 for development to $11 savings, (3) new, life-like restorative materials which have an average life twice that of earlier silicate resotrations. This last development has been estimated to save American patients over $284 million yearly.

We are confident that increased funding for this collaborative research effort will produce tangible benefits for the American public. Support for the National Bureau of Standards program is currently provided under the Research and Development Contract activity of NIDR. We respectfully urge this Committee to recommend an additional $128,000 for this purpose.

In summary we are requesting that the Administration's proposed 1978 Budget for the National Institute of Dental Research be increased by a total of $3.6 million to support the activities noted above.

General Research Support

For the past few years, the Administration has proposed the elimination of General Research Support Grants, currently termed Biomedical Research Support Grants. Fortunately, the Congress, based on the recommendations of this Committee, has not agreed to these actions. The Administration again proposes to eliminate this program in fiscal 1978. Termination of this program will drastically affect the developing research programs in many of our dental schools and research institutes. As we have consistently pointed out, the purpose of general research support is to improve the overall quality of research. Such support is essential if dentistry is to be successful in its efforts to become an integral part of the biomedical research community. I should add that we not only speak of traditional general research support but also support for developing research programs. This latter support is especially critical to those institutions which had not developed a sufficient research base by the time the older General Research Support program was restructured two years ago. When the research base was raised to $200,000, two years ago, one-quarter of the dental schools no longer qualified for the general grants, but are eligible for developmental grants under the Biomedical Research Support Grant program. In other words, in 1977 one-quarter of the dental schools in this country can still be considered developing research institutions, and therefore, need support to develop their research potential. We respectfully urge that the Biomedical Research Support Grant program be restored at approximately $41 million, the 1977 level.

Dental Disease Prevention: In 1976 the responsibility for dental disease prevention, including the nationwide fluoridation effort, was transferred from the Division of Dentistry to the Center for Disease Control. At the time, our Associations expressed concern that the emphasis which had been given to this important activity would be reduced in a non-dental agency. To a large extent this has occured. We are, for example, unable to identify any specific funding for the

fluoridation program within the CDC budget. In addition, it is our understanding that the program, as presently constituted, is able to provide only limited technical assistance to those communities and school systems which seek to fluoridate their water supplies.

Mr. Chairman, I do not believe that it is necessary to convince this Committee that fluoridation is a safe, economical and effective means of preventing dental decay in large numbers of people. Unfortunately, public acceptance of fluoridation in this country is lagging. Despite studies which demonstrate that $30-50 can be saved in dental care costs for every dollar spent on fluoridation, less than one half of the population have access to fluoridated water systems. Only 13 states have fluoridated school water supplies. It is imperative, in our opinion, that the Center for Disease Control assume a leadership role in promoting and supporting this important preventive measure. As a first step in accomplishing this objective, we recommend that a minimum of $3 million be appropriated to assist communities in the installation, initial operation and maintenance of fluoride dispensing equipment. This effort should be accompanied by a major program of public information directed toward state legislatures, local governments and public officials, urging them to assign a high priority to fluoridation as part of their disease control programs.

Mr. Chairman that concludes our statement. We would be pleased to answer any questions you or members of the Committee might have.

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SUPPLEMENTAL INFORMATION

National Institute of Dental Research

During previous testimonies, it has been stated that the development of the dental research community and the subsequent progress of dental research is the direct product of the assistance and encouragement that Congress has given to the NIDR. The situation has not changed. Little, if any funding from private foundations was available then and is not now available for support of dental research. No one can dispute the fact that the improved standards of oral health of the American people, particularly our children and young adults, were due directly to the continuing support for research from the Congress. It is hoped

that the Committee will understand the deep concern of our Associations that adequate funding for the NIDR is not only desirable but it is absolutely necessary if the nation's dental health is to be improved by attempts to eliminate and prevent dental disease.

The Associations have reviewed the scientific programs of the NIDR and have noted the significant and documented progress which has been made in research involving six, high priority target areas, namely: Dental Caries; Periodontal Disease; Soft Tissue Stomatology and Nutrition; Craniofacial Anomalies; Restorative Materials; and Pain Control and Behavioral Studies. Many new effective methods have been developed for use in the prevention and treatment of oral-facial diseases and related conditions. The time has come to evaluate these findings by means of new, advanced laboratory and clinical studies. Some examples include:

1. Clinical Trials of Topical Antimicrobial Agents:
Dental decay will not occur if microorganisms can be prevented from collecting and reproducing on tooth structure. Laboratory tested, anti-bacterial agents are now ready for clinical evaluation. These particular agents, used primarily as a mouth rinse, prevent micro-organisms from attaching themselves to the surfaces of the teeth. Initial clinical studies have produced encouraging results, however, longer-term observations and evaluations must be initiated. Additionally, other chemical agents, as developed, must be continually screened and studied for their antimicrobial properties.

2. Demonstration of School-Based Fluoride Mouth Rinsing Programs:
Initial clinical studies have shown that supervised weekly fluoride mouth rinsing procedures reduce the incidence of dental decay by 30 to 50 percent. These school-based demonstration studies have been warmly appreciated by the parents of participating students. The Associations agree with the NIDR that these studies should be expanded to include as many as possible of the 25,000,000 children now living in fluoride deficient communities.

3. Continuous "Slow-Release" of Anti-Caries Agents in the Mouth:
A procedure has been developed and laboratory tested wherein an inert plastic device containing fluoride is fastened to a tooth by means of an orthodontic bracket. The device releases into the saliva an optimum amount of fluoride during each 24 hours for a period of up to six months. The safety and effectiveness is assured and the technique is now ready for clinical testing.

4. Periodontal Disease:
Periodontal disease, often insipid and asymptomatic to the victim, is recognized as a major health problem throughout the world. In the USA alone, it is estimated that 94 million people have some form of the disease. The result if untreated, is the partial and full loss of an individual's teeth. The mission of the NIDR periodontal disease program is to develop sufficient knowledge which hopefully will lead to the prevention and eradication of this disease. To speed these objectives, it is recommended that the following programs be initiated as soon as possible:

a. Development of Improved Clinical Techniques for Determining Therapeutic Effectiveness

In many instances, tissue changes occuring during the treatment of periodontal disease are subtle, hidden below the gums and difficult to quantify during clinical evaluation. Measurement techniques such as tactile and x-ray examination need vast improvement in order to permit objective evaluation of any type of treatment or preventive measures on a short-term basis.

b. Relationship Between Systemic Diseases and Periodontal Disease

Periodontal disease often seems to be present in patients afflicted with such systemic disease as diabetes and osteoporosis, the latter being a loss in bone density followed by bone resorption; however, destruction of the diseased periodontium seems to follow no consistent pattern. Severe bone loss may also occur in juvenile diabetic patients. The condition of the supporting bone often resembles an osteoporotic state. Two vital questions need to be answered:

1. Is periodontal disease a form or possibly an indicator of potential systemic osteoporosis?

2. If a patient is predisposed towards periodontal disease, does the presence of diabetes enhance the chances and/or can severe destruction of the alveolar bone support and the resulting loss of teeth be prevented?

c. Support for Specialized Periodontal Clinical Research Centers
It is felt that these and other pertinent questions can be ascertained and evaluated through the establishment of a number of periodontal clinical research centers. Their efforts would be devoted towards transferring the information previously obtained from basic fundamental studies concerning the microbiological, immunobiological and pharmacological properties of periodontal disease and thus applying this new knowledge in the treatment of the periodontally diseased patient. These centers would support and exemplify one of several over-all objectives set forth in the NIH Technology Transfer Program wherein the findings of sophisticated laboratory research can now be applied for realistic clinical applications.

It is noted that funds are not available for the support of either competing or new Institutional Training Awards. Instead, greater emphasis is being directed towards support for Individual Training Awards. Our Associations feel that funds in the amount of $1,208,000 should be restored to support the Institutional Awards Program for two important reasons. One, Institutional Awards enable the NIDR to make certain that personnel will be adequately trained by a faculty group conducting research in programs targeted by the NIDR as high in relevance. Secondly, the time required for an investigator to recieve an Individual Award takes about nine months. In many instances, by the time the application has been approved and processed, the talented applicant has found some other source of support and he is lost to the dental research community. In contrast, Institutional Awards permit the trainee to enter the program in a matter of days or weeks.

It is also noted that there has been no change in the level of support for the Dental Research Institutes and Centers Program. These five institutes, now in their tenth year, are beginning to develop coordinated clinical capabilities. Much of the basic information obtained from approximately 200 on-going laboratory studies will be applied to new projects of clinical relevance. This action represents one of the true purposes of research. It is recommended that an additional $950,000 be appropriated to support these new projects as well as for the replacement of worn and obsolete laboratory equipment.

With reference to destructive periodontal disease, interceptive therapy can often stop the progress of the disease, however, the amount of bone that is lost during active disease is practically irreplaceable. It would thus seem logical that greater emphasis should be placed on the

preventive aspects of the disease in studies similar to those in the prevention of dental caries. Proper identification of the microorganisms associated with the various stages of periodontal pathology needs special attention. It is recommended that an additional sum of $800,000 be appropriated for these aspects of the periodontal program.

Reliable methods must also be found or developed whereby an accurate diagnosis of oral cancer can be made at an earlier stage of the disease. The only existing, universally acceptable method at the present time is that of excisional biopsy and subsequent microscopic examination of the tissues. Early malignant lesions resemble many benign conditions, hence some type of topically or locally applied disclosing agent needs to be identified and evaluated. The sum of $400,000 is recommended for these studies.

Severe overcrowding of present NIDR laboratory and clinical work spaces has seriously handicapped the Institute's research efforts. The NIDR Forward Plan 1979-1983 calls for an increase in clinical research by NIDR Institute Staff as well as the establishment of two new laboratories of Pharmacology and Microbiology. No expansion of these programs is possible because of limited facilities. In addition, because of the lack of space, many programs are being conducted in rented areas in various buildings off campus in Bethesda and Rockville. Consolidation of the staff into one location would result in greater efficiency and productive efforts.

A resolution calling for alleviation of the current space shortage by means of a new extension to Building 30 has been approved by the NIDR Board of Scientific Counselors on October 31, 1975, the National Dental Advisory Council on November 20, 1976 and the Council on Dental Research of the American Dental Association on March 4, 1977. Preliminary studies indicate that 35,750 square feet of new space will be required to fulfill these needs at an estimated cost of $8,008,000. It is highly recommended that initial funds in the amount of $850,000 be appropriated for the National Institutes of Health buildings and facilities budget to support the costs of engineering, design and planning procedures.

## STATEMENT OF ANNE MURPHY, DIRECTOR OF NURSES, BURLINGTON INDUSTRIES, INC.

PREPARED STATEMENTS

Senator MAGNUSON. You are Ann Murphy?

Ms. MURPHY. Yes, sir.

Senator MAGNUSON. Who do you represent?

Ms. MURPHY. I work for Burlington Industries, but I am here in the interest of the Arthritis——

Senator MAGNUSON. Yes. I understand that.

Can you put your statement in the record? We will read it.

Ms. MURPHY. Yes. I would prefer to give it, naturally.

Senator MAGNUSON. We will read it. We read all of these.

I just got stuck here. I can't help it. I am late over there now.

We will read it. We are sympathetic to what you have to say, I am sure.

Ms. MURPHY. Well, I too, have been listening to testimony this afternoon and all these prime diseases are so important and I admire you for the work you are doing.

Senator MAGNUSON. We will be very happy to include any other written statements into the record.

Thank you very much.

[The statements follow:]

## STATEMENT OF ANNE MURPHY, R.N.

Mr. Chairman:

I am Anne Murphy, Director of Nurses for Burlington Industries, Incorporated. As an Occupational Health Nurse, I have over the years recognized and seen the devastation that arthritis can cause the working community. It's a known fact that arthritis has been the cause for tardiness, absenteeism, low productivity and for many disability claims. Early retirement because of disability caused by arthritis is reported to have increased by 500 per cent between 1955 and 1974. Currently, the amount of Social Security Disability Insurance paid annually to former workers, whose claims of disability because of arthritis have been recognized, exceeds $1.1 billion. In addition to the permanent loss of these trained workers, the Public Health Service estimates that nearly 15 million days are lost from work each year because of arthritis. This represents a great expense to the employer and to industry; moreover, it is extremely costly to the nation's economy and to the afflicted individual.

Although we are all aware that the group of diseases called "arthritis" ranks second only to heart disease as a cause of disability, absenteeism and financial loss, to date there have been no concentrated programs in the United States to help alleviate or rectify this situation. Only recently in North Carolina have we had the opportunity and the funding through the help of the Regional Medical Program and The Arthritis Foundation to jointly initiate a program to provide the facilities, personnel, and training programs aimed at improving available arthritis care, from diagnosis to back-to-work programs, for the employees in Burlington Industries.

Through this pilot program, which we all call our "Arthritis in Industry Program", we provide professional training for each industrial nurse of six selected pilot plants, wherein each nurse is trained in early detection of arthritis, and to enchance her knowledge of counselling, monitoring and referring patients. Further, it includes a patient education component which encourages employees to seek early treatment of their disease at clinics or "centers" which are located closest to their places of employment. Proper employee and employer education will certainly reduce the present problem of arthritis victims from hiding their disease for fear of losing their job. It is too early in the program to come up with the actual statistics on the amount of reduction that we have accomplished on absenteeism and low productivity, but our nurses are beginning to have success with getting employees to seek counsel about their arthritis problems, whereas in the past the majority of them would never say much about it.

Our nurses, too, are more alert to early symptoms of the disease and may therefore initiate the conversation. The program has encouraged the employee to consult with the Plant Nurse, and she in turn has encouraged the employee to seek early treatment. She has also been able to follow along with the patient to insure that he is following the prescribed management procedures that were set forth by his physician or the specialist by whom he has been attended. We feel the educated Plant Nurse is going to save both employer and employee time and money by performing these detection, referral, monitoring and counseling functions within the place of employment.

As an example of what can be accomplished through the program, let me

cite just one example. A widow with three children was just about ready to quit work and go on welfare. Her productivity was extremely low and she was an absentee problem. The Plant Nurse had noted before our arthritis program began that this employee walked with some difficulty, but she had had this problem for some time. The nurse was not sufficiently astute at being able to connect this walking problem, the absenteeism and the low productivity with arthritis until she had received her training in our program. She then went back to this employee, confirmed the diagnosis of arthritis, and talked her into going to the University of North Carolina Medical Center at Chapel Hill to see a rheumatologist there. At Chapel Hill they were able to treat her arthritis, fit her with orthopaedic shoes and return her to work with a renewed spirit in life. This woman is no longer an absentee problem, and her productivity has improved tremendously. And, when she returns home at night to her three children, she's not exhausted like she was before her arthritis was treated, so she is not only a better employee, but also a better mother. She thinks it's absolutely marvelous what has been done for her.

To accomplish this, it takes time, teaching staff, clinics and a good coordinated effort by industry itself. We could never have produced our program, nor could we have made it as successful as it is, without the help of the medical institutions in our State, and what we refer to as our "arthritis centers". They have provided the teaching staff, and professional staffing of the few clinics that we have in the State, so that we have a place to which we can send our patients. The centers have provided the other back-up personnel through training programs so that these new additions to the arthritis team can then counsel and treat our employees.

Each of the nurses that are in our pilot program in the six pilot plants have received over 70 hours of instructional training in what we call "on-campus" time. This means that each of the nurses have attended scheduled work shops, symposia, clinical training and counsultation periods. Each nurse has been provided a limited professional library, and has immediate access to the center's facilities, and to the center's personnel, so that she in turn can bring first hand knowledge to the employee that something can be done -- that there are places where a person victimized by arthritis can go for treatment. Employees are thus encouraged to seek help for their disease rather than hide it and permit it to continue until it gets to the crippling stage.

We at Burlington Industries are very satisfied with the results of our program thus far, however, we do recognize that this program could not have been successful without the resources of North Carolina's arthritis center, its facilities and its personnel. Therefore, I strongly urge this Committee to place heavy emphasis and to provide financial support for the development of Arthritis Centers, in order that the training of Occupational Health Nurses may be incorporated in the educational programs of the Centers and that within these same Centers employees may actually receive treatment by a Rhumatologist. In addition, funds should be provided to Arthritis Centers to train and staff outreach clinics, which will in turn enable more arthritis victims to receive early diagnosis and treatment.

The emphasis in Occupational Health is Early Detection and Prevention. The Occupational Health Nurse has closer contact with the working population, and is in a pivotal position for early recognition of a disease's manifestations, and counseling the employees, not only about their problems but those of their families as well. With this additional training provided through these Arthritis Centers,

the Occupational Nurse will be sensitive to these early symptoms long before the employee would recognize or admit the seriousness of the problem to a degree sufficient to motivate him to seek medical diagnosis and treatment.

With the possibility of expanding the distribution of the outstanding educational materials provided by The Arthritis Foundation, the training of competent Rhumatologists, and the development of conveniently located outreach clinics, staffed and supervised by personnel properly trained in Arthritis Centers, a new approach to this national health problem can finally be realized.

However, this realization will only be possible if Congress appropriates the funds authorized by the National Arthritis Act for arthritis centers -- $18.7 million; for community demonstration projects, such as the one at Burlington Industries -- $3 million; and for a national arthritis data system so that we may all be better informed about what is happening in other parts of the country in respect to arthritis research and in regard to innovative community programs, which will hopefully improve the delivery of care to the nation's 20 million arthritis victims -- $1 million. This is such a small total amount -- $22.7 million, about $1 per arthritis patient, especially when you consider what an enormous amount of good it could do.

## STATEMENT OF DAVID D. SHOBE

DIMENSIONS OF THE PROBLEM

Disability retirements attributed to musculoskeletal impairments increased by 500 percent between 1955 and 1974. Arthritis and related musculoskeletal diseases currently account for approximately 15 percent of Social Security Disability Insurance payments. The value of these payments is estimated at $1.1 billion, plus another $300 million which goes to the dependents of those disabled by arthritis, America's number one crippling disease. Nearly a half million persons, including dependents, are involved in this support program. In addition, nearly 160,000 persons are receiving $150 million a year in VA benefits because of arthritis.

Only heart disease outranks arthritis as a major cause of limitation of activity. In respect to limitation of mobility, arthritis is responsible for twice the cases attributable to heart condition -- 24.4 percent vs. 12.6 percent.

Approximately 3.5 million Americans are disabled by arthritis, nearly 750,000 of whom either require assistance in moving from place to place, or are confined to their beds. These figures relate only to the non-institutionalized population. According to the 1969-70 Public Health Service Household Interview Survey, over 14 million work days are lost each year because of arthritis.

The worker disabled as the result of arthritis is treated with almost complete neglect by his employer and by the rehabilitative system, especially the Vocational Rehabilitation Administration, which in 1973 reported only 4,710 arthritis patients as being "rehabilitated", representing 1.3 percent of the VRA "population". This neglect must be irradicated if arthritis victims are to avail themselves of todays possibilities for rehabilitation.

Not all the blame can be attributed to industry or to the VRA. Much is the result of personal neglect. A recent survey by the Arthritis Foundation found that less than five percent of those severly disabled with arthritis and receiving disability insurance seek VRA assistance. The reasons given were (1) age; (2) lack of motivation resulting from a self-assessed unsuitability for being retrained for another job; (3) lack of sufficient or no prior work experience; (4) inadequate education; (5) discriminatory hiring practices, even with disability waiver; (6) risk of loss of disability compensation when re-employment is viewed as holding only short-term prospects for monetary gain, and eventual loss of income over the long-term; (7) unwillingness of employers and unions to allow jobs to be adapted to the applicant's disability in the belief that this job would henceforth be "frozen" and available only to persons "qualified by disability"; and (8) the inordinate length of time required to go through the VRA rehabilitative process, be re-trained, and then wait for a position which may never develop.

With accessability to care as one of the nation's major concerns, accessability for disabled arthritis victims to care is especially important because of the economic impact this disease has on the national economy.

Obviously if we are to reduce the economic impact of arthritis, we must pay special attention to the educational needs of the 20 million patients with arthritis as well as their medical needs.

In addition to the 95 percent of severely disabled persons with arthritis who reportedly do not seek VRA assistance, recent surveys show that 12 million of the 20 million Americans with arthritis are not under a physician's care for this

problem. Why? Fear? Ignorance? Lack of motivation? Lack of financial support? Lack of family support?

There are serious psychological accompaniments to arthritis caused by the progressive pain, debilitation and deformity caused by the disease. Some victims becomes slaves to their disease, relegating themselves to lives of loneliness, desertion by their families, and to the general abhorrence with which the well often treat those who are lame and disfigured. The emotional and psychological effects of arthritis are thus often as delibitating as the disease itself, and tend to exacerbate the disease process in an as yet not understood manner.

There are few persons with arthritis who today cannot be helped in some way, even though none of the causes of the some 100 forms of arthritis are yet known. Drug therapy, physical therapy, corrective surgery, psychological counseling, and vocational guidance are all available but too often the patient is not placed in contact with the few health professionals who are trained in the modern management of arthritis.

Let us look at what we can do with one group of arthritis victims, -- those who face disability retirement because of their disease.

ARTHRITIS IN INDUSTRY

Analysis of the relationship of the problem of the arthritis patient as it relates to industry requires consideration of several factors. One factor is the relationship of occupation to the etiology of certain rheumatic diseases. Evidence indicates that some forms of rheumatic disease, particularly osteoarthritis, are in part occupational or traumatic and thus preventable or capable of modification. In addition, it is important to evaluate the prevalence of rheumatic complaints in the working population and to assess the effect on work capacity and work loss. Finally, of major import to both patient and industry, is the problem of employability of the arthritis patient.

It has been demonstrated in a number of studies that patients with major arthritic diseases are capable of effective full-time or part-time employment. The success of intensive rehabilitation programs in improving functional status and enabling up to 40 percent of patients disabled by rheumatoid arthritis to return to full-time employment is well-documented. Sample estimates of costs and benefits accruing from such programs have been made. In one British series, the cost of treating 100 cases was $40,000, which was offset by annual earnings of $90,000 by those placed in employment. Such programs include vocational guidance, the importance of which is well illustrated by the work of the New York State Employment Service. In its studies during the 1960's, although only one in four arthritis job applicants was initially successful, expert help in selective occupational placement resulted in 80 percent finding employment.

Effective placement and work capabilities requires taking advantage of good personal attitudes and motivation on the part of the patient, appropriate rehabilitation techniques, intensive medical therapy, and full cooperation of knowledgeable persons in industry. Employer attitudes must change from a negative to a positive stance in accepting and retaining handicapped patients.

Goals of programs in industry should include those directed toward decreased absenteeism, employment for the first time of those patients with arthritis,

and return of the arthritis patients to their previous employment. Great ingenuity has led to the availability of adaptive equipment and work methods for the severely handicapped which allows successful employment in industry. Transit to and from work can be designed to provide practical methods for the maintaining employment. Reduced absenteeism and continued employability of patients with arthritis diseases can lead to substantial savings in terms of monies otherwise necessarily provided by public welfare programs.

Rehabilitation with respect to employment requires a team effort program. The team includes the individual patient, his employer, social services already available to the community, physical therapy and occupational therapy facilities, vocational guidance and placement services, work shops and knowledgeable people in industry. A review by vocational counselors allows determination of prognosis of disease and the presence of disability which might adversely affect future employment. It is essential that the counselor have intimate knowledge of the requirements of the job at which the patient is to be employed and to provide confidence to the patient in the future. Close contact both with union and management personnel is of major importance.

Although some of the goals identified above can be accomplished to some degree by presently available resources, maximal achievement in solving the problem of employment of arthritics in industry requires development of large, well-organized work classification and employment centers. The goal is to place the handicapped arthritic individual in profitable employment, so that he retains his dignity, avoids becoming a public charge, and resumes his place as a taxpaying citizen. Strong interrelationship with available government and voluntary vocational rehabilitation services is obviously indicated. Consideration should be given to protection of the employer by a "hold harmless clause" backed by appropriate legislative measures which provide protection to industry resulting from such disabilities.

## THE CONTROL OF ARTHRITIS IN INDUSTRY

Most arthritis patients in industry try to cover up their disease for as long as possible for fear they will be fired. Most industrial nurses report that their first knowledge of a worker with arthritis is when they come in for their retirement counselling session. The chronic absenteeism of many arthritis patients who are trying to self-medicate is apparently seldom investigated. Only when their disease becomes too painful and disabling does the average worker with arthritis opt for disability retirement. By then, the disease has taken its toll, and rehabilitation is made much more difficult.

The earlier in the disease process an individual with arthritis can be identified, the greater the possibility for effective rehabilitation and control of the disease process. The initial years of rehabilitation in arthritis are the most critical and the most intensive, for if good management practices are not introduced at this point, the possibility of acute exacerbation becomes increasingly great.

And, since arthritis is a progressive disease, marked in certain forms by both acute episodes and sudden remissions, it must be carefully and regularly monitored, and the patient's total condition periodically re-evaluated to ascertain the degree of compliance with therapy, the effectiveness of the therapy, and the degree to which debilitation has either progressed or has been stablized.

There are numerous forms of lesser arthritic or rheumatic complaints and disorders which are almost impossible to objectify. These include bursitis, tendivitis, low-back syndrome, neck and single-joint problems, tenosynovitis, etc. Some may be brought on by trauma, strain or excessive (unaccustomed) exercise. Many are easily treated, even in the acute form, and will gradually disappear. In some instances, changes of normal activity, even one's job, may be neccessitated to ameliorate the stresses and strains which could have caused the temporary diability and which could exacerbate it if continued.

Thus, industry must learn how to set the psychological stage whereby a worker will no longer feel threatened if his arthritis is found out. Industrial physicians and nurses must be trained in the diagnosis of arthritis and must be made aware of community resources which can be brought to bear upon the needs of the patient.

Epidemiological studies of industrial populations should also be undertaken to examine factors of environment, stress, age, sex, ethnic group, familial aggregations, trauma and joint strain to see how these relate to the development, prevelence and exacerbation of arthritis.

THE NEED TO EDUCATE

The problem of inadequate information about arthritis being made available to the general public, to patients and to health professionals has already been noted as key to much of the disability caused by this disease. The National Commission on Arthritis and Related Musculoskeletal Disease cited the need for improved education at all levels as the number one priority in the implementaion of The Arthritis Plan.

Much of this education -- of the public, of patients, and of health professionals -- can be accomplished through a national system of Arthritis Centers which would work closely with The Arthritis Foundation and its 73 local chapters. The Foundation began the initial financing of such a centers' system in 1965 and is now providing token support to some 44 "centers", which are basically Rheumatology Units or Divisions in medical schools. The present level at which the Foundation is able to assist these "centers" is grossly inadequate to needs. This is demonstrated by the fact that when the National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD) circulated the initial call for Arthritis Center grant applications last fall, 66 institutions responded, asking for over $25 million in aid, ten times that which was appropriated in the FY1977 budget. Therefore, for FY1978, the Foundation is requesting that $12.2 million be made available for Arthritis Centers, an amount still far from meeting the diverse needs of the applicant institutions in respect to the training of health professionals, patient and public education, community demonstration projects, and basic and clinical research.

During the past three years, over $9 million has been spent on arthritis outreach programs under the aegis of the now defunct Regional Medical Programs. These programs have been eminently successful for the most part in bringing knowledge from the medical center out into smaller communities where the general practitioner is the one from whom the average citizen seeks aid when suffering from arthritis. Unfortunately, 70 percent of these physicians have never been

exposed to any formal training about arthritis, so the care they are capable of dispensing is sometimes minimal, sometimes non-existent, sometimes harmful, but seldom very effective. These physicians, their patients, and the allied health personnel who work with them, need to be brought into the mainstream of modern management of the arthritis patient. This will not happen without some stimulus from the Federal Government. And, unless, and until it does, millions of Americans will continue to receive grossly inadequate care, and thousands each year will continue to join the lists of those disabled by arthritis, unable any longer to lead fruitful, productive lives.

Despite this crying need, Congress failed to appropriate a single dollar for community demonstration projects in arthritis in FY1977, although $3 million was specifically authorized for this purpose. The Foundation is requesting that $2 million be appropriated for community demonstration projects in FY1978, and that the Associate Director for Arthritis be given adequate staff to effectively oversee these projects as well as for the administration of the Arthritis Centers program.

WHAT WILL AN ARTHRITIS CENTER DO BESIDES EDUCATE?

Arthritis is a uniquely human disease. It cannot be wholly duplicated in an animal model. Thus, clinical, or bedside, research is together with basic research, a requisite component of a national attack on arthritis. Clinical research, however, cannot easily be performed when arthritis patients are spread all over a hospital's wards. There therefore needs to be a central focus for clinical research, yet there are even very few teaching hospitals which have concentrated their arthritis patients in a single area to which the rheumatologist, orthopaedic surgeon, physical therapist, nurse, social worker, occuptional therapist, and other members of the arthritis team can then attend. There is, however, a trend in this direction to which the Federally-funded Arthritis Centers program could make a major contribution, benefitting both patients and researchers, reducing duplication of effort, and leading to major reductions in patient care costs, especially when extended care facilities and out-patient care can be used as viable options to in-patient care. This of course will require major changes in the structure of third party payments for medical care.

There also needs to be a certain degree of targeted research in arthritis. During the hearings on the National Arthritis Act before the House Subcommittee on Public Health & Environment, the Director of the National Institute of Arthritis, Metabolism & Digestive Diseases (NIAMDD), Dr. G. Donald Whedon, provided a breakdown of the $8,343,000 expended on extramural research grants in arthritis during FY1974. Only $388,000 was spent that year on research into the causes of Juvenile Rheumatoid Arthritis, which affects some 400-500, children in the U.S.; $420,000 was spent on research in osteoarthritis which affects 13-14 million Americans; and only $344,000 on gout which affects 900,000 - 1,000,000 persons in this country. Systemic lupus erythematosus (SLE), which is a potentially fatal disease in young women if not treated quickly and expertly, although funded at a slightly greater rate -- $608,000 -- is considered underfunded by at least three hundred percent. These are only a few of the major areas of arthritis which are begging for greater attention and for research results which will bring some greater relief to the millions disabled by these diseases.

Another primary research area is how torn cartilage relates to arthritis. Sports injuries often cause serious arthritis later in life if not properly cared for. Knowledge in this area is still insufficient to prevent several thousand high school and college athletes each year from facing possible crippling in their 40's. Only $179,000 was spent on research in this area in 1974.

The Foundation is requesting an increase of $5,595,000 in the arthritis research budget of NIAMDD in FY1978 to meet these critical needs.

EXPLANATION OF ENCLOSED BUDGET CHART

The enclosed Budget Chart reflects the Foundation's hopes for FY1978, in respect to the arthritis programs of NIAMDD. Of the $16.7 million increase requested over the President's Budget, half would go to Arthritis Centers, one-third to Research, and lesser amounts to initiate priority programs recommended by the National Arthritis Commission and authorized by the National Arthritis Act, as amended: Community Demonstration Projects, National Arthritis Data System, and a National Arthritis Information Services program. We also request that $300,000 be made available to the Institute to fund the activities of the National Arthritis Advisory Board.

ARTHRITIS PROGRAMS OF THE
NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM
AND DIGESTIVE DISEASES - FY1976 - FY1978

(Amounts in Thousands of Dollars)

| | Research Grants | Centers | RCDA | National Research Service Awards | Training Grants | Comm. Demon. Proj. | Data | Nat'l Info. Svs. | Contracts | Sub-total Extra-mural | Intra-mural | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FY1976 | 13,604 | 0 | 420 | 402 | 28 | 0 | 0 | 0 | 465 | 14,919 | 3,176 | 18,095 |
| FY1977 | 13,389 | 2,500 | 394 | 986 | 0 | 0 | 0 | 0 | 1,300 | 18,569 | 3,820 | 22,389 |
| Authorized FY77 PL93 640, & PL94-278 | | 20,000 | | | | 3,000 | 1,000 | | | | | |
| Pres. Ford's proposed FY78 | 14,253 | 4,200 | 717 | 1,202 | 0 | 0 | 0 | 0 | 1,300 | 21,672 | 4,089 | 25,761 |
| Arthritis Commission's proposed FY78 | 28,781 | 24,000 | 1,200 | 2,750 | 0 | 5,000 | 1,500 | 750 | 2,500 | 67,481 | 4,750 | 72,231 |
| Foundation's proposed FY78 | 19,284 | 12,200 | 717 | 1,421 | 0 | 2,000 | 500 | 400 | 1,600 | 38,122 | 4,339 | 42,461 |
| Increases over FY78 Pres. Budget | 5,031 | 8,000 | | 219 | | 2,000 | 500 | 400 | 300 | 16,450 | 250 | 16,700 |
| Authorized PL94-562 | | 18,700 | | | | ** 3,000 | 1,000 | | * 300 | | | |

* For National Arthritis Advisory Board

** Includes Public Information Projects such as those envisaged as being carried out by the National Arthritis Information Services.

## STATEMENT OF EPHRAIM P. ENGLEMAN

The Congress of the United States has become increasingly aware, in recent years, of the inadequacy of federal support of research, training, education, and other efforts to combat arthritis. This growing awareness has largely been the result of the selfless labors of The Arthritis Foundation and members of the arthritis community throughout the country. On December 21, 1973, Senator Alan Cranston of California, joined by Senators Jacob Javits of New York and Harrison Williams, Jr., of New Jersey, proposed legislation that eventually led to the National Arthritis Act. Companion legislation was introduced in the House of Representatives by Congressman Paul Rogers of Florida, cosponsored by Congressman Tim Lee Carter of Kentucky.

Congressional hearings, conducted in the fall of 1974, documented the enormous medical, social, and economic consequences of arthritis on patients and on society in general. It was apparent from the testimony presented that the rheumatic diseases had been seriously neglected by health agencies at the federal, state, and local levels. In December 1974, Congress unanimously approved the National Arthritis Act of 1974, and on January 4, 1975, the Act was signed into law by President Gerald Ford. By this action the Congress and the President recognized the magnitude of the arthritis problem in the United States: the 22 million victims of all ages, children as well as adults; the catastrophic effect of arthritis on the economy in the amount of $13 billion; and even more important, the devastating effect of these diseases on the quality of life of the victims and their families.

In addition to other charges, the Act instructed the Secretary of Health, Education, and Welfare to establish an 18-member National Commission on Arthritis and Related Musculoskeletal Diseases to study the arthritis problem in depth, and to develop an Arthritis Plan with specific recommendations for action. The membership of the commission was drawn from a wide spectrum of disciplines and lay people from outside the government and also included appropriate governmental officials.*

In its development of the Arthritis Plan, the Commission surveyed existing arthritis activities (as requested in the Act); it heard testimony in cities all over the country from patients and their families, senior citizens, labor, management, state and local government representatives, and the general public. The Commission also sought the opinions and recommendations of leading scientists, educators, physicians, and other health professionals, many of whom are not rheumatologists. These experts were appointed to six Work Groups: Community Programs, Data Programs, Education, Epidemiology, Research, and Public Policy.

From all of the sources of information tapped by the Commission, it is apparent that much that can be done for the arthritis patient is not being done. There are obvious, serious deficiencies in our knowledge and thus in our ability to develop more effective methods of treatment. Nevertheless, it is a fact that many arthritis patients who could benefit from current knowledge are not receiving adequate care. It is not difficult to identify the reasons for this intolerable situation—the lack of professional manpower, the need for education, not only of physicians and other health professionals, but also of the patient, his or her family, and the public at large. Current arthritis programs of every kind, including research, and at every level, public and private, are totally inadequate. New programs must fulfill the requirements of today's patients as well as the patients of the future. At the same time greater efforts toward more lasting solutions to the arthritis problem must be undertaken.

The report of the Arthritis Commission to Congress was presented on May 6, 1976. It is published in four volumes.

Volume I—The Arthritis Plan, available on request from the NIAMDD, Bethesda, Maryland

Volume II—Work Group Reports

Volume III—Survey of Current Programs

Volume IV, Parts I through IV—Public Hearings

The Arthritis Plan suggests no dramatic or immediate solution to the full problem of arthritis. The proposed programs, whether educational, research, community, or other, are justified and advocated by the Commission on the basis of how well they will benefit the patient. The Plan calls for both short-term approaches—doing what can be done now—and long-term programs aimed at improving knowledge about etiology and pathogenesis, and developing better treatments and better techniques to utilize community resources for the best possible patient care.

Because of the dramatic consequences and sometimes dramatic "cures" of the more acute diseases, health services and research in this country have tended to focus on these acute conditions. The enactment of the National Arthritis Act is indicative of a growing awareness of the need to devote more attention to the difficult and costly problems of chronic disease. With this in mind, the Arthritis Plan has been designed so that it can also be applied to programs for the control of other chronic diseases.

### Goals of the Arthritis Plan

There are six major long-range goals of the Arthritis Plan.

1. Every American should be aware of the early symptoms of arthritis and recognize the need to seek care.

2. Every primary and family physician should know criteria for early diagnosis of arthritis, techniques of treatment, and when to refer patients for specialized care.

3. Teaching programs in arthritis should exist in every medical school.

4. Research efforts should be greatly intensified to achieve major improvements in the treatment of arthritis.

5. Arthritis centers or community programs should be accessible to major population areas.

6. Arthritis programs should be developed as models for action against other chronic diseases.

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From the University of California School of Medicine, San Francisco, California.

Presented in part at the 40th Annual Scientific Session of the American Rheumatism Association, Chicago, Illinois, June 11, 1976.

Ephraim P. Engleman, M.D.: Chairman, National Arthritis Commission, and Clinical Professor of Medicine, University of California, San Francisco.

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Submitted for publication September 21, 1976; accepted September 22, 1976.

* The members of the Commission are Verna Patton Anthrop, PHN, K. Frank Austen, MD, Rosalind Russell Brisson, William F. Donaldson, MD, William R. Felts, MD, William Gay, DVM, Howard Jenerick, PhD, Ronald LaMont-Havers, MD, Lt. Col. Oliver J. Lawless, MD, USA, Vivian Floyd Lewis, PhD, Doris Melich, Neil Olchin, MD, Howard F. Polley, MD, Gordon C. Sharp, MD, Marlin N. Shields, RPT, G. Donald Whedon, MD, William H. Batchelor, MD, Executive Secretary, and Ephraim P. Engleman, MD, Chairman.

## Arthritis Centers

The major new authorization of the National Arthritis Act and a keystone of the Commission's Plan is the immediate funding of arthritis centers throughout the country. Each center can be defined, not as a structure of steel and concrete, but as a group of cooperating health personnel whose program and facilities are designed to demonstrate and stimulate the prompt and effective application of available knowledge, and to develop urgently needed new knowledge. Centers would carry out activities in each of the three areas of education, research, and community resource development, but they need not do all things with equal emphasis. They would seek to strengthen those areas in which they are weak. Some may wish to specialize in a particular area, such as pediatric arthritis or rehabilitation or a specific disease entity. Some may choose to collaborate with other similarly specialized centers.

Of the many possible center activities, the highest priority should be given to training and education. Because primary care physicians—family physicians, general internists, and general pediatricians—will probably continue to provide care for the vast majority of arthritis patients, these professionals must receive adequate training in arthritis. This training should be provided in the center for students, house officers, and physicians already in practice. More practicing rheumatologists should also be trained. There is a particular need for pediatric rheumatologists, orthopedists skilled in arthritis, and physiatrists, and there should be educational programs for allied health professionals, patients, their families, and the public at large.

In order to fulfill these educational goals, it is apparent that the greatest emphasis in the centers' educational program must be given to an intensive training program for professionals who will ultimately serve as career educators and leaders. These individuals will be indispensable to the development and implementation not only of the educational activities but of all other programs in the Arthritis Plan as well. As indicated above, training and educational activities should be given the highest priority in the centers, especially in the early years of the Plan. As educational and training activities are implemented, increasing program emphasis in the center should be placed on research and other programs.

Each center should have a carefully planned research activity, or a demonstrated ability to develop such an activity. This function is important not only as a contribution to the ultimate solution of the problem, but also as a scholarly component of the educational and community-related efforts. Much of the research within an individual center may be funded by governmental or private sources other than the center grant.

The kinds of community activities that the center might develop could include systems of referral that link the service of centers with those provided in the community. The centers would stimulate the development of arthritis programs in the geographic region they serve through satellite clinics, mobile units, and whatever other techniques might be used to demonstrate the best possible care to patients. The center would encourage community action against arthritis, identify community leaders, include them in program planning, and offer technical advice. Indeed the Commission recommends a community liaison officer in each center.

Each center would be established within either an individual teaching institution or a consortium of such institutions and would be designed insofar as possible to match its program to community needs. Emphasis should be placed on establishing enough centers to provide for widespread geographic representation, rather than on establishing a few "megacenters." Some centers would be built on existing programs that already have strength and commitment in the basic areas of activity; others would be built where current efforts are limited and need strengthening; and still others would be established as new programs in institutions demonstrating the commitment and potential to develop an effective program. Center awards to the last group offer an excellent vehicle by which arthritis programs can be established in the 26 medical schools now lacking such programs.

The Plan proposes that $18.7 million be available to support centers in fiscal year 1977. It is suggested that individual center grants would range between $150,000 and $500,000.

## Community Demonstration Projects

Over and beyond the community activities to be carried out by the centers, the Commission recognized the need for community programs that are actually initiated by the community itself. The Plan therefore calls for independent community demonstration projects that will determine local needs, organize existing resources, and develop resources to meet these needs. Some of the activities that might be included in community projects are public and professional educational programs in arthritis; programs to provide psychologic and social support to arthritis patients such as group therapy, self-help projects, and recreation programs; programs to help patients modify their homes to accomodate their physical incapacities, and to encourage modification of public buildings and greater access to public transportation; job and industry programs that emphasize long-term vocational guidance, retraining, and reemployment; development of more ambulatory care services including outpatient rehabilitation programs and halfway houses to reduce the need for expensive hospitalization; transportation programs to help patients get to treatment sites; and many others.

As in all aspects of the Arthritis Plan, evaluation of these community-initiated projects is essential at all levels of planning, development, and operation. The Commission proposed that any federal funds allocated to community demonstration projects should be considered seed money, with the stipulation that successful projects would eventually be supported through local resources. Any interested community group with an organizational structure and with appropriate professional management and fiscal capability might initiate such a community demonstration project. The Plan calls for $3 million to be appropriated to support such projects in fiscal year 1977.

## A National Arthritis Data Program

The National Arthritis Act calls for the development of a national arthritis data system to be used primarily for screening and detection. The Plan recognizes that these are only two of the many areas that might benefit from the development of such a national data system. Others could include the evaluation and improvement of patient care, measurement of therapeutic effectiveness, analysis of drug interactions and toxic effects, analysis of banked serum, registry of biomaterials and devices, assessment of implants, epidemiologic studies, assistance to educational activities, and community resources development.

The Plan calls for gradual development of the system through a program of research and development grants that would be available to those who are interested in working on various components of the system. Thorough evaluation and documentation of the usefulness of all components would be demonstrated before incorporation into a nationwide program. Special attention would be given to maintaining patient confidentiality and to the reliability and objectivity of the data entered into the system.

It is proposed that $1 million be allocated to support the data program in the initial year. This allocation would be expanded incrementally in later years to allow for growth and expansion of the system, based on demonstrated accomplishment.

## Special Activities

Several other projects are proposed that would have a major impact on many components of the Arthritis Plan. They include a detailed survey of professional manpower to give an accurate guide to future needs in each category of teaching, research, and practicing professionals; a survey to identify and assess the rehabilitation resources available for arthritis patients; and a National Arthritis Information Service to be a readily accessible source of objective, up-to-date information for patients, government officials, the media, and the general public. It will also design and test new educational and informational approaches.

## Arthritis Research

In addition to the above recommendations for specific programs authorized in the Arthritis Act, the Commission was asked to assess the need for additional support for arthritis research. Important and exciting investigations, especially in genetics, virology, and immunology, offer the promise of major advances in understanding the causes of the rheumatic diseases. Based on an intensive analysis of existing governmental support, primarily from the National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD) and other Institutes in The National Institutes of Health (NIH), the Commission recommended that funds for arthritis research should be doubled.

As noted in Table 1, the total expenditures of NIH for arthritis-related research in fiscal year 1975 was $33 million. This sum represents only 1.5% of the total NIH research budget, and yet these diseases afflict more than 10% of the population. Current research expenditures for heart disease and cancer are 10 and 20 times greater than those for arthritis (Table 2). To begin correcting this imbalance, the Plan recommends that $67 million be allocated for arthritis research and research manpower—exclusive of epidemiologic research and manpower—in fiscal year 1977 (Table 1). At the outset the highest priorities should include investigations in the fields of rheumatoid arthritis, osteoarthritis, arthritis in children, systemic lupus erythematosus, infectious agents, immunology, inflammation, genetics, and bioengineering techniques.

**Table 1.** *National Arthritis Plan Distribution of Arthritis Research Dollars by Institute in FY 1977 (in Thousands of Dollars)*

| Institutes | FY 75 Expenditures | Proposed FY 77 Additional Dollars | FY 77 Total |
|---|---|---|---|
| National Institute of Arthritis, Metabolism and Digestive Diseases | $13,623 | $14,049 | $27,672 |
| National Institute of Allergy and Infectious Diseases | 7,774 | 8,047 | 15,821 |
| National Institute of Aging | 4,014 | 4,132 | 8,146 |
| National Institute of Child Health and Human Development | 3,664 | 3,809 | 7,473 |
| National Institute of Dental Research | 2,055 | 2,119 | 4,174 |
| National Institute of General Medical Sciences | 1,620 | 1,679 | 3,299 |
| National Heart and Lung Institute | 214 | 257 | 471 |
| National Institute of Neurological and Communicative Diseases and Stroke | 85 | 117 | 202 |
| National Cancer Institute | 41 | 26 | 67 |
| National Institute of Environmental Sciences | — | — | — |
| National Eye Institute | — | — | — |
| Total | 33,090 | 34,235 | 67,325 |

**Table 2.** *Research Expenditures in FY 1975—Cancer, Heart Disease, and Arthritis (in Thousands of Dollars)*

| | |
|---|---|
| National Cancer Institute | $691,666 |
| National Heart and Lung Institute | 324,630 |
| Arthritis research in all Institutes of NIH | 33,090 |
| Arthritis research in National Institute of Arthritis, Metabolism and Digestive Diseases | 13,623 |

A research discipline that has been grossly neglected in arthritis is epidemiology. Few epidemiologists have had the necessary specific training in arthritis and no large-scale epidemiologic study of arthritis is being conducted, even by such agencies as the Center for Disease Control. It is shocking that so little is being done in arthritis to exploit a form of research that identified in heart disease such risk factors as smoking, high blood pressure, and high cholesterol levels. Epidemiologic studies in arthritis not only would pinpoint early symptoms and risk factors, but also would supply essential baseline data needed to show the effectiveness of any control program. The Commission believed that these studies are long overdue and requested $4.5 million for their support in 1977.

* The Plan calls for a relatively small sum of $370,000 to accelerate international cooperation and exchange of knowledge in arthritis. International fellowships would be provided to promising physicians and scientists from other countries to gain research training in the US, and to outstanding teachers and investigators from the US to serve as visiting professors and investigators in institutions abroad.

## Budget

The total budget of the Arthritis Plan for fiscal year 1977 is $97,765 million (Table 3). This sum represents an investment of less than 1% of the annual $13 billion cost of arthritis to the nation's economy. Indeed the budgetary recommendations are conservative and were made after critical assessment not only of the needs, but also of the available manpower and other resources to fulfill the needs.

## Future Directions

The report and recommendations of the Commission represent only a beginning of what the Arthritis Commission hopes will be a major long-term program of action against arthritis. The existing Arthritis Act will terminate in 1977. In order to assure sustained momentum for a national arthritis initiative, the Commission has recommended an extension of the National Arthritis Act for 3 more years, with modifications to reflect the

**Table 3.** *National Arthritis Plan Total Budget Request for FY 1977 (in Thousands of Dollars)*

| Activity | Amount |
|---|---|
| Centers* | $18,700 |
| Community demonstration projects* | 3,000 |
| Data programs* | 1,000 |
| Special activities (manpower survey; rehabilitation resources survey; national special program development)* | 1,300 |
| Research, including manpower | 67,325 |
| Epidemiology, including manpower | 4,530 |
| International exchange | 370 |
| Program administration | 1,540 |
| Total | $97,765 |

* Authorized in the National Arthritis Act, as amended.

program directions outlined in the Plan and to respond better to national needs.

An Associate Director for Arthritis has been appointed by the NIAMDD to assume responsibility for arthritis programs within the NIAMDD and for the administration and implementation of The Arthritis Plan. (The appointment of Lawrence E. Shulman, M.D., as Associate Director for Arthritis for the NIAMDD was announced on July 1, 1976.) Members of the Commission will be available temporarily to advise the Associate Director on guidelines for operation and evaluation of the programs supported under the Act. However the Commission feels strongly that a more permanent advisory body is needed to provide broad policy guidance for the Arthritis Plan. It has therefore recommended that a National Arthritis Advisory Board be appointed by the Secretary of Health, Education, and Welfare for this purpose. The membership of this board should be drawn from a wide spectrum of disciplines and lay people outside of government who have special interests or skills in arthritis. Appropriate government officials would be ex officio, nonvoting members.

An interagency Arthritis Coordinating Committee has been meeting for more than a year to determine how all existing governmental programs can participate in the national arthritis initiative. The Associate Director for Arthritis is Chairman of this committee, and he will work to promote cooperation and coordination among the arthritis-related activities of member agencies. An important function of the National Arthritis Advisory Board will be to review the efforts of the Coordinating Committee and to make recommendations on how the agencies can contribute to achieving the goals of the Arthritis Plan.

## Conclusion

At this time it appears unlikely that Congress or the Administration will approve the Commission's fiscal recommendations for 1977. Just how much money will be available for 1977 is not yet known. Nevertheless, it appears likely that the amount available in 1977 or in any year thereafter will depend largely on the degree of successful mobilization of grass roots demand for action. A clamor for action—a clamor not only by the lay and professional volunteers of The Arthritis Foundation, but also by the 22 million patients and their families—*will* be heard by the lawmakers. Appropriate action would almost surely follow such widespread demand. The arthritis community has a unique opportunity.

## STATEMENT OF ISADORE ROSENFELD, M.D.

Mr. Chairman and Members of the Committee:

I am Dr. Isadore Rosenfeld, Associate Clinical Professor of Medicine, Cornell University Medical College. I am also engaged in the private practice of cardiology in New York City.

I am deeply grateful for the privilege of being able to submit a statement for your consideration on behalf of the appropriations for the National Heart, Lung, and Blood Institute. As you know from my previous testimony before this Committee, I have a deep interest in cardiovascular diseases and am currently serving as a member of the Joint US-USSR Working Group on Sudden Cardiac Death and am Chairman of the Subcommittee on Therapy of the NHLBI Task Force on Hypertension. Several years ago I also served as a member of the Institute's Arteriosclerosis Task Force. As a practicing physician I am much concerned with these disease areas on a daily basis.

Considerable progress has been made in our understanding of heart diseases over the past two decades and this research is now paying off in several ways. In 1975, for example, deaths from all cardiovascular diseases fell below one million in the U.S. for the first time since 1967 despite an ever increasing and aging population. Overall, the death rate for cardiovascular diseases had declined approximately 30% in 1975 as compared to 1950. It is easy to cite a long list of favorable trends in morbidity and mortality statistics and also to list the underlying research accomplishments in such areas as improved diagnosis and treatment for specific cardiovascular diseases but I still find it distressing that we are not able to deal more satisfactorily with many of these diseases in our everyday practice.

As the members of this Committee are well aware, the clinical sequelae of arteriosclerosis are coronary heart disease, (primarily heart attacks), cerebrovascular disease (stroke) and peripheral vascular disease (vascular disease of the extremities). Epidemiological research conducted over the past two decades has delineated and quantified the risk factors associated with these diseases. Such risk factors as elevated serum lipids, high blood pressure, and smoking are well known to you. Arteriosclerosis has its onset during the second and third decade of life but is generally not manifest as clinically overt disease until many years later. Until recently, there has been no direct evidence that the process could be retarded or perhaps even reversed. However, several investigators have now been able to demonstrate regression of arteriosclerotic placques in animals and there is recent suggestive evidence that this may also be made to occur in humans. This is clearly an area of biomedical research that is deserving of immediate and urgent attention. We must improve our understanding of the underlying mechanisms and develop techniques that can be used to retard or delay, indeed even prevent, progressive development of arteriosclerotic placques which, of course, are the underlying cause of most heart attacks and strokes.

As a corollary to this investigation, we must also develop diagnostic instrumentation that can be used to detect the disease early in life, long before overt clinical disease is present. Again, progress is being made in the area of non-invasive, diagnostic instrumentation using special x-ray imaging techniques and other energy sources such as ultra-sound. Research on these and other techniques must continue to be emphasized.

I urge the Committee to appropriate approximately $15 million for this purpose. It would appear that we are on the brink of a major advance in this field and currently available research opportunities must be urgently exploited to the fullest extent possible.

My second area of interest has to do with sudden cardiac death. Something over half of all patients who die of heart attacks continue to do so suddenly, often before they reach medical attention. As a member of the US-USSR Working Group on Sudden Cardiac Death, I have occasion to review programs in progress in these two countries as well as elsewhere. During the past ten years considerable progress has been made in our understanding of the risk factors associated with this syndrome and within the recent past, since 1972, several clinical trials have been reported from Great Britain, Sweden, and New Zealand using a class of drugs known as beta adrenergic blocking agents. Because of deficiencies in study protocols and side effects associated with some of the drugs, the results from these trials are not conclusive; however, the results appear to be highly promising. During the Spring of 1976, the Institute convened a workshop which included many of the investigators associated with these clinical trials to review world-wide experience in this area. From this experience a definitive clinical trial protocol is being developed using a beta adrenergic blocking agent that is only now coming into use for this purpose in this country although it has been used for the treatment of angina pectoris (chest pain) for several years. The clinical trial will involve some 4200 patients who have had at least one heart attack and will require a total of approximately five years for planning, patient recruitment and followup, and data analysis. I urge the Committee to provide appropriations for the full funding of this clinical trial and for a continuation of related basic and clinical research aimed at further elucidation of the underlying mechanisms and risk factors associated with sudden cardiac death. An additional appropriation of $10 million is recommended for this purpose.

Lastly, I would like to speak briefly about hypertension (high blood pressure). As you know, high blood pressure affects some 23 million Americans. It is an important risk factor for strokes and heart failure. We now have the capability for treating most patients with

hypertension; however, the medications must be taken for the remainder of the patient's life and some anti-hypertensive agents currently in use are not without side effects.

As I indicated earlier, I am currently serving as a member of the Institute's Hypertension Task Force and I am Chairman of the Subcommittee on Therapy. The Task Force expects to complete its work and deliver a report early next fall. It will represent a very intensive effort that has taken almost two years. The Task Force may be expected to identify a number of opportunities for further research related to hypertension. It will also identify an urgent need for additional manpower training in this area and for special research resources so that technical advances from other areas of biomedicine can be applied in this area.

I urge the Committee to include an additional $10 million for these purposes and for the continuation and expansion of existing programs of research and high blood pressure education both for the medical professions and the public.

SUBCOMMITTEE RECESS

Senator MAGNUSON. The subcommittee will recess at this time.

[Whereupon, at 4:30 p.m., Tuesday, April 5, the subcommittee was recessed, to reconvene at the call of the Chair.]

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